

HEALTH INSURANCE REFORM IN SHANGHAI AND HONG KONG: USING
THE LENS OF HISTORICAL INSTITUTIONALISM

By

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Abstract

Since the mid-1980s, both Shanghai and Hong Kong have implemented health insurance reform to contain healthcare costs. But the reform result in these two places represents polar extremes. While Shanghai witnessed a revolution in healthcare financing in 2000, Hong Kong remains status quo on healthcare financing. Using the theory of historical institutionalism, this study examines how the complex interplay of forces affects health insurance reform implementation in these two places. It finds that Shanghai succeeded in implementing health insurance reform because of contextual influences, ideological shift, policy feedback, the authoritative political institutions, the dominance of key bureaucratic stakeholders in health insurance reform process, the endorsement of new ideas, and the decentralization power given to local governments. On the other hand, it finds that Hong Kong failed to implement any health insurance reforms in 1993 because of a more democratic political system, policy feedback, the persistence of old ideas, and a robust economy. Besides, it finds that the government failed to implement healthcare financing reforms in 1999 and 2000 because of a disjointed political system, difficult economic circumstances, the new idea lacking public acceptance, policy feedback, and the institutionalization of old ideas.

Dedicated to my father (Roger Luk) and my mother (Sandy Chu)

for their support and unconditional love

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Finally, I would like to use Amanda Bradley quotes for wishing the people I mention above all the best:

Within our reach lies every path we ever dream of taking.

Within our power lies every step we ever dream of making.

Within our range lies every joy we ever dream of seeing.

Within ourselves lies everything we ever dream of being.

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List of Abbreviations

BMI	Basic Medical Insurance
CCP	The Chinese Communist Party
CUHK	The Chinese University of Hong Kong
DAB	The Democratic Alliance for the Betterment of Hong Kong
DRG	diagnosis-related groups
EAASSP	employees' average annual salary of Shanghai in the previous year
Exco	The Executive Council
GDP	Gross Domestic Product
GHS	Government-funded Healthcare Scheme
HA	The Hospital Authority
HKSAR	The Hong Kong Special Administrative Region
HPA	Health Protection Account
HPS	Health Protection Scheme
HSP	Health Security Plan
LAMI	Local Additional Medical Insurance
Legco	The Legislative Council
LIS	Labor Insurance Scheme
MEDISAGE	Saving Accounts for Long Term Care
M&HD	The Medical and Health Department
MOH	The Ministry of Health
MOLSS	The Ministry of Labor and Social Security
MPF	Mandatory Provident Fund
MSA	medical savings account
NHS	National Health Service
OECD	Organization for Economic Cooperation and Development
OTC	over-the-counter
PHR	Personal Healthcare Reserve
POAS	Principle Officials Accountability System
PRC	The People's Republic of China
SID	Supplier-induced demand
SMHB	The Shanghai Municipal Health Bureau
SOEs	state-owned enterprises
SPF	social pooling fund
UDHK	The United Democrats of Hong Kong
UK	The United Kingdom

UEBHIP	Universal Excess Burden Health Insurance Plan
U.S.	The United States
USC	The Universities Service Centre for China Studies

CHAPTER ONE: INTRODUCTION

Over the past two decades, healthcare has become a major international concern (Lassey et al., 1997, p.xi) and a primary political, economic, social, ideological, and ethical issue (Field, 1989, p.1; Lassey et al., 1997, p.xi). Ageing populations, rapid developments of new medical technologies, and heightened demands and expectations of citizens (Blank and Burau, 2007, p.1) have compelled the governments in different welfare states to review and reform their healthcare systems (Figueras et al., 1998, p.1) in order to organize, finance and deliver healthcare in a better way. In the aspect of healthcare financing, the governments driven by the need to contain costs desire to find alternative options for generating financial resources for healthcare (Lee and Goodman, 2002, p.97). However, their policy choices are not easy to make. Healthcare is “about maintaining life, preventing death and keeping people comfortable” (Gauld, 2005a, p.6). It is not simply an economic issue, but very much an issue surrounded by questions of equity and justice (Gauld, 2005a, p.6). Hence, governments face a major challenge in balancing sustainable and equitable funding for healthcare with available resources (Figueras et al., 1998, p.7) when making healthcare decisions.

The 1990s was “a decade of major health system reform” (Saltman, 1994, p.287). Healthcare reforms were widespread among Western welfare states although they varied in terms of the pace and scope because of cross-national differences in healthcare systems. In the aspect of healthcare financing reform, governments in Western welfare states made efforts to effectively use their financial resources and contain healthcare costs by introducing elements of market and competition to their healthcare systems, albeit to varying degrees and by different methods. Like their western counterparts, both Shanghai and Hong Kong were under great pressure to reform their healthcare systems because of limited funding and rapid healthcare cost escalation caused by ageing populations, increasing healthcare demand, and technological advancement (Gauld, 2005a, pp.4-5). Shanghai, which is a market-Leninist welfare regime in the East, established a free healthcare system containing the dual Labor Insurance Scheme (LIS) and the Government-funded Healthcare Scheme (GHS) in the early 1950s. Before the establishment of the free healthcare system, more than 96 per cent of Shanghai residents had to pay medical expenses from their own pocket when seeking medical care at hospitals which began to charge medical fees in the early twentieth century (Nakajima, 2004, pp.36-50; Zhang and Shao, 1998, p.114). Only the poor could receive free medical treatment provided by limited hospitals, clinics and charitable organizations (Zhang and Shao,

1998, p.114). When the Chinese Communist Party (CCP) came into power in China in 1949, it implemented free healthcare for certain employees of the work units and social groups as a welfare benefit, which alleviated the financial burden of those who enjoyed the benefit when seeking medical treatment. In 1951, the CCP implemented the LIS, which provided employees in state-owned enterprises (SOEs) and the collective enterprises with free outpatient and inpatient services financed by the work units (Zhang and Shao, 1998, p.114). Although the CCP used the term ‘insurance’ to describe free healthcare it provided for employees of SOES and the collective enterprises, the LIS was not actually an insurance scheme in the real sense because it involved no premium contributions and no insurance institutions to manage the Schemes (Gu, 2001a, pp.200-201). In 1952, the CCP implemented the GHS, which provided free healthcare for government employees and retirees, army veterans, university and college students, staff in the cultural, education, health and science sectors, and retirees from these sectors (Grogan, 1995, p. 1074; Cheung, 2001, p.65; Gu, 2001a, p.200) that was financed by the state budget. Meanwhile, non-workers still had to pay medical expenses from their own pocket (Zhang and Shao, 1998, p.114).

Hong Kong, which is a productivist welfare regime, established a national healthcare system heavily subsidized by taxation in the early 1960s. Before the

establishment of the national healthcare system, the colonial government played a negligible role in healthcare provision and left the tasks of building hospitals and offering free medical services to churches, missionaries and benefactors (Gauld and Gould, 2002a, p.39; Scott, 2010, p.121) in order to save public expenditure and avoid tax increases (Scott, 1989; Scott, 2010). However, the importance in providing a healthy workforce for the expansion of industrializing economy (Wong, 1999, p.87) triggered by the change in geopolitical environment in the 1950s motivated the colonial government to become more directly involved in healthcare provision. The national healthcare system provided free medical services for its population. Patients only needed to pay a nominal charge when they received medical treatment at public hospitals. The pressures induced by changes in demography, demand for medical services and medical technology drove Shanghai and Hong Kong to embark upon a sustained process of reform. Both the places opted for health insurance reform. But the reform result in these two places represents polar extremes. While Shanghai witnessed a revolution in healthcare financing in 2000, Hong Kong retains the status quo on healthcare financing.

This study finds that health insurance reform in Shanghai was implemented in a gradual and peaceful manner. In the mid-1980s, Shanghai entered the exploration

phase (1984-1988) to experiment with co-payment schemes to contain healthcare costs. In the mid-1990s, it entered the experimental phase (1994-1996) to reform its healthcare financing system by implementing a pilot hospitalization insurance scheme coupled with a hospital revenue cap policy. And finally in 2000, it officially reformed its healthcare financing system by implementing a mandatory cost-sharing health insurance system which required contributions from both the work units and employees. The new health insurance scheme contained an individual medical savings account (MSA) and a social pooling fund (SPF), which respectively covered the outpatient and inpatient charges.

On the other hand, this study finds that health insurance reform in Hong Kong was implemented in a slow and winding process. The government's proposals for a coordinated voluntary insurance in 1993, a two-tier mandatory health insurance scheme in 1999 and a mandatory medical savings scheme in 2000 were shelved due to severe political and public oppositions. At the time of this study, the government is analyzing citizens' views on a regulated voluntary private health insurance scheme proposed in October 2010 after the public consultation came to an end in January 2011. If implemented successfully, the proposed voluntary private health insurance scheme, as a supplementary financing option, will not affect "tax-based public

funding as the major financing source for healthcare services” (Food and Health Bureau, 2008a, p.2). It means that Hong Kong will still stick to its original path of funding the universal healthcare system through taxation.

Therefore, the divergent reform results in Shanghai and Hong Kong suggests the main research question of this thesis: why has Shanghai been able to implement health insurance reform from the mid-1980s onwards while Hong Kong has failed to do so? This further raises a sub-question: How does the complex historical interplay of forces, namely contextual conditions, ideas, actors, political institutions, timing and sequences, path dependency and policy feedback, respectively affect the success and failure of health insurance reform implementation in Shanghai and Hong Kong over time? The implementation of health insurance reform would affect stakeholders in many aspects: citizens’ access to, affordability of and demand for healthcare, healthcare providers’ capacity of and efficiency in healthcare delivery, insurers’ profits and their freedom of action. Since different stakeholders had different interests and expectations toward health insurance reform, they would respond differently to the proposed or actual changes. This raises another sub-question: How do elites and different stakeholders in Shanghai and Hong Kong respectively respond to the changes brought or proposed by health insurance reform?

1.1 Literature Review, Research Gaps and Research Contributions

Over the past two decades, the implementation of healthcare financing reforms in Western welfare states has triggered an intellectual debate on the convergence or divergence of healthcare systems (Hurst, 1991; Immergut, 1992; Ham and Brommels, 1994; Wilsford, 1994; Wilsford, 1995; Freeman, 1998; Hacker, 1998; Giaimo and Manow, 1999; Giaimo, 2001; Wendt and Thompson, 2004; Blank and Burau, 2006; Bandelow, 2007; Hassenteufel and Palier, 2007; Cacace and Schmid, 2008; Wendt and Kohl, 2010). Convergence suggests that the structure and policies of national healthcare system become more alike (Saltman, 1997, p.449; Blank and Burau, 2006, p.266) when welfare states facing similar pressures or problems adopt similar reform strategies or solutions (Wendt et al., 2004, p.1). Conversely, divergence emphasizes the extent to which the structure and policies of national healthcare system “reflect deeply rooted values and norms which differ between societies” (Saltman, 1997, p.449) and thus lead to welfare states adopting different reform strategies or solutions (Saltman, 1997, p.449). A review of the available literature in the West shows that there is an observed diversity of research findings, which argues for the convergence (Cacace and Schmid, 2008), divergence (Immergut, 1992; Ham and Brommels, 1994; Wilsford, 1994; Wilsford, 1995; Freeman, 1998; Hacker, 1998; Giaimo and Manow,

1999; Giaimo, 2001; Bandelow, 2007; Hassenteufel and Palier, 2007; Wendt and Thompson, 2004; Wendt and Kohl, 2010) or a convergence-divergence mix of healthcare systems (Hurst, 1991; Blank and Burau, 2006). But the balance and strength of the evidence suggests most support for the divergence of healthcare systems.

A review of the available literature about health insurance reform in China and Hong Kong, on the other hand, shows that the intellectual debate on the convergence or divergence of healthcare systems in these two places has yet to exist. Besides, it shows that health insurance reform in Shanghai and Hong Kong are understudied. Also, most of the existing studies reviewed are descriptive studies lacking explanatory power. The empirical puzzle about why Shanghai being able to implement health insurance reform since the mid-1980s while Hong Kong failing to do so has not been studied before. Since the few studies that base their research upon theories tend to adopt the theory of historical institutionalism to explain the divergent healthcare reform paths in Western welfare state, this study fills the research gap by adopting the theory of historical institutionalism to examine this empirical puzzle and contribute to Western scholarly debate over convergence and divergence of healthcare systems. Qualitative research is chosen as the research methodology of this study. The case

study is used as the research strategy to respectively examine health insurance reform in Shanghai and Hong Kong in detail. Multiple sources are used to collect data. Semi-structured interviews in these two places are supplemented and cross-checked with existing literature, research reports, government documents, archival records, as well as newspaper articles.

1.2 The Rationale of This Study

This study examines why Shanghai and Hong Kong offer a contrasting situation when it comes to the implementation of health insurance reform. Shanghai and Hong Kong are interesting case studies because they “are very much like blood sisters” (Wong and Gui, 2004, p.1). They “share a common history as two of the five trading ports along the coast of China forcibly opened by the West under the Treaty of Nanking in 1842” (Sung, 2009, p.2) after China’s defeat in the First Opium War (1839-1842). Under the Treaty of Nanking, “Hong Kong was ceded to Britain as a colony, a status that was to last until 1997” (Wong and Gui, 2004, p.1). Shanghai, on the other hand, was turned into a semi-colony, “when the principle of extra-territoriality took the physical form of the international settlements” (Wong and Gui, 2004, p.1). Hong Kong, which “was then a mere fishing village” (Sung, 2009, p.2), and Shanghai, which “was then a small local town” (Sung, 2009, p.2), simultaneously took over “Guangzhou’s prestigious

status as China's window for foreign trade" (Hong Kong Museum of History, 2009, p.11) and "served as prime stops along the route for missionaries, merchants and travelers who ventured into China" (Hong Kong Museum of History, 2009, p.11).

The opening of Shanghai and Hong Kong as treaty ports marked the start of the cities' modernization (Hong Kong Museum of History, 2009, p.17), leading to a chapter of economic and social changes (Yeung, 2001, p.2). "In the following one hundred years, Shanghai and Hong Kong led the rest of China with their urban development" (Hong Kong Museum of History, 2009, p.17) and "developed into thriving metropolises" (Hong Kong Museum of History, 2009, p.19) over the course of time. They "developed rapidly under western influence" (Sung, 2009, p.2). There were public utilities, such as power stations, water plants, fire stations, post offices and hospitals (Hong Kong Museum of History, 2009, p.45). Besides, there was the establishment of new management structures, the prosperity of the industrial and commercial sectors, and the practice of urban planning (Hong Kong Museum of History, 2009, p.19). All of these "served as hallmarks of the cities' modernization" (Hong Kong Museum of History, 2009, p.19). During the modernization process, both Shanghai and Hong Kong "evolved into the great hubs of trade and industry unmatched by any other Chinese city" (Wong and Gui, 2004, p.1). While "Hong Kong

became the entrepôt of South China” (Sung, 2009, p.2), Shanghai became China’s largest city and “the hub of the Yangzi River Delta” (Sung, 2009, p.2), epitomizing “cosmopolitanism, enterprise and urbanism” (Cheung, 1996, p.50).

During the Second World War (1939-1945), both Shanghai and Hong Kong shared the same fate of falling to the Japanese occupation (Bergère, 1981; Tsang, 2004). After the end of the Second World War, the CCP came into power in China. It soon transformed Shanghai “from a glamorous financial and commercial centre into a leading socialist industrial base” (Cheung, 1996, p.50) after establishing the People’s Republic of China (PRC) in October 1949. In the following three decades, Shanghai “was cut off from the world market” (Sung, 2009, p.2). It “was no longer a global city” (Sung, 2009, p.2) but “a key industrial city in the [PRC], supplying industrial products, skilled personnel, as well as a huge amount of revenue” (Cheung, 1996, p.52). Meanwhile, Hong Kong rapidly transformed its economy after the Second World War (Yeung, 2001, p.2). The PRC’s “national policy that discouraged commerce and foreign trade” (Cheung, 1996, p.53) led to Hong Kong losing its entrepôt trade (Sung, 2009, p.2). But the influx of Shanghai capital, skills, and people sped up Hong Kong’s export-oriented industrialization (Wong and Gui, 2004, p.2), which in turn “stimulated the development of banking and business services” (Sung,

2009, p.2). In the 1970s, Hong Kong emerged as “an international financial centre” (Sung, 2009, p.2) and became one of the Four Asian Dragons, which also included Singapore, South Korea, and Taiwan (Castells, 1992, p.33).

By the 1980s, “the opening of the [PRC] and the lure of its cheap land and labor” (Wong and Gui, 2004, p.2) led to the manufacturing industries of Hong Kong moving to the PRC. Deindustrialization in Hong Kong “gave way to a vast expansion of the financial, real estate, and tertiary sectors” (Wong and Gui, 2004, pp.2-3) and “propelled Hong Kong into an unprecedented period of growth and prosperity” (Wong and Gui, 2004, p.3). In 1990, Shanghai re-emerged as a financial centre when Pudong (former eastern suburb of the city) was opened as the biggest special economic area in the PRC (Cai and Sit, 2003, pp.436-7). In the following 10 years, Shanghai “recorded two-digit annual economic growth” (Cai and Sit, 2003, p.437), which increased both “its economic strength and economic controlling power in [the PRC]” (Cai and Sit, 2003, p.437). The rapid economic growth of Shanghai raised “the question of whether and when Shanghai will overtake Hong Kong” (Yeung, 2001, p.4).

Both Shanghai and Hong Kong have undergone rapid, deep, and wide-ranging transformation (Wong and Gui, 2004, p.4). The economic transformation is

accompanied by social development in these places. Both Shanghai and Hong Kong provide housing, education, healthcare and other welfare support for their citizens. When they become prosperous, however, they also face a series of problems such as ageing populations, increasing citizens' demand for social services, increasing social inequality, and fiscal strains (Yeung, 1985; Wong and Gui, 2004). The fiscal strain calls for "ingenuity in adjusting and improving the system of social protection" (Wong and Gui, 2004, p.7) and concurrently raises the policy dilemma of whether the government or the people is responsible for service provision (Yeung, 1985, p.39). Both Shanghai and Hong Kong have made efforts to review their social policies in order to improve their systems of housing, education, social security, and healthcare (Wong and Gui, 2004, p.7). In the aspect of healthcare, both of them desire to utilize their financial resources and contain healthcare costs in a better way through the implementation of health insurance reform. However, the reform result of Shanghai is significantly different from that of Hong Kong. While Shanghai has been able to implement health insurance reform since the mid-1980s, Hong Kong has failed to do so. What are the reasons behind these divergent reform paths?

Implementing healthcare financing reform is not an easy task. Healthcare funding itself is "more than the technicalities of raising and allocating financial

resources” (Blank and Burau, 2007, p.63). In fact, it is “also a pointer to power, and control of funding is a major resource in health policy” (Blank and Burau, 2007, p.63). Healthcare can be funded through four major sources: (1) taxation; (2) social insurance; (3) private insurance; and (4) out-of-pocket payment (Doorslaer and Wagstaff, 1993, p.20; Chinitz et al., 1998, p.56; Blank and Burau, 2007, p.13). While taxation and social insurance belong to public expenditure, private insurance and out-of-pocket payment belong to private expenditure (Abel-Smith, 1994, p.149). Different methods of healthcare financing reflect different principles and they “differ in the extent of control that they give to the financing agency” (Wessen, 1999, p.19).

Taxation devoted to healthcare is general revenues collected “by local, provincial, or national government authority on incomes, land, sales, corporation profits, and the like” (Roemer, 1976, p.15). National healthcare systems financed by taxation are committed to the principle of universal access to healthcare (Blank and Burau, 2007, p.75; Roemer, 1976) and have the strongest public control resided primarily with the government (Blank and Burau, 2007, p.75). The government, as the payer of healthcare, is likely to prioritize cost efficiency and containment when raising and allocating healthcare funding (Blank and Burau, 2007, p.76).

Social insurance is hypothecated taxation levied through the payroll (Leung and Bacon-Shone, 2006, p.343) that requires employers and employees to “pay mandatory contributions towards health care costs” (Leung and Bacon-Shone, 2006, p.343). Contribution rates “are often a flat percentage of salaries” (Chinitz et al., 1998, p.59) and a ceiling is imposed on the salary to calculate premiums (Chinitz et al., 1998, p.59). Healthcare systems funded by social insurance are “based on the principle of social solidarity” (Blank and Burau, 2007, p.75). It has a weaker public control of funding because healthcare resources are allocated from bottom up. The government is limited to “setting (and altering) the framework in which the insurance funds and providers operated” (Blank and Burau, 2007, p.76).

Private insurance is funds voluntarily “raised through periodic contributions” (Roemer, 1976, p.15) “by individuals or by groups in such forms as corporate insurance coverage for employees” (Leung and Bacon-Shone, 2006, p.344). Private insurance schemes are “usually offered by competing insurers that charge different premiums for different coverage packages based on the baseline health risk of the insured” (Leung and Bacon-Shone, 2006, p.344). Healthcare funding raised from private insurance emphasizes individual responsibility (Blank and Burau, 2007, p.75). It has the weakest public control of funding because of “the predominance of private

funding” (Blank and Burau, 2007, p.77), and “the fragmentation of insurance funds and provider organizations” (Blank and Burau, 2007, p.77).

Out-of-pocket payment is money drawn “from the individual’s personal resources, including those he may have borrowed or received from another source (a relative, friend, loan company, and so on)” (Roemer, 1976, p.15). It is “the simplest method of financing” (Wessen, 1999, p.19) which “entails direct, non-reimbursable payment at the point of service” (Leung and Bacon-Shone, 2006, p.346). Besides, it is the least problematic and most commonly used “when costs are trivial or low” (Wessen, 1999, p.19). However, it is “the most regressive form of financing for health care” (Chinitz et al., 1998, p.61) because it constitutes “a much greater share of income for the sick and poor than for those who are healthy and better off” (Chinitz et al., 1998, p.61). Similar to private insurance, out-of-pocket emphasizes individual responsibility and has the weakest public control of funding because the money rests in the hands of individuals.

From the above, it shows that different methods of healthcare financing --- taxation, social insurance, private insurance and out-of-pocket payment --- reflect different principles and different types of control. In reality, there is a wide variety of

combinations of these funding methods within a single healthcare system (Blank and Burau, 2007, p.13). All healthcare systems in different countries adopt pluralistic financing “with tendencies to one method rather than another” (Blank and Burau, 2007, p.13). The efforts to find alternative or complementary ways to generate financial resources for healthcare is a challenge to policy makers when implementing healthcare finance reform. It requires careful and detailed examination before the policy makers can determine which financing option should be chosen to reform the healthcare financing system. Since there is the lack of study on health insurance reform in both Shanghai and Hong Kong, this study fills this research gap by examining this issue.

1.3 The Structure of This Thesis

The remainder of this study is structured as follows: Chapter Two reviews the current literature of welfare states and healthcare financing reforms in detail and identifies the research gaps. Chapter Three introduces the theory of historical institutionalism which is adopted by this study to examine health insurance reforms in both Shanghai and Hong Kong. Chapter Four outlines the research methodology and the methods of data collection. Chapter Five briefly examines the historical development of the healthcare system in Shanghai in the pre-reform era before 1980. Chapter Six thoroughly

examines health insurance reform in Shanghai and presents the research results.

Chapter Seven briefly examines the historical development of the healthcare system

in Hong Kong in the pre-reform era before 1990. Chapter Eight thoroughly examines

healthcare financing reforms in Hong Kong and presents the research results. Chapter

Nine is a conclusion chapter presenting the cross-case analysis and major findings of

this study by placing materials from the preceding chapters in a comparative context”.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviews the current literature of healthcare financing reforms in detail. It is divided into five sections. Section 2.2 defines what welfare states are, gives an overview of the welfare state development and introduces typologies of welfare regimes in the West and in the East. Section 2.3 examines the relationship between welfare states and healthcare, the scholarly debate over the convergence or divergence of healthcare systems in the West and healthcare financing reforms in China and Hong Kong. Section 2.4 examines the importance of applying theories into health policy studies. Section 2.5 offers a conclusion.

This study uses the theory of historical institutionalism to solve a real world puzzle about health insurance reform: why has Shanghai been able to implement health insurance reform from the mid-1980s onwards while Hong Kong has failed to do so? In order to locate the study “in the context of what has been done before” (Wellington and Szczerbinski, 2007, p.47), the author conducted a literature review on health insurance reform. As Neuman (2003) argued, it was best to review the accumulated knowledge about a question before one tried to answer it (p.96). By conducting a literature review, as Neuman (2003) argued, one could fulfill one or

another of four goals: to “demonstrate a familiarity with a body of knowledge and establish credibility”; to “show the path of prior research and how a current project is linked to it”; to “integrate and summarize what is known in an area”; and to “learn from others and stimulate new ideas” (p.96).¹

2.2 Welfare States and Healthcare Reforms

Healthcare is a major component of the welfare state (Moran, 2000, p.135). However, “the literature on health-care policy is often semi-detached from the wider literature on the welfare states, being immersed instead in its own specialist controversies” as noted by Moran (2000, p.135). This study contributes to addressing this gap by providing a background about the development of welfare states and linking it to the debate about healthcare reform.

¹ When conducting a literature survey, this study adopted a search strategy which located relevant published materials in three ways. Firstly, the author made use of the online university library catalogue system to locate the scholarly books or book chapters by title and by keywords. Important terms such as healthcare reform, health insurance reform, medical insurance, healthcare finance, healthcare financing reform, and historical institutionalism were used to search the relevant books and book chapters. Secondly, the author made use of the e-journal portal of the online library system and the *Social Science Citation Index*® subscribed by the university libraries to locate relevant academic journals which may contain articles useful to this study. Once the relevant journals were located, the author used the search or advanced search engine to search the contents of the journal in order to locate relevant journal articles by typing keywords. The list of relevant journals included *Health Affairs*, *Health Care Analysis*, *Health Economics*, *Health Policy*, *Health Policy and Planning*, *International Journal of Health Planning and Management*, *International Journal of Health Services*, *Journal of Health Economics*, *Journal of Health Politics, Policy and Law*, *Social Science & Medicine*, *International Journal of Social Welfare*, *Journal of European Social Policy*, *Critical Social Policy*, *Journal of Social Policy*, and *Social Policy & Administration*. Thirdly, the author examined the bibliography of books, book chapters and journal articles to find additional published materials related to the research topic.

2.2.1 Defining the Welfare State

According to Briggs (1961), a welfare state was a state deliberately using political or administrative means to modify the play of market forces in three directions---first, by guaranteeing the poor a minimum income; second, by reducing the extent of insecurity felt by those in distress when facing social contingencies such as sickness, unemployment and old age; and third, by ensuring the provision of an agreed range of social services well above the minimum standard for all citizens regardless of their social status (p.228). As Cochrane et al. (2001) noted, the use of the term welfare state suggested that “the state plays a role in shaping the context within which welfare is provided” (p.12).

2.2.2 Four-Stage Development of Welfare States in the West: the Generic Trend

The development trajectory of welfare states in the West, according to Pierson (1998), could be divided into four stages: (1) the epoch of legislative innovation (1880-1920); (2) the epoch of consolidation (1920-1940); (3) the ‘Golden Age of the Welfare State’ (1945-1975); and (4) the retrenchment of welfare states in the post-1975 era. The epoch of legislative innovation from 1880 to 1920 marked the birth of welfare states when states implemented legislation covering industrial accidents, health, unemployment and old age (Pinch, 1997; Pierson, 1998). (**See Table 1**). Originally,

the general prevalence of laissez-faire beliefs, as formulated in Adam Smith's *Wealth of Nations* (1776), favored a free market and disfavored the state's regulation of the economy, which was obstructive to the development of welfare services. Nevertheless, states which attempted to preserve social order and solve the problems stemming from the growth of industrial capitalism "implemented various acts of legislation to regulate factory hours, improve the quality of housing and to deal with the problems affecting public health" (Pinch, 1997, p.9).

Then, the epoch of consolidation from 1920 to 1940 was the decisive epoch in the development of the post-war welfare states when the government actively established welfare institutions, extended welfare coverage and increased welfare spending (Pierson, 1998, pp.112-114) after the First World War (1914-1918) to meet "a major expansion of pension, health, housing and rehabilitation demands from those millions incapacitated or bereaved" (Pierson, 1998, p.113). According to Pierson (1998), the social expenditure levels in Organization for Economic Cooperation and Development (OECD) countries rose from three per cent of Gross Domestic Product (GDP) in 1914 to more than five per cent in 1940 (p.107) (**See Table 2**).

The period from 1945 to 1975 was 'Golden Age of the Welfare State' in which

welfare states experienced a fantastic pace of growth after the Second World War (Esping-Andersen, 1990). During this period, most of the developed states made a quantitative and qualitative leap in the public provision of welfare (Pierson, 1998, p.99). States subscribing to the post-war consensus were committed to maintaining a comprehensive welfare state and sustaining economic growth (Pierson, 1998, p.125). They “[went] beyond the provision of a bare minimum towards ensuring that all [had] equal opportunity, so far as the country’s resources [allowed]” (Sleeman, 1973, p.5). And by 1975, the social expenditure levels in Belgium, Denmark, France, Germany, the Netherlands and Sweden exceeded 25 per cent of their GDP (Pierson, 1998, p.133).

After the 1975, welfare states entered the era of retrenchment. The unsustainable burden of ageing population, the ‘stagflation’--- a combination of high unemployment and high inflation--- caused by the oil crisis of 1973 (Pinch, 1997, p.26) and ensuing times of financial stringency led to the sustainability of welfare states being questioned (Wessen, 1999, p.10). This drove national governments of both left and right to implement a wave of economic reforms such as privatizations, tax cuts and opening of national boundaries (Fourcade-Gourinchas and Babb, 2002, pp. 533-534). Concurrently, they dismantled social welfare apparatuses (Fourcade-Gourinchas and

Babb, 2002, p. 533) and adopted a series of retrenchment measures such as reducing the eligibility, level and the duration of welfare benefits (Pierson, 1998, p.164) (See **Table 3**). However, radical welfare retrenchment was far more difficult to achieve in reality. Pierson (1994) argued that both Thatcher and Reagan's efforts to roll back the welfare state did not lead to "a marked curtailment of social expenditure or a radical shift toward residualization" (p.131) in the UK and the U.S. because policy feedback acted as a crucial determinant of retrenchment results in two ways (Pierson, 1994, p.47). On one hand, previous social policy choices in both countries "generated resources and incentives that helped structure the development of relevant interest groups" (Pierson, 1994, p.47) to defend social programmes. On the other hand, past policy commitments produced lock-in effects that they "sharply circumscribed options for radical reform" (Pierson, 1994, p.48) and "retrenchment advocates [found] existing policies hard to reverse" (Pierson, 1994, p.47). In another study, Pierson (1996) argued that welfare retrenchment in the UK, the U.S., Germany and Sweden had been pursued cautiously that changes had been incremental (pp.173-4) and "the evidence of continuity [was] even more apparent" (Pierson, 1996, p.173) because of "conservative characteristics of democratic political institutions" (Pierson, 1996, p.174), "high electoral costs" (Pierson, 1996, p.174), and organized interested produced by maturing social programmes to defend the welfare state (Pierson, 1996,

p.175).

An overview of the development trajectory of welfare states shows that the role of the state in welfare provision has changed over time due to changes in attitude towards the role of the state in the community over time. From the 18th to 20th century, the drastic economic transformation “from essentially agrarian, localized and traditional to definitely industrialized, (inter)national and modern societies” (Pierson, 1998, p.12) led to the government playing a more important role than the family, the church and mutual aid in welfare provision. During the period of laissez faire, the state was “merely the policeman who kept law and order, or the arbiter who settled disputes” (Sleeman, 1973, p.1). But in the years after 1945 when the term ‘welfare state’ came into general use, the state was seen “as a positive agent for the promotion of social welfare” (Sleeman, 1973, p.4) and an actor who was obligated to steer the operation of the market economy in a socially desirable direction (Sleeman, 1973, p.5). Significantly, welfare states emerged in places where the nation state and capitalism were already well-established (Pierson, 1998, p.100). And these pre-existing state and economic formations “prescribed the limits of subsequent welfare state development” (Pierson, 1998, p.100).

In fact, Stewart (2007), who examines historical dimensions of welfare provision, argues that there has always been a mixed economy of welfare comprising the state, the market, the family which is the informal sector, and charitable bodies which are the voluntary sector (p.37). However, the role and the extent of each of these components in delivering welfare has changed and will continue to change over time (Stewart, 2007, p.24). Besides, the relationship and boundaries between these components of the mixed economy of welfare have “[shifted] over time as well as being porous and overlapping, rather than rigidly fixed and delineated” (Stewart, 2007, p.36). Stewart (2007) argues that the role of the state varies “according to particular historical circumstances” (p.37). Its role is not homogeneous that it “can be that of direct provider, or funder, or enabler of welfare” (Stewart, 2007, p.37). The change in the role of the state would also lead to the changes in the roles of other components of the mixed economy of welfare. In the last quarter of the 20th century, a shift away from support for the state being the direct provider of key welfare services led to a reemphasis on the importance of the market, the family, and charitable bodies in welfare provision (Stewart, 2007, p.28). The study of Stewart (2007) shows that the mixed economy is characteristic of welfare states (p.24). Alcock and Powell (2011) also argue that the concept of mixed economy of welfare is “a useful reminder that welfare can be supplied from various sources, and that the welfare mix can change

over time and between countries” (p.3).

2.2.3 Typologies of Welfare Regimes

There are many welfare states across the world. They vary in terms of their sizes, their funding bases, “their patterns of entitlement, their forms of delivery and their redistributive capacity” (Pierson, 1998, p.178). Since the late 1980s, they have been categorized into different ‘welfare regimes’ which conceptualize “the welfare programs, outcomes, and effects of those capitalist societies that have been transformed into welfare states” (Gough, 2002, p.50).

The assumption of path dependency is attached to the notion of ‘regime’ that “outcomes from political economy and the deliberate interventions of state and non-state actors reproduce stratification, inequalities and power differences” (Wood and Gough, 2006, p.1698) over time. Welfare regimes “owe their origins to different historical forces, and they follow qualitatively different development trajectories” (Esping-Andersen, 1990, p.3). In the West, there are liberal, conservative and social democratic welfare regimes identified by Esping-Andersen (1990) and the ‘Latin rim’ rudimentary welfare regime identified by Leibfried (1993, 2000). In the East, the situation is rather complicated. Different typologies are adopted to identify welfare

regimes in East Asia, including the Oikonomic or Confucian welfare states by Jones (1990, 1993), the East Asian welfare model by Kwon (1997), the conservative welfare state system by Aspalter (2001), the productivist welfare capitalism by Holliday (2000), and the market-Leninist welfare regime by London (2008). As illustrated below, the adoption of different typologies are due to advocates of the East Asian welfare regime using different perspectives to examine welfare development in East Asia.

2.2.3.1 Welfare Regimes in the West

(a) Esping-Andersen's Three Worlds of Welfare Capitalism: 'Liberal', 'Conservative/Corporatist', and 'Social Democratic' Welfare Regimes

Esping-Andersen (1990) famously develops a tripartite typology of liberal, conservative and social democratic regimes to demonstrate the clustering of advanced capitalist countries in the West. He uses three salient characteristics of welfare states --- de-commodification, social stratification and the public-private mix--- to distinguish these three welfare regime types (Esping-Andersen, 1990, pp.3-4). De-commodification refers to the degree to which an individual can maintain a livelihood without relying on market forces (Esping-Andersen, 1990, p.37). Social stratification refers to the degree to which a welfare state differentiates different social

classes in relation to equality (Esping-Andersen, 1990, pp.76-7). The public-private mix refers to the interplay of state and market in pension provision (Esping-Andersen, 1990, p.79).

In the liberal welfare regime, the state upholds the market principles and only plays a minimal role in welfare provision. Citizens are expected to be self-reliant. Social assistant programmes characterized by stigma and strict eligibility rules only provide modest benefits to those most in need. Liberal welfare regimes have a low degree of de-commodification and a high degree of social stratification. They exist in the United States (U.S.), Canada, and Australia (Esping-Andersen, 1990, p.27). Then in the corporatist welfare regime, the Church-shaped state upholds status differences and preserves traditional familyhood (Esping-Andersen, 1990, p.27). Rights are “attached to class and status” (Esping-Andersen, 1990, p.27). The state emphasizes the principle of ‘subsidiarity’ that it would only interfere when the family is incapable of servicing its members (Esping-Andersen, 1990, p.27). The degrees of de-commodification and social stratification induced by corporatist welfare regimes lie between that of the liberal and social democratic welfare regimes. Corporatist welfare regimes exist in “Austria, France, Germany, and Italy” (Esping-Andersen, 1990, p.27). And finally in the social democratic welfare regime, the state is strongly

committed to the principles of egalitarianism and universalism (Esping-Andersen, 1990, p.27) that it plays a leading role in providing comprehensive and universal welfare for its citizens. Welfare eligibility is not tied to work records or family status but citizenship. Social democratic welfare regimes have a high degree of de-commodification and a low degree of social stratification. They exist in Scandinavian countries such as Sweden and Norway. In brief, the liberal welfare regime prioritizes the market, the conservative welfare regime preserves the status, and the social democratic welfare regime emphasizes equality. The characteristics of liberal, corporatist, and social democratic regimes are summarized in **Table 4**.

Esping-Andersen's (1999) later work shows that his criteria of distinguishing welfare regime types have changed. He adds the concept of de-familisation parallel to de-commodification as a new measure of welfare outcomes to capture policies which reduce an individual's welfare dependence on the family (Esping-Andersen, 1999, p.51). Besides, the idea of social risks is emphasized and the role of households is added to form the welfare mix which refers to the articulation of the state, the market and the family in the production of welfare and managing social risks (Esping-Andersen, 1999, pp.33-5).

However, Esping-Andersen's (1990, 1999) welfare regime approach is criticized by Powell and Barrientos (2011) for having inconsistent terminology and definitions and shifts in these concepts and measures over time (p.74) that "leads to the problem of operationalizing welfare regimes" (Powell and Barrientos, 2011, p.76). Besides, Powell and Barrientos (2011) argue that both de-commodification and de-familisation are uni-dimensional indices to identify welfare regimes that these measures fail to reflect Esping-Andersen's (1999) new conceptual primacy of the welfare mix (Powell and Barrientos, 2011, p.79).

(b) 'Latin rim' Rudimentary Welfare Regime

Leibfried (1993, 2000), who thinks that another category should be added to Esping-Andersen's (1990) tripartite typology, develops the 'Latin rim' rudimentary welfare regime to identify underdeveloped welfare states in the southern countries of Western Europe. States in this regime rely on a subsistence economy with "a strong agricultural bias" (Leibfried, 1993, p.142) and "do not have a full employment tradition" (Leibfried, 1993, p.142), especially for women. They emphasize residualism and give no rights to welfare (Leibfried, 1993, p.141). They try to catch up with more developed northern counterparts². They make "strong promises pointing

² The 'Latin rim' rudimentary regime, together with the Scandinavian regime, the 'Bismarck' regime, and the Anglo-Saxon regime, are four worlds of welfare capitalism in the European Union developed by Leibfried (1993, 2000). However, the Scandinavian regime, the 'Bismarck' regime, the

towards a ‘modern welfare state’ in their constitutions” (Leibfried, 1993, p.142) but lack “the legal, institutional, and social implementation” (Leibfried, 1993, p.142) in reality. They exist in Spain, Portugal and Greece.

2.2.3.2 Welfare Regimes in the East

(a) The Oikonomic or Confucian Welfare States

Jones (1990, 1993), who thinks that the western-centric framework of Esping-Andersen (1990) is inapplicable in the Asian context, becomes a pioneer to develop the Oikonomic (Jones, 1990, p.446) or Confucian welfare states (Jones, 1993, p.204) to collectively characterize welfare states in Japan, Hong Kong, Singapore, South Korea and Taiwan. Confucianism is placed at the heart of these welfare states (Jones, 1990, p.450), which contains the values of compliance, consensus, duty, hierarchy, harmony, order, stability and staying power (Jones, 1993, p.202).

However, Jones’s (1990, 1993) cultural approach is challenged by White and Goodman (1998), who argue that this is an unhelpful approach and has residual explanatory value because political, economic and demographic factors play a more important role in explaining welfare development in East Asia (p.15). It is also

Anglo-Saxon regime adopted by Leibfried (1993, 2000) are like Esping-Andersen’s social democratic, conservative/corporatist, and liberal welfare regime respectively.

challenged by Kwon (1998), who argues that political, institutional and economic factors play a more a more important role than Confucian ethics in structuring welfare states in East Asia. Aspalter (2005) argues that the Confucian approach is not convincing or representative enough to examine welfare development in East Asia because there is no causal linkage between Confucian values and welfare policy proposals or implementation, especially when the Confucian heritage is not shared by some East Asian countries at all or is just shared by Southeast Asian countries to a very limited extent (p.6). And Walker and Wong (2005a, 2005b) argue that the Confucian welfare state label is neither a helpful or very precise classification. They only regard Confucianism as an adjunct to political ideology (Walker and Wong, 2005a, p.16; Walker and Wong, 2005b, p. 218), which provides “powerful backing to the conservatism of East Asian governments in the formative stages of social policy” (Walker and Wong, 2005b, p. 218). They argue that each country in East Asia has its own path of development in welfare, being influenced by different situational factors such as geopolitical size, location, economic development, migration and ethnicity (Walker and Wong, 2005a, p.9; Walker and Wong, 2005b, pp. 216-9). In their view, “the explanatory power of Confucianism has been overemphasized with reference to both the past and the present of welfare regimes in East Asia” (Walker and Wong, 2005b, p.214).

(b) The East Asian Welfare Model

Following Jones (1990, 1993), Kwon (1997) finds that Esping-Andersen's (1990) conservative welfare regime type fails to capture the salient characteristics of welfare systems in Japan and Korea (p.476). On one hand, he finds that welfare systems in Japan and Korea share three characteristics of Esping-Andersen's conservative welfare regime, including the structure of social policy being organized "mainly according to the principle of compulsory insurance with the idea of public assistance for the poor" (Kwon, 1997, p.477), the family playing "a central role in guaranteeing minimum welfare provision" (Kwon, 1997, p.477), and the emphasis on maintaining prevailing order (Kwon, 1997, p.477). On the other hand, he finds that welfare systems in Japan and Korea are different from Esping-Andersen's conservative welfare regime for three reasons, including little public intervention "in the area where the family is supposed to be responsible" (Kwon, 1997, p.478), having lower level of welfare provision than conservative welfare regime in the West, and the inapplicability of class politics to explain the welfare development in these two countries. Hence, he suggests an East Asian welfare model, at least regarding these two countries (p.467). Kwon's (1997) recognition of the role of the family in welfare provision shows that he is aware of the mixed economy of welfare in Japan and Korea.

Although he does not mention what criteria should be used to establish the East Asian welfare model, he argues that “it is necessary to pay attention to the role of the state” (p.479) in order to understand the politics of social policy in Japan and Korea. He argues that the state plays “a major role in introducing and expanding welfare” (p.479) in Japan and Korea. It implies that he takes a political or an institutional perspective when suggesting the East Asian welfare model. The merit of Kwon’s (1997) East Asian welfare model is that it goes beyond a one-dimensional account of provision to a three-dimensional account of provision, finance and regulation to examine the role of the state in social welfare. Kwon (1997) argues that the role of the state in social welfare in Japan and Korea “is predominantly that of regulator” (p.471). As Powell (2007) argues, “a one-dimensional view of provision alone is inadequate, and it is necessary to also examine the dimensions of finance and regulation” (p.15).

(c) The Conservative Welfare State System

Aspalter (2001), who argues for the existence of an East Asian welfare model, adopts a political approach to examine welfare development in Japan, Hong Kong, Singapore, South Korea, Taiwan, and China (p.2). He argues that the analysis of the political determinants of these six places --- political systems, party systems, state structures, elections, party politics, the impact of constitutions, the politics of legitimization, and

social movements (Aspalter, 2001, pp.2-3) --- reveals that it is political parties pursuing a conservative social policy characterized by a social insurance system being divided into occupational classes (Aspalter, 2001, p.4). Besides, these places have a highly stigmatized social assistance, with the state's "strong disapproval of government financed social welfare policies" (Aspalter, 2001, p.4). Hence, he uses the conservative welfare state system to collectively characterize the welfare states of these places (Aspalter, 2001, p.2).

However, Aspalter's (2001) use of the conservative welfare state system to characterize welfare states in East Asia contains three problems. Firstly, his adoption of the term 'the conservative welfare state system' can be easily confused with Esping-Andersen's conservative welfare regime. Since his original purpose is to distinguish welfare states in the East from that of the West and the criteria he uses to identify welfare states in East Asia are different from that of Esping-Andersen, another term should be used to show the uniqueness of the East Asian welfare model. Secondly, it is inappropriate to put China and the rest of five states together. It is because China is a communist state with a developing economy while Japan, Hong Kong, Singapore, South Korea and Taiwan are capitalist states with a developed economy. It is misleading to show that there is a homogeneous conservative welfare

state system without diversity. Thirdly, the contention of Aspalter (2001) that it is political parties pursuing a conservative social policy is incorrect and does not apply to the case studies of Hong Kong and China. In Hong Kong, there is no social insurance system. Besides, there is no causal linkage between the Democratic Party and the social policy pursued. In China, there was a comprehensive welfare benefits financed by the government before the late 1970s. The state did not disapprove government's financed social welfare policies before the late 1970s because the comprehensive welfare benefits served the political purpose of state building and the economic purpose of maintaining a healthy production force. The government transformed the government-financed welfare system to a cost-sharing welfare system financed by work units' and employees' contributions in the 1980s. However, this should be regarded as a pragmatic rather than a conservative action taken by the Chinese government in order to adapt to the changing economic environment.

(d) Productivist Welfare Capitalism

Holliday (2000), who argues for the existence of an East Asian welfare model, develops a productivist welfare regime which stands alongside Esping-Andersen's three types of welfare regimes (Holliday, 2000, p.706). States in the productivist welfare regime share with states from Esping-Andersen's three regimes "an ultimate

objective of social solidarity and regime legitimation” (Holliday, 2000, p.716). However, it is “the ways in which they pursue that objective that set them apart” (Holliday, 2000, p.716). The productivist welfare regime has two salient characteristics of assigning priority to production and economic growth and subordinating social policy to economic policy (Holliday, 2000, p.709). Within the productivist welfare regime, three distinct sub-sets known as facilitative, developmental-universalist and developmental-particularist can be identified. Each sub-set “addresses the central issues of growth orientation and subordination of non-economic policy in different ways” (Holliday, 2000, p.710), leading to differences in terms of social rights, stratification effects, and state-market-family relationship (**See Table 5**). According to Holliday (2000), Hong Kong belongs to a facilitative state. Japan, South Korea and Taiwan belong to developmental-universalist states. Singapore belongs to a developmental-particularist state.

Holliday’s (2000) productivist welfare regime is the most comprehensive framework to examine welfare development in East Asia. The term ‘productivism’ is “a key unifying theme” (Wilding, 2011, p.19) bringing East Asian countries together to make up its own brand of welfare regime. At the same time, three distinct sub-sets within the productivist welfare regime shows that Holliday (2000) recognizes the

social policy differences among East Asian countries and does not blindly pursue a homogeneous East Asian welfare model. Wilding (2011), who uses Holliday's notion of 'productivism' to examine recent welfare development in East Asia, argues that it is more useful to divide the welfare states examined into two clusters, with Hong Kong Singapore and Taiwan still being productivist states, and Korea being "more of a [welfare] hybrid" (Wilding, 2011, p.29). While the findings of Wilding (2011) show that welfare development in Korea does not stay fixed in one shape over the past decade due to political and economic changes, it shows that Holliday's framework is still helpful in analyzing welfare development in East Asia. The argument for the existence of a productivist welfare regime in East Asia prevails.

(e) Market-Leninist Welfare Regime

Recently, London (2008) has developed a market-Leninist welfare regime to characterize welfare states in formerly state-socialist settings that can be found in Vietnam and China. The market-Leninist welfare regime has two salient characteristics of subordinating social policy to developmentalist economic policies (London, 2008, p.21) and being ruled by the communist party that professes "commitment to universalism and --- more importantly--- feature polities that have been steeped in market-Leninism" (London, 2008, p.21). It uses the market to

promote political imperatives including eternal one party rule, legitimacy, social order, economic accumulation, and social welfare (London, 2008, p.10). It commodifies most essential services under the authority of this regime that is committed to achieving a ‘socialist oriented’ market economy (London, 2008, p.13). It has a dual and overlapping stratification outcome, with the inequalities generated by the communist party’s “exercise of arbitrary power and the political allocation of economic resources” (London, 2008, p.13) on one hand, and the inequalities generated by the market on the other hand (London, 2008, p.13). London’s (2008) market-Leninist welfare regime shows that there is another distinct welfare cluster in East Asia apart from Holliday’s (2000) productivist welfare regime. It helps extend one’s understanding and perception to welfare development in East Asia and enriches the welfare regime studies.

In brief, there are different welfare regimes across the world, each of which has its own historical forces, institutional arrangements, social stratification effects and path of development.

2.3 Welfare States and Healthcare Systems

No matter which welfare regime the welfare states belong to, they all face the

problem of fiscal sustainability when entering the era of retrenchment. The sustainability problem has put policy makers in different welfare states under great pressure to review their healthcare systems and in particular how healthcare should be financed (Chinitz et al., 1998, p.64) because healthcare system is “an integral part of the creation of the welfare state” (Chinitz et al., 1998, p.63). As Moran (2000) points out,

“...in the welfare state, health care is a major component--- whether we measure by resources consumed, numbers employed in creating and delivering health-care goods and services, historical importance in the statecraft that built welfare states, or the subjective attachment of citizens to the services of health-care institutions” (p.135).

In the OECD countries, special attention was paid to reviewing the healthcare financing system because of the oil crisis of 1973 and ensuing times of fiscal strain on one hand, and the drastic increase in healthcare expenditures on the other hand. The drastic increase in healthcare expenditures was caused by a number of reasons, including ageing population, chronic diseases and disability, the proliferation of advanced medical technologies, and heightened public expectations and demands for better healthcare services (Wessen, 1999, p.9; Blank and Burau, 2007, p.1). In 1992,

the total healthcare expenditure accounted for between 6.5 and 14 per cent of GDP in all but two of the OECD countries as compared with 1.5 to 5.5 per cent of GDP in 1960 (OECD, 1996, p.18) (**See Table 6**). Besides, public healthcare expenditure in OECD countries accounted for between 1.4 and 7.8 per cent of GDP in 1992 as compared with 0.9 to 3.5 per cent of GDP in 1960 (OECD, 1996, p.18) (**See Table 7**). Governments in the OECD countries were under great pressure to constrain healthcare costs. Since the early 1990s, they had introduced different market-derived mechanisms which were believed to be more efficient and effective “in differing combinations and with differing emphasis on the finance, production, and/or allocative components of their healthcare systems” (Saltman, 1994, p.288) (**See Table 8**).

2.3.1 The Convergence or Divergence of Healthcare Systems in the West

Over the past two decades, the implementation of healthcare financing reforms in welfare states has triggered an intellectual debate on the convergence or divergence of healthcare systems. Convergence suggests that the structure and policies of national healthcare system become more alike (Saltman, 1997, p.449; Blank and Burau, 2006, p.266) when welfare states facing similar pressures or problems adopt similar reform strategies or solutions (Wendt et al., 2004, p.1). Conversely, divergence emphasizes

the extent to which the structure and policies of national healthcare system “reflect deeply rooted values and norms which differ between societies” (Saltman, 1997, p.449) and thus lead to welfare states adopting different reform strategies or solutions (Saltman, 1997, p.449). A review of the available literature in the West shows that different approaches are adopted to examine this issue, including a descriptive approach, the actor-based approach, the institutional or political approach, and the path dependence approach. Besides, it shows that there is observed diversity of research findings, which argues for the convergence, divergence or convergence-divergence mix of healthcare systems. However, as illustrated below, the balance and strength of the evidence suggests most support for the divergence of healthcare systems.

(a) The Descriptive Approach

Hurst (1991) examined the impact of healthcare reforms implemented in the 1980s on the healthcare systems in seven West European countries, including “Belgium, France, Germany, Ireland, the Netherlands, Spain, and the United Kingdom [UK]” (p.8). He had an interesting finding that on one hand, healthcare systems of these seven countries show “some signs of convergence on the public contract model” (Hurst, 1991, p.19) which involved public payers contracting with private health-care

providers and “increased reliance on market or quasi-market relationships that permit governments to regulate at arms length” (Hurst, 1991, p.19). On the other hand, they diverged from each other in terms of the methods of paying providers and regulations (Hurst, 1991, p.19). It is very ambitious for Hurst (1991) to examine seven healthcare systems in his study. However, he does not employ any theoretical lens to stringently and systematically examine the issue. His descriptive approach leads to his finding lacking theoretical basis and explanatory power.

Blank and Burau (2006) used Bennett’s (1991) three-part framework---policy goals, policy content, and policy instruments--- to systematically examine whether health priority setting policy converges in nine developed capitalist countries, including Germany, the UK, the U.S., Australia, the Netherlands, New Zealand, Sweden, Japan and Singapore. They found that there were signs of a convergence at conceptual level when the countries examined shared the common goals of rationing, cost containment and introducing market mechanism to healthcare systems. But divergence continued in policy content and the preferred policy instruments across the countries examined (Blank and Burau, 2006, p.279).

There is no doubt that the study of Blank and Burau (2006) is more systematic

than that of Hurst (1991) when convergence is examined from three phases of policy process. However, the study of Blank and Burau (2006) contains the problem of unclear and inconsistent time frame that when the policy content and instruments were implemented in the countries examined are mostly unknown except mentioning that diagnosis-related groups was implemented in the U.S. in the 1980s (Blank and Burau, 2006, p.277) and strong market reforms were implemented by New Zealand in the early 1990s (Blank and Burau, 2006, p.279). Healthcare reform has been implemented since the 1980s that different kinds of reform instruments have been adopted in different time periods. The ambition of Blank and Burau (2006) to examine nine countries without clearly setting a time frame affects country comparison and risks producing inconsistent results which reduce the analytical power of their study.

(b) The Actor-based Approach

Hassenteufel and Palier (2007) took an actor-based view to explain why France, Germany and the Netherlands followed different health insurance reform trajectories since the 1980s. They argued that the main reason was “differences between the emergent new policy elites in health policy” (Hassenteufel and Palier, 2007, p.592). In France, a group of senior servants who specialized in health insurance policies and

occupied strong position played a growing role in the decision-making process (Hassenteufel and Palier, 2007, p.592). Since these policy elites thought that the strengthening of the state could increase the efficiency of the health insurance system, they favored implementing reforms with regulatory elements, such as global budgets for hospitals, therapeutic norms for ambulatory care and hospital management (Hassenteufel and Palier, 2007, p.592). As to Germany and the Netherlands, it was academic expertise playing a growing role in the decision-making process (Hassenteufel and Palier, 2007, p.592). The expertise who was more internationalized and “inspired by foreign examples” (Hassenteufel and Palier, 2007, p.592), favored “more policy transfer of competition mechanisms”(Hassenteufel and Palier, 2007, p.592) when reforming the health insurance systems.

While Hassenteufel and Palier (2007) show that there is a causal linkage between new policy elites and the types of reform strategies adopted, they only provide a partial answer to explain the differences in health insurance reform trajectories. In fact, their study unavoidably raises the question of structure-agency problem that has been longstanding in political science. Their emphasis on the importance of new policy elites reflects their excessively voluntaristic view of agency, which overstates the role of new policy elites in determining the health insurance reform outcomes while

downplaying the structural influences or constraints on their goals, choices and behavior.

(c) The Institutional or Political Approach

(i) Healthcare Systems as the Main Explanatory Factor

In fact, most of the available research on healthcare financing reforms shows that institutional or political approach is largely adopted by scholars to examine healthcare trajectories on a comparative basis. The institutional or political approach emphasizes the role of healthcare systems and political institutions in defining the interests of key actors and structuring their behavior when implementing healthcare financing reform. Freeman (1998) examined how different types of healthcare systems led to different patterns of reform to contain healthcare costs in France, Germany, Italy, Sweden, and the UK in the 1980s. He found that governments in Italy, Sweden and the UK with national health systems were “much more disposed to radical, pro-competitive reform” (Freeman, 1998, p.395) which increased “elements of management and competition, albeit to different degrees and in different ways” (Freeman, 1998, p.396). They thought that competition was conducive to “managing resource constraint in an increasing complex and demanding political environment” (Freeman, 1998, p.396). In France and Germany, however, governments with social insurance health systems

adopted “more assertive central regulation” (Freeman, 1998, p.396) to contain healthcare costs.

Like Freeman (1998), Giaimo and Manow (1999) examined how the structure of healthcare systems led to the UK, Germany, and the U.S. under severe financial strain pursuing a distinctive reform response since the late 1980s. However, unlike Freeman (1998), who classified the healthcare systems examined based on the funding dimension, Giaimo and Manow (1999) classified the healthcare systems examined based on different modes of regulation or governance: the state-led, corporate-governed and market-driven healthcare systems. They found that the UK having a state-led healthcare system adopted a market-plus-state strategy by introducing an internal market accompanied by centralized state control to the National Health Service (NHS) (Giaimo and Manow, 1999, pp.971-4). Then, they found that Germany having a corporatist-governed healthcare system adopted “a more mixed menu of cost containment policies, including a cautious market forces and greater state intervention” through regulation (Giaimo and Manow, 1999, p.968). And finally, they found that the U.S. having a market-driven healthcare system failed to implement government-regulated market competition within a framework of national health insurance (Giaimo and Manow, 1999, p.985). However, its failed attempt was

replaced by an “employer-led reform through unregulated market competition” (Giaimo and Manow, 1999, p.990). As a result, cost containment reforms in the U.K. and Germany were more successful than that of the U.S. in “safeguarding solidarity and equitable access to care” (Giaimo and Manow, 1999, p.969).

Wendt and Kohl (2010) also examined the impact of healthcare systems on healthcare financing in the UK, Germany and the U.S. since the 1980s. Like Giaimo and Manow (1999), they used the modes of regulatory mechanisms to classify three healthcare systems examined although they refer healthcare systems to ‘the mode of public policies’: direct public control, self-regulation by non-government actors (including doctors), and market mechanisms (Wendt and Kohl, 2010, p.12). They found that the UK with public policies favoring direct state control had “below average health expenditure” (Wendt and Kohl, 2010, p.11). Then, they found that Germany with public policies favoring “a high level of self regulation” (Wendt and Kohl, 2010, p.15) had “above OECD average health expenditure” (Wendt and Kohl, 2010, p.11) due to “high levels of health care providers” (Wendt and Kohl, 2010, p.11). And finally, they found that the U.S. with public policies favoring market mechanisms had “comparatively high total health care costs” (Wendt and Kohl, 2010, p.11).

The studies of Freeman (1998), Giaimo and Manow (1999), and Wendt and Kohl (2010) showed that different healthcare systems led to different reform patterns in the countries examined because they are embedded in different political and economic contexts, embrace different values, have different funding structure and medical coverage, being affected by different political legacies, and have different stakeholders having different levels of influence in healthcare systems. Hence, the countries examined adopted different strategies to reform their healthcare systems.

Like Freeman (1998) and Giaimo and Manow (1999), Wendt and Thompson (2004) examined the impact of structural specifics of the healthcare systems on cost-containment effort in the UK, Denmark, Germany and Austria since the 1980s (Wendt and Thompson, 2004, p.418). However, they differed from Freeman (1998) and Giaimo and Manow (1999) in terms of the cost-containment strategies studied. While Freeman (1998) and Giaimo and Manow (1999) predominantly focused on studying “the cost dimension of the health care demand-supply equation” (Wendt and Thompson, 2004, p.416), Wendt and Thompson (2004) focused on studying structural reform strategies targeting both ambulatory and inpatient care (p.418). They found that the national healthcare systems of the UK and Denmark were more successful than

the legally enacted health insurance systems of Germany and Austria in containing costs (Wendt and Thompson, 2004, p.417). It was because the national healthcare systems of the UK and Denmark had lower density of both physicians and non-physician healthcare personnel in ambulatory care contributing to providing lower volume of medical services, heavily relied on general practitioners as gatekeepers to significantly reduce drug consumption, had greater coordination between inpatient and community care, had greater integration between ambulatory and inpatient care, and enhanced the continuity of care through greater reliance on primary care providers (Wendt and Thompson, 2004, pp.421-6).

On the other hand, the study of Cacace and Schmid (2008) generated a different result which supported convergence caused by different healthcare systems. Cacace and Schmid (2008) argued that “the healthcare system itself, its deficiencies and functional requirements” (p.396) was the “most influential explanatory factor” (p.396) to explain why the healthcare systems of the U.S. and Canada that “once differed largely with respect to spending pattern” (p.412) in the 1960s had converged in the financing dimension over the past 15 years (Cacace and Schmid, 2008, p.411). They found that the private healthcare system in the U.S. had “incorporated many public elements, while the public healthcare system in Canada [had] increasingly [relied] on

a private supplementary scheme” (Cacace and Schmid, 2008, p.411) that both healthcare systems become mixed types. It was the U.S. and Canada systematically introducing non-system-specific elements “which were originally less developed or completely missing” (Cacace and Schmid, 2008, p.398) to their healthcare systems that the funding structure of both healthcare systems became more similar and thus led to convergence.

The problem of the study of Cacace and Schmid (2008) is that they wrongly regarded the mixed sources of healthcare funding as convergence. The funding dimension has repeatedly been used as a central distinguishing factor to establish healthcare typologies or conceptual models that differentiate healthcare systems across the world (Wendt et al., 2009, p.78). Healthcare typologies or conceptual models are known as ideal types because healthcare systems in reality are funded through different sources such as taxation, social health insurance, private contributions and out-of-pocket payment. Nevertheless, healthcare systems “demonstrate a leaning in one direction or another, making it possible to distinguish among predominant funding types” (Wendt et al., 2009, p.78). Mixed types of funding is a common practice among different healthcare systems in reality. Therefore, the argument made by Cacace and Schmid (2008) that mixed types of healthcare funding

is a sign of convergence is weak. In fact, the data of sources of funding in percentages of total expenditure in the U.S. and Canada from 1990 to 2005 showed that taxation continued to be the predominant source of funding in the Canadian healthcare system although its financial share decreased from 73.5 per cent in 1990 to 68.8 per cent in 2005 (Cacace and Schmid, 2008, p.402). As to the U.S. healthcare system, private insurance financing continued to be the predominant source of funding, with its financial share increasing from 34.2 per cent in 1990 to 36.6 per cent in 2005 (Cacace and Schmid, 2008, p.402). The Canadian healthcare system remains tax-based while that of the U.S. remains market-based. Therefore, the healthcare systems of the U.S. and Canada have not converged over the past 15 years, which is opposite to the contention of Cacace and Schmid (2008).

(ii) Political Systems as the Main Explanatory Factor

Ham and Brommels (1994) argued that a country's political process greatly affected the pace and scope of healthcare reform to contain costs and raise efficiency in resource use in the UK, the Netherlands and Sweden since the late 1980s. They argued that the UK benefited from a unitary political system with governments enjoying legislative majorities and being committed to change (Ham and Brommels, 1994, p.118) and thereby having the quickest pace and the widest scope of healthcare

reforms. Then in the Netherlands, they argued that the succession of coalition government led to the revision of the original healthcare reform proposals (Ham and Brommels, 1994, p.118) that it had the slowest pace and the narrowest scope of healthcare reform. And finally in Sweden, they argued that the elected county councils were able to implement healthcare reform in a decentralized manner “within the context of national legislation” (Ham and Brommels, 1994, p.119) that its pace and scope of healthcare reform lied between that of the UK and the Netherlands (Ham and Brommels, 1994, p.108).

The problem of the study of Ham and Brommels (1994) is that it fails to establish the causal linkage between the political process and the pace and scope of healthcare reform because Ham and Brommels (1994) only used a short paragraph in the concluding comment section to make their contention that a country’s political process greatly affected the pace and scope of healthcare reform without exactly using the political approach to examine the issue. Instead, much space was used to cover the reform contents of three countries studied. One can only see the descriptive information of each reform strategy and what kind of healthcare reform was implemented in each country. However, how the political process affects the actors’ reform options and the speed of reform in the countries examined was unknown.

Wilsford (1995) used a political approach to empirically examine how different patterns of interaction between the state's autonomy in healthcare and providers' political mobilization led to a cross-national difference in the reform strategies adopted to restrain healthcare costs in Germany, Japan, Canada and the UK since the 1980s. He found that in Germany, the state having moderate autonomy in healthcare succeeded in restraining the growth of healthcare expenditures by diminishing the structural strength of medical interests through establishing new regulations, implementing strict budgetary measures and a system to monitor doctors' treatment pattern (Wilsford, 1995, p.584). Then in Japan, he found that the state having high autonomy in healthcare and being coupled with business and insurance societies as its capable allies was able to contain healthcare costs through fee negotiations when doctors originally having high interest mobilization lost their internal cohesiveness since the 1980s (Wilsford, 1995, p.590). Also in Canada, he found that the state having high autonomy in healthcare was able to contain healthcare costs because it reduced the political effectiveness of doctors originally having high interest mobilization by passing regulations which imposed tighter controls on doctors' prerogatives in policy formulation and implementation (Wilsford, 1995, p.595). And finally in the UK, he found that the state having high autonomy in healthcare was able

to implement reforms which favored market elements because it made the perception of a ‘crisis’ in the healthcare system become widespread (Wilsford, 1995, p.602) while at the same time weakening the political effectiveness of the medical profession which had already become “a more heterogeneous, fragmented interest” (Wilsford, 1995, p.602) since the early 1980s by excluding the medical profession from the reform process (Wilsford, 1995, p.602).

The study of Wilsford (1995) shows that the states examined strategically increased their reform capacities at the expense of the interests of the medical profession. It shows that since healthcare policy in each country has its own development path, it led to the healthcare system established embracing its own values, granting the state different degrees of autonomy in healthcare and granting the medical profession different levels of political mobilization. Therefore, the healthcare systems examined diverged in methods of restraining the growth of healthcare expenditures.

(iii) Healthcare and Political Systems as the Main Explanatory Factors

Giaimo (2001) examined how the joint effects of existing healthcare and political systems provide the state and stakeholders with different opportunities or constraints

to pursue cost containment reforms in the UK, the U.S. and Germany since the 1980s. She found that in the UK, the tax-funded healthcare system granted “the state [which was the single payer] unlimited freedom to decide health policy” (Giaimo, 2001, p.340) while the centralized political system coupled with parliamentary majority helped the state implemented healthcare reform more easily. However, since the healthcare system emphasized universalism and “the state must answer to taxpayers who ultimately finance the health care budget” (Giaimo, 2001, p.340), cost-containment reform implemented in the UK “had the best record on cost containment while preserving equity at the same time (Giaimo, 2001, p.335). Then in the U.S., she found that the fragmented political system which provided different actors with veto points hampered the government’s effort to implement healthcare reform (Giaimo, 2001, p.341) while the healthcare system characterized by private and voluntary fringe benefits “encouraged employers and insurers to take cost-cutting actions that worked in the direction of desolidarity” (Giaimo, 2001, p.335). And finally in Germany, she found that the statutory national health insurance system which stressed equal responsibility between employers and employees to finance healthcare required the coalition governments having “the legal authority and the institutional means” (Giaimo, 2001, p.356) to balance “the goals of cost control with equity” (Giaimo, 2001, p.355). Germany represented an intermediate case between

the UK and the U.S., “spending more than the former but without resorting to the gaping inequities of the latter” (Giaimo, 2001, p.335).

(iv) The Path Dependence Approach or the Theory of Historical Institutionalism

Bandelow (2007) used the path-dependent perspective to explain why the UK and Germany diverged in healthcare reform strategies and outcomes from 1997 to 2005. He argued that different healthcare systems, different starting points, governments’ different perceptions of the main healthcare policy problems, and the past reform direction “determined by the action of the previous government” (Bandelow, 2007, p.162) were the main reasons for explaining divergent reform paths in these two places. In the UK, the New Labour government’s healthcare policy “started with the results from the ‘internal market’ that the Conservatives had introduced in 1991” (Bandelow, 2007, p.153). It concerned with increasing the quality and quantity of the tax-funded healthcare system (Bandelow, 2007, p.153). It followed a similar reform direction of its Conservative predecessor by increasing “patient choice and provider competition” (Bandelow, 2007, p.153). As to Germany, he found that healthcare policy had “traditionally been seen as a central element of employment policy” (Bandelow, 2007, p.153) that the SPD-Green government faced the problem of rising healthcare costs which led to “rising contribution rates and ultimately higher

non-wage labour costs” (Bandelow, 2007, p.157). It could only implement incremental reforms which limited the global size of budget and increased patient co-payments (Bandelow, 2007, p.158) because healthcare providers who benefited from a corporatist healthcare system acted as “highly effective veto players” (Bandelow, 2007, p.157). Path-dependent studies mainly focus on how the pre-existing institutions create strong inertial tendencies that restrain the policy options key actors can choose and thus make the implementation of revolutionary reforms extremely difficult. However, the study of Bandelow (2007) lacked institutional analysis. Although Bandelow (2007) mentioned that healthcare policy in the UK and Germany “remain dominated by national political institutions, interests and ideas” (p.162), his main focus was key political actors’ reaction to previous reform decision made by the previous government without seriously examining the impact of healthcare and political institutions on political actors’ policy preferences.

The studies of Wilsford (1994), Immergut (1992), and Hacker (1998) also used the theory of historical institutionalism or path dependency theory to examine how established political institutions generate inertia and impose constraints on the options that can be chosen by political actors to reform their healthcare systems. Since these studies will be discussed in more depth in the next chapter to illustrate some important

concepts of historical institutionalism, they would only be briefly discussed in this section.

Wilsford (1994) used a path-dependent perspective to examine how the structure of political institutions enacted or blocked healthcare reforms in Germany, France, the UK and the U.S. since the 1980s. But his understanding of the impact of political institutions on healthcare reform in the countries examined except the US was contradictory. On one hand, he argued that the political structure of Germany, France and the UK acted as institutional impediments to implement policy changes. On the other hand, he argued that the centralization of decision process and hierarchical ordering commonly shared by the political institutions of Germany, France and the UK facilitated policy changes. His inconsistent interpretation of political institutions significantly reduces the explanatory power of his study.

Immergut (1992) examined how the number and locations of institutional veto points created by constitutional rules and electoral results provided different opportunities for the medical profession to block the national health insurance legislation in Sweden, France and Switzerland before 1970. She showed that the legislation could be passed in Sweden where veto points did not exist and in France

where veto point no longer existed after changes in constitutional rules. On the other hand, the legislation was blocked in Switzerland where there were many veto points. The study of Immergut (1992) implies that states have greater opportunities to pass their legislations or reform policies when they operate in political systems with fewer veto points than those operating in political systems with more or multiple veto points. However, there is reservation about the explanatory power of veto points because veto points can change over time when changes occur in constitutional rules or electoral results. Besides, veto points are limited to explain the political processes of parliamentary system or parliamentary democracies that they cannot be applied in authoritarian political systems or developing countries.

Compared with that of Immergut (1992), the study of Hacker (1998) used a broader perspective to examine the development of health insurance programmes in advanced industrial democracies. Hacker (1998) employed the theory of historical institutionalism to examine how “the sequence and timing of major government interventions in the medical sector” (p.59) and policy legacies affected the emergence of national health insurance programmes in the UK, Canada, and the U.S.. Instead of a single force, Hacker (1998) argued that it was the “complex historical interplay of forces that leads countries to adopt particular national health policies” (p.58). He

identified and explained how the larger political, economic and ideological climate surrounding healthcare policies, “a number of sequential historical moments” (Hacker, 1998, p.83), “the distinctive matrix of incentives and constraints created by [different] political institutions” (Hacker, 1998, p.81), the way in which political institutions articulated political demands for policy reform (Hacker, 1998, p.60), and “the important turning points in the development of each country’s national health policies” (Hacker, 1998, p.77) led to the establishment of NHS in the UK in 1946, Medicare in Canada in 1966, and Medicare and Medicaid in the U.S. in 1965. The study of Hacker (1998) provides a more comprehensive view and makes stronger arguments about the cross-national difference in healthcare development than studies which only give descriptive, atheoretical or monocausal accounts.

In brief, the review of the available literature in the West shows that the intellectual debate mainly focuses on whether healthcare reform implemented since 1980s has led to healthcare systems in different welfare states moving towards convergence. Although a review of the available literature in the West shows that there is an observed diversity of research findings, which argues for the convergence, divergence or convergence-divergence mix of healthcare system, the balance and strength of the evidence suggests most support for the divergence of healthcare

systems. Besides, it shows that most of the studies on healthcare reform give descriptive, atheoretical or monocausal accounts. Studies which really adopt the theory of historical institutionalism to stringently examine how the complex historical interplay of sequence, timing, political institutions and contextual pressures affects the healthcare reform path in welfare states are rare.

2.3.2 Urban Health Insurance Reform in China

Like its western counterparts, China as the market-Leninist welfare regime also implemented urban health insurance reform in 1998.³ It established a compulsory, employment-based and cost-sharing health insurance system consisting of an individual MSA and a SPF to replace the non-contributory LIS and GIS that were

³ China also implemented rural healthcare financing reform in 2003. In China, the establishment of the people's commune in 1958 as the highest level of a collectively owned economic organization in rural areas (Sun, 1980, pp.24-5; Saich, 2004, p.245) was followed by the establishment of the Cooperative Medical System in rural areas. The people's communes could only establish the Cooperative Medical System "on the basis of voluntary participation and mutual assistance" (Chen, 1984, p.129) to provide medical services for rural population. The System was financed by individual contributions and collective welfare funds from brigades and production teams (Cheung, 2001, p.65) to cover the cost of treatment and medicine received by commune members and to build and maintain healthcare facilities (China Health Care Study Group, 1974, p.42). Its capacity to provide healthcare services mainly depended on "the productivity and stability of the local economic base" (Lampton, 1977, p.237). Deng's economic reform which used farming households to replace the people's commune as an autonomous agricultural production unit (Jackson et al., 1996, p.409) led to the dismantling of the commune system in the early 1980s (Grogan, 1995, p.1073; Pearson, 1995, p.93; Hsü, 2000, p.846). The abolition of the commune system led to "the end of collective funding for rural health care" (Jackson et al., 1996, p.416). The Cooperative Medical System collapsed in the 1980s. The participation rate of the Cooperative Medical System sharply dropped from 90 per cent in 1980 to 5 per cent in 1985 (Liu and Cao, 1992, p.504). Most of the participants of the Cooperative Medical System "transferred to fee-for-service" (Liu and Cao, 1992, p.505). In 2003, the Chinese government implemented the New Rural Cooperative Medical System, which focused on "serious diseases planning, mutual aid and fraternity among rural residents in health care" (Wang, 2007, p.67). The new System is based on voluntary participation (Wang, 2007, p.71). It is financed by "individuals, collectives and the government" (Wang, 2007, p.67) to insure rural participants against serious diseases (Wang, 2007, p.69).

collapsed in the 1980s. To China, this national health insurance reform which implemented a completely new health insurance model represents a big policy change because it significantly departs from the original path it has followed for almost four decades. The implementation of urban health insurance reform has drawn scholarly interest. A review of the available literature shows that different approaches are adopted to examine this issue, including a descriptive approach, a quantitative approach, an economic approach, an actor-based approach, and the institutional or political approach. However, as illustrated below, none of the available studies reviewed adopts the theory of historical institutionalism to examine how the complex historical interplay of sequence, timing, political institutions and contextual pressure shapes the healthcare reform path in China.

(a) A Descriptive Approach

The studies of Cheung (2001), Liu (2002), Rösner (2004), Tang and Meng (2004), Liu et al. (2004), and Dong (2009) used a descriptive approach to review the evolution of urban health insurance system since the founding of PRC in 1949. They traced the historical development of the urban health insurance system in different periods, described how the system functioned, reviewed the reform process, analyzed the major problems and challenges of the new health insurance model. The problem of

these studies is that they do not employ any theoretical lens to stringently and systematically examine what and how major forces shaped the development trajectory of health insurance reform in China. The studies of Tang and Meng (2004) and Liu et al. (2004) briefly mentioned that the lack of risk pooling of the traditional health insurance system, China's transition to the market economy since 1978, and hospitals' profit-seeking behavior after the economic reform were the major drivers for rapid escalation of healthcare expenditures and the major reasons for urban insurance reform. But they are not useful enough to understand about the healthcare reform development path, especially when they do not examine the role of political institutions in shaping the urban health insurance reform. Studies adopting the descriptive approach lack explanatory power.

The studies of Dong (2003, 2008) used a descriptive approach to review the health insurance reform in Shanghai since the 1980s. They briefly talked about the urban health insurance system in the pre-reform era, the economic pressure for reform, the institutional design of the new health insurance model and the problems created by the new health insurance model in Shanghai. Like the aforementioned studies, the studies of Dong (2003, 2008) lack explanatory power and are unhelpful in providing an insight to understand what forces shape the development trajectory of health

insurance in Shanghai.

(b) A Quantitative Approach

Another type of studies uses a quantitative approach to analyze the impact of urban health insurance reform on a particular set of issues, including public and private enterprises (Wu et al., 2005), hospital charges (Meng et al., 2004), out-of-pocket payment (Liu and Zhao, 2006), equity in healthcare access (Liu et al., 2002), and access to essential medicines (Zhu et al., 2008). This approach collected data through different sources, including a household survey at a district level (Wu et al., 2005), a multiyear survey collected at the city level (Liu et al., 2002; Liu and Zhao, 2006), a database within the community health service management center (Zhu et al., 2008), and patient medical records in hospitals (Meng et al., 2004).

This type of study contains three problems. Firstly, most of the studies reviewed in this category do not base the research upon theories. Apart from the study of Liu et al. (2002) and that of Liu and Zhou (2006) which respectively used an economic model and the Anderson Behavior model to examine urban health insurance reform, the studies of Meng et al.(2004), Wu et al. (2005) and Zhu et al. (2008) do not apply any theories to examine the issue. Studies lacking theoretical basis is unhelpful for

understanding and explaining the causal linkage between urban health insurance reform which is the independent variable and the dependent variables examined.

Secondly, it fails to give a full picture about the development trajectory of health insurance reform in China. This type of study examines urban health insurance reform in a specific locality in China such as Zhenjiang city (Liu et al., 2002; Liu and Zhao, 2006), Nantong and Zibo cities (Meng et al., 2004), Shenzhen (Zhu et al., 2008), and Beijing (Wu et al., 2005). Besides, it only studies urban health insurance reform in a particular year (Wu et al., 2005; Zhu et al., 2008) or specific short period of time ranging from two to five years (Meng et al., 2004; Liu et al., 2002; Liu and Zhao, 2006). Since the development trajectory of health insurance reform in China is not a one-time event but rather an ongoing historical process shaped by complex interplay of forces, this type of study is not conducive to understanding about the shifting of reform path in China.

Thirdly, it treats urban health insurance reform as an independent variable in order to examine the impact of urban health insurance reform. But the study of the development trajectory of health insurance reform would treat health insurance reform as a dependent variable in order to see how its content or implementation is shaped by

political institutions or other independent variables. Therefore, this study is irrelevant to study the development trajectory of health insurance reform in China.

(c) An Economic Approach

The studies of Gu (2001a) and Gu and Zhao (2006) used an economic perspective to examine how China's transition from a planned to a market economy since 1978 led to an institutional transformation of the urban health insurance system in China. Both studies argued that the rapid process of marketization led to the non-contributory health insurance system which functioned well in the institutional configuration of a planned economy falling into a serious financial crisis in the late 1980s, which imposed an unbearable financial burden on the enterprises and ultimately on the state and concurrently became an institutional impediment for further economic reform. This drove the state to implement the urban health insurance reform by establishing a contribution-based health insurance system to replace the non-contributory health insurance system in the 1990s. The problem of the studies of Gu (2001a) and Gu and Zhao (2006) is that their economy centered approach under-emphasizes the role of the state or political institution in shaping the economic reform, especially when China was an authoritarian state with the CCP enjoying the monopolistic power to control the territory and people. Although it is true that the economic reform caused the

collapse of the traditional health insurance system, it only acted as a turning point or a critical juncture for the healthcare system to move to a new path. Instead, it was the state shaping the reform path of healthcare by deciding how and when the health insurance reform should take place, which institutional design of the new health insurance reform should be adopted and how the new health insurance model should function. It is unable to provide a full picture about the evolution of urban health insurance system without emphasizing the role of the state or political institutions.

(d) An Actor-based Approach

Duckett (2001) used an actor-based approach to examine the impact of different political interests on the implementation of urban health insurance reform in Beijing, Shanghai, Tianjin and Suzhou between 1997 and 2000. She argued that the vested interests of enterprise managers, state enterprise employees, healthcare providers, medicine producers and government officials created by the pre-reform health insurance system resisted change and led to slow implementation of the urban health insurance reform and created “two main problems of poor participation and balancing the income and expenditures of the social [health insurance] funds” (Duckett, 2001, p.297). While she showed that how different actors took actions to defend their interests during the reform implementation stage, she also recognized that their

capacity of hindering health insurance reform was due to “weak local government capacity that [was] in turn founded on the weak rule of law and poor government accountability” (Duckett, 2001, p.302). It shows that actually it was the institutional weakness of the legislative and political systems giving opportunities for actors to influence the implementation of urban health insurance reform. In fact, institutions matter in structuring the interests of different actors who in turn affect the urban health insurance reform.

(e) A Political or Institutional Approach

In another study, Duckett (2003) used a political approach to examine how political institutions and state bureaucratic interests shaped the urban health insurance reform policy since the mid-1980s. She found that urban health insurance programme was a product of compromise because the healthcare reform process was “the protracted and incremental policy process” (Duckett, 2003, p.212) involving complex interaction and bargaining among top leaders and multi-institutions such as four government ministries (Finance, Health, Labor, Personnel), the Economic System Reform Commission, and four bureaus (Health Insurance, Drug Administration, Medicine, Material Pricing) (Duckett, 2003, p.219) with competing interests operated within vertical functional structures and bureaucratic rank (Duckett, 2003, p.212). Besides,

she found that the reform being implemented in a decentralized manner allowed local governments to influence the design of the local health insurance schemes (Duckett, 2003, p.227). Also, she found that the vested interests of enterprises, hospitals and civil servants created by the pre-reform health insurance system were able to hinder the implementation of the health insurance reform (Duckett, 2003, p.227).

The study of Duckett (2003) shows that how key bureaucratic actors within the context of political institutions affected the development of the urban health insurance reform. It is a more comprehensive study because it recognized that both political institutions and bureaucratic actors were closely intertwined and jointly shaped the urban health insurance reform. However, this study could have been better if it could also mention the reform background in China. By mentioning what factors or contextual pressures drove China to implement health insurance reform, the study could help justify why the urban health insurance reform was needed in the first place and help the audience, in particular those who were not familiar with China, understand why different key actors pursue different interests during the policy-making and implementation processes.

In her recent work, Duckett (2011) uses a political approach to examine how and

why the Chinese state has retreated from its role in funding healthcare since 1978. Using “an analytical framework drawn from studies of state retrenchment in industrialized democracies and in post-communist Eastern Europe” (Duckett, 2011, p.3), Duckett (2011) argues that health retrenchment in China is not simply the product of economic reforms and domestic fiscal constraints (pp.8-9). Instead, she argues that politics is “central to both catalyzing and shaping retrenchment” (Duckett, 2011, p.16). Centrally, “governmental and ideological change and political struggles among stakeholders in a health policy arena shaped by China’s political institutions” (Duckett, 2011, p.99) thoroughly explain why the Chinese state has retreated from health since 1978. The merits of Duckett’s (2011) work are that research on retrenchment politics has been extended to a major authoritarian state and a more complete picture of the transformation of Chinese healthcare system over the past three decades has been given through a systematic and thorough political analysis of the three dimensions of the Chinese state’s health retreat.

In brief, a review of the available literature shows that different approaches are adopted to examine urban health insurance reform in China, including the descriptive, quantitative, economic, actor-based, and the institutional or political approaches. These approaches have merits of their own. But none of them can provide a complete

picture about the development trajectory of the urban health insurance reform in China. Studies which adopt the theory of historical institutionalism to examine the urban healthcare reform in China are yet to exist.

2.3.3 Health Insurance Reform in Hong Kong

Like the western countries, Hong Kong as a productivist welfare regime has been under pressure for reforming its healthcare financing system since the early 1990s due to ageing population, rising healthcare expenditures, heightened public expectations and changing medical needs. However, the government's repeated attempts to reform the tax-funded healthcare system have not been successful. Its proposals for a coordinated voluntary insurance in 1993, a two-tier mandatory health insurance scheme in 1999 and a mandatory medical savings scheme in 2000 were shelved due to severe political and public opposition. At the time of this study, the government is analyzing citizens' views on a regulated voluntary private health insurance scheme proposed in October 2010 after the public consultation came to an end in January 2011. Hong Kong represents a case of the status quo without any fundamental changes to its healthcare financing system "despite the loud rhetoric about the need to reform" (Cheung, 1994, p.352). It still sticks to its original path of funding the universal healthcare system through taxation. Hong Kong is an interesting case study.

However, a review of the available literature shows that there is a lack of theoretically grounded work on examining the development trajectory of health insurance reform in Hong Kong. As illustrated below, most of the studies reviewed are historical or descriptive studies that they are less helpful in understanding about the development trajectory of health insurance reform in Hong Kong.

(a) A Historical Approach

The studies of Chao (1999), Gauld (1997, 1998) and Gould (2005, 2006) gave a historical overview of the development of healthcare policy in Hong Kong from the colonial era (since 1841) to the post-colonial era (since 1997). Their reviews showed that the free healthcare system implemented since 1964 had remained unchanged after the government's failed attempts to reform the healthcare financing system. While these studies provide rich information and a clear historical timeline of healthcare development in Hong Kong, they are far too descriptive and fail to explain why the mode of healthcare funding remains unchanged.

(b) A Descriptive Approach

The studies of Leung (1993), Cheung (1994) and Wong (1996) were descriptive studies giving a brief review of the financing options proposed in the 1993 healthcare

financing reform. They respectively claimed that the failure in implementing this healthcare financing reform was due to “increasing politicization of the society” (Leung, 1993, p.233), “the absence of demand for reform from the society at large” (Cheung, 1994, p.353), and the emergence of more elected legislator who were more critical of government proposal (Wong, 1996, p.450). The study of Gauld and Gould (2002a) reviewed the proposed financing options of and public reaction to the 1993 and 1999 healthcare financing reforms and found that the reform failure was due to the lack of community acceptability (p.139). The study of Cheng (2007) which briefly gave an overview of healthcare development in Hong Kong from 1997 to 2007 argued that the lack of major progress in healthcare financing reforms during this period was attributed to “professional dominance in policy decisions, the power imbalance between professionals and the community, as well as the difference in perceptions and community values” (p.812). The study of Low and Lo (2006) briefly reviewed the reform strategies proposed in the 1999 and 2000 healthcare financing reform and argued that the government should devise an appropriate reform by taking “its tax regime, economic development, demographic trends and social values” (p.468) into account. The problem of these studies is that they do not apply any theoretical lens to stringently examine what were the main explanatory determinant(s) of healthcare reform failures. Their arguments are too vague and they fail to introduce substantial

evidence in support of their contention through thorough investigation.

(c) An Economic Approach

The studies of Hay (1992) and Ho (1997, 2001) used an economic perspective to examine the healthcare system in Hong Kong. Hay (1992), who was a health economist, argued that the Hong Kong healthcare system was outdated and inefficient. He suggested the creation of a competitive market for healthcare service by implementing a voluntary publicly subsidized insurance scheme called ChoiceCare, which allowed the insured family to obtain healthcare services either from the public or private hospitals. Ho (1997, 2001), another economist, argued that the efficiency of healthcare delivery and financing in Hong Kong could be improved by implementing Universal Excess Burden Health Insurance Plan (UEBHIP), which combined tax-funded payment and a uniform yearly spending limit paid by the insured participants. At the same time, fees for medical services at public hospitals would be sharply increased to “reflect the direct costs of providing these services” (Ho, 2001, p.159).

The problem of these studies is that they ignore the complex nature of healthcare which cannot be solely examined from a purely economic perspective. Although the

“issue of financing health services is strongly associated with ever increasing health care costs and ever tighter budgetary constraints” (Kanavos, 1999, p.11), healthcare is not simply a consumer good which can be easily calculated by cost-benefit analysis. As Lessard (2007) argued, economic evaluation in healthcare oversimplifies complex healthcare decision because it ignores “important health consequences, contextual elements, relationships or other relevant modifying factors” (p.1754). Healthcare financing reform is an issue involving multi-objectives and multi-stakeholders (Lessard, 2007, p.1754). It is not simply an economic issue but a political, social and moral issue as well. Therefore, studies based on an economic analysis are unhelpful in understanding about the development trajectory of healthcare finance system in Hong Kong when the development path of healthcare is shaped by complex interplay of forces.

(d) A Political Economy Approach

The study of Wong (1999) used the political economy perspective to examine then financing options proposed in the 1993 healthcare financing reform. Wong (1999) argued that the reasons why the colonial government preferred voluntary health insurance to compulsory social health insurance was due to the fact that the latter was perceived as an hypothecated health tax which threatened the government’s “freedom

to allocate resources and to its commitment to maintain the low-tax policy in Hong Kong” (p.205), being “at odds with the government’s policy of ‘positive non-intervention’ in private health care” (p.210), and became a undesirable move towards collectivism which was against Hong Kong’s mode of capitalism (p.212). Since this study was limited to reviewing health insurance reform of a particular year, it does not provide a clear and complete picture about the development trajectory of health insurance reform in Hong Kong.

In brief, a review of the available literature shows that there is a lack of studies on the development trajectories of healthcare financing reform in Hong Kong. Different approaches are adopted to examine healthcare financing reform in Hong Kong, including the historical, descriptive, economic and political economy approaches. However, while studies based on the historical or descriptive approach are unhelpful in explaining how the development trajectory of healthcare financing reform is shaped over time, studies based on economic approach oversimplify complex healthcare decisions. And studies based on political economy approach to examine healthcare financing reform in a particular year can only provide a partial answer to the development trajectory of health insurance reform in Hong Kong.

2.3.4 Comparative Studies of Healthcare Policy in China and Hong Kong

A review of the available literature also shows that there are studies examining the healthcare system of China and Hong Kong on a comparative basis (Cheung and Gu, 2004; Fitzner et al., 2000; Yu, 2006). The study of Fitzner et al. (2000) compared the health status, healthcare policy, and the efficiency of healthcare system of Hong Kong with that of China. But it contains three problems. Firstly, Hong Kong and China is incomparable in terms of the unit of analysis because the former is a city of 6.5 million while the latter is a country of 1.3 billion. Secondly, the study is a descriptive study lacking explanatory power because it does not apply any theoretical framework to stringently examine the issue. And thirdly, it only briefly described its use of four criteria---demand barriers, technical efficiency, adequacy of supply, and allocative efficiency (Fitzner et al., 2000, p.152) --- to assess the efficiency of healthcare system in Hong Kong and China. Without substantial data support, it quickly jumped to the conclusion that both Hong Kong and China required “structural reform to increase the efficiency of their respective health systems” (Fitzner et al., 2000, p.152) and “contain the growth of health care expenditure” (p.153). The contention made by Fitzner et al. (2000) is not convincing.

The study of Yu (2006) used a path dependence perspective to examine the

causes and key features of healthcare financing reforms and the difficulties in launching the reforms in urban China and Hong Kong in the late 1990s. It argued that the governments in both places shared the common intention of using healthcare financing reform as a means to secure “more compatible (but not necessarily equal) relationship between the development of social welfare and the operation of the private market” (Yu, 2006, p.847). However, their healthcare financing reform options differed because of the influence of “previous policies on social welfare” (Yu, 2006, p.860). The Chinese government, which did not give up “its practice developed in the pre-market-reform period of relying on state-owned enterprise to provide welfare for their workers” (Yu, 2006, p.860), implemented a mandatory cost-sharing health insurance system requiring “state-owned enterprises to fulfill their welfare commitment to their workers” (Yu, 2006, p.860). The Hong Kong government, which upheld the time-honored low-tax policy, proposed a mandatory savings scheme. The study of Yu (2006) contains three problems. Firstly, urban China with Hong Kong is incomparable in terms of the unit of analysis. Secondly, the term ‘urban China’ is very ambiguous, giving the audience no idea of which part of China the study refers to. And thirdly, Yu (2006) does not apply the path dependence notion well into his study because the causal linkage between previous policies and current reform strategies is missing in his study when much space was used to describe the contents of reform

strategies.

The study of Cheung and Gu (2004) gave an overview of the healthcare financing reform trajectories in Shanghai and Hong Kong since the 1980s and found that the current healthcare financing reforms in both cities were “triggered by financial constraints” (p.23) and their reform processes illustrated “conflicts among objectives of financial viability, equitable coverage, and citizens’ affordability to pay for their health care” (p.23). This study is descriptive in nature without theoretical basis.

In brief, a review of available literature shows that previous comparative studies on the healthcare systems in Hong and China contain the methodological problem of being incomparable in terms of the unit of analysis and the problem of lacking explanatory power. It also shows that the empirical puzzle about why Shanghai being able to implement health insurance reform since the mid-1980s while Hong Kong failing to do so has not been studied before.

2.4 The Importance of Applying Theory into Health Policy Studies

A review of the available literature on healthcare finance reveals the problem of

lacking studies which adopt theories to examine the issue. Most of the studies examined are descriptive studies without a theoretical foundation. There are studies which adopt certain approaches or perspectives without really applying a theory. This type of study still has explanatory power but can only provide a partial answer to the issue it examines. In fact, the use of theory is important when conducting research, in particular health policy. As Neuman (2003) argued, the primary purpose of a theory is to explain (p.54) “why specific events and patterns of events occur as they do” (Wellington and Szczerbinski, 2007, p.37). It provides researchers with different ‘lenses’ to look at complicated problems (Reeves et al., 2008, p.631), helps them understand and “translate for policy makers and healthcare providers, the processes that occur beneath the visible surface and so to develop knowledge of underlying (generating) principles (Reeves et al., 2008, p.634)”. As Parson (1938) argued, theory has the advantages of providing researchers with “selective criteria as to which are important and which can safely be neglected” (p.20), “a basis for coherent organization of the factual material” (p.20), “a crucially important guide to the direction of fruitful research” (p.20), and “a source of cross fertilization of related fields of the utmost importance” (p.20).

2.5 Conclusion

To conclude, the literature review of the available studies shows that the empirical puzzle about why Shanghai being able to implement health insurance reform since the mid-1980s while Hong Kong failing to do so has not been studied before. None of the available studies adopts the theory of historical institutionalism to stringently examine why the healthcare financing reform trajectory of Shanghai is divergent from that of Hong Kong. In order to fill this research gap, this study uses the theory of historical institutionalism to solve this real world puzzle. Besides, it contributes to Western scholarly debate over convergence and divergence of healthcare reform. The next chapter will introduce and discuss the theory of historical institutionalism in detail.

CHAPTER THREE: THE THEORY OF HISTORICAL INSTITUTIONALISM

3.1 Introduction

This chapter introduces the theory of historical institutionalism which will be adopted to examine healthcare financing reform in Shanghai and Hong Kong. It is divided into five sections. Section 3.2 briefly introduces the historical development of institutional theories in political science. Section 3.3 highlights six key features of historical institutionalism. Section 3.4 examines the limitations of historical institutionalism to explain change and evaluates the existing approaches that are adopted by historical institutionalists to explain institutional change. Section 3.5 discusses how this study is going to refine the theory of historical institutionalism before it is applied into the case studies of Shanghai and Hong Kong to explain their divergent reform paths in healthcare. Section 3.6 give a conclusion.

3.2 Historical Development of Institutional Theories in Political Science

(a) Old Institutionalism

The study of political institutions constituted the basis of political science which professionalized as a modern academic discipline in the late 19th and early 20th

century (Almond, 1996, p.64; Rhodes, 1995, p.43; Rothstein, 1996, p.137).⁴ The original institutionalism or old institutionalism studied the formal government institutions and “defined the state in terms of its political, administrative, and legal arrangements” (Schmidt, 2006, p.99). It dominated the discipline from 1880 to 1930, finding the pillars of order in politics and facilitating the routine operation of the polity (Orren and Skowronek, 1995, p.298). According to Peters (1999), old institutionalism had five characteristics, including: legalism, which was concerned with the central role of law in governing; structuralism, which emphasized that political systems determined political behavior; holism, which compared the whole political systems instead of examining individual institutions; historicism, which examined how history influenced the development of contemporary political systems; and normative analysis that ascertained which political institutions produced good government (pp. 6-10). However, it was criticized for four reasons, including: being atheoretical and descriptive when explaining the relations among branches of government; being unscientific when its concern with norms and values failed to distinguish facts from values; being ethnocentric when it failed to function well in developing countries with less formalized institutional arrangements; and disregarding

⁴ According to Almond (1996), American political science professionalized in the late 19th and early 20th century when the corruption of local and national political processes caused by the rapid growth of industry and the proliferation of large cities in the U.S. became a subject of deep concern (p.64). It was founded by political scientists including Woodrow Wilson, Frank Goodnow and Charles Merriam, who linked their scholarly concerns with the needs to improve government (Almond, 1996, p.76).

the influence of informal features of politics and the calculations of individual utility on political behavior (Peters, 1999, pp.6-10).

(b) Behavioralism and Rational Choice Theory

During the 1950s and 1970s, behavioralism and rational choice theory that focused on individuals and their behavior became the predominant approach in political science (Schmidt, 2006, p.100). Both behavioralism and rational choice theory put emphasis on making political science a true science by developing theory and using systematic and rigorous scientific methods to collect and analyze data (Hay, 2002, pp.8-13; Peters, 1999, pp.12-3). They “came to be seen as more likely to yield generalization and enable comparison” (Lecours, 2005, p.3). The primacy of behavioralism was to produce an inductive and predictive science based upon “extrapolation and generalization from observed empirical regularities” of political behavior (Hay, 2002, p.10). The primacy of rational choice theory was to produce a deductive and predictive science based on the simplifying assumption that political actors were rational, instrumental, and self-serving utility maximizers who engaged in “a cost-benefit analysis of each and every choice available to them” (Hay, 2002, p.8). The reductionist tendency adopted by behavioralism and rational choice theory to reduce the explanation of political processes to social and economic attributes

(Rothstein, 1996, p.139) and its emphasis on input from society such as voting to explain political outcomes (Peters, 1999, p.14) meant that political institutions played little or no roles in influencing political behavior (Rothstein, 1996, p.139) but was portrayed simply as arenas within which political behavior occurred (March and Olsen, 1984, p.734).

The tendency of behavioralism and rational choice theory to deny the central role played by political institutions to determine political outcomes provoked severe criticism from institutionalists because the society- and economy-centered analysis of political behavior advocated by these two theories assumed that political science lost its original explanatory power (Héritier, 1996, p.27). March and Olson (1984) were the first to criticize behavioralism and rational choice theory for five reasons. They included being contextual by subordinating politics to contextual forces such as class structure and economic conditions; being reductionist by ascribing the political outcomes to the aggregate consequences of individual actors; being utilitarian by seeing political action solely as the product of calculated self-interest rather than political actors' response to obligations; being functionalist by assuming that institutions was independent of the historical path and rapidly moved to an equilibrium; and being instrumentalism that defined decision making and resource

allocation as the major concerns of political life rather than recognizing the meaning of political life through ceremonies, rituals, and symbols (pp.735-8).

In fact, the main problem of behavioralism and rational choice theory was that their focus on the attitudes and behaviors of individuals and groups to explain political outcomes failed to answer the question of why individuals and groups with similar attitudes, preferences, and strength “could not always influence policy in the same way or to the same extent in different national contexts” (Thelen and Steinmo, 1992, p.5). Since behavioralism and rational choice theory had theoretical limitation on explaining these cross-national differences, there was a renewed interest in reviving an institution-centered analysis of political behavior (Héritier, 1996, p.27).

(c) New Institutionalism

On the basis of their criticisms of behavioralism and rational choice theory, March and Olson in 1984 became the initial advocates of new institutionalism which was a new theoretical framework in political science blending elements of old institutionalism into new theoretical and empirical directions (March and Olson, 1984, pp.742-7). New institutionalists argued that “theorizing in political science must take into account that action does not occur in an institutional vacuum” (Lecours, 2005, p.6)

and political analysis was “best conducted through a focus on institutions” (Lecours, 2005, p.6). They rejected “the input-weighted political analysis of behavioralism and rational choice theory” (Hay, 2002, p.11) and emphasized the relative autonomy of political institutions, the complexity of political processes and systems, historical inefficiency and the importance of symbolic action to understand politics (March and Olson, 1984, p.738). New institutionalism did not constitute a unified body of thought but contained three disparate analytical approaches: rational choice, sociological, and historical institutionalisms (Koelble, 1995; Hall and Taylor, 1996; Immergut, 1998; Thelen, 1999; Lecours, 2000; Lecours, 2005; Oliver and Mossialos, 2005; Steinmo, 2008).⁵ While these three analytical approaches did not share a generally accepted definition of an institution (Immergut, 1998, p.5), they were united by rejecting

⁵ The list of new institutionalism goes longer nowadays when other strands of new institutionalism are added to the list. For example, Peters (1999) argued that there were seven strands of new institutionalism, including: rational choice institutionalism, sociological institutionalism, historical institutionalism, normative institutionalism, societal institutionalism, empirical institutionalism, and international institutionalism. Normative institutionalism examined how the norms of political institutions determined political behavior (Peters, 1999, p.19). However, it overlapped sociological institutionalism which regarded institution as interest representation and examined the structuring of interactions between state and society. Besides, it overlapped historical institutionalism which talked about asymmetry of power. Empirical institutionalism was closer to old institutionalism and argued that the structure of government affected the way policies were processed and the choices made by governments. It conducted empirical research on the impact of structure (e.g. presidential and parliamentary government) on the policy outcomes of government. International institutionalism emphasized ‘the theoretical place assigned to structure in explaining the behavior of states and individuals’ (Peters, 1999, p.20). Schmidt (2006) used the term ‘discursive institutionalism’ for the fourth strand of new institutionalism that focused on ideas to explain change, emphasized the use of ideas in the mass process of public persuasion in the political sphere, and it largely avoided the economic, historical or cultural determinism of the other three strands of new institutionalism. She said that this ideational approach followed from the historical institutionalism tradition, although the dividing line is admittedly fuzzy. Since this chapter examines how new institutionalism arose in the early 1980s as a response to behavioralism and rational choice theory, it only discusses rational choice institutionalism, sociological institutionalism, and historical institutionalism that arose during that period.

observable behavior as the basic datum of political analysis and by sharing a theoretical core that institutions within which political behavior occurred played an important role in affecting political behavior (Immergut, 1998, p.6).

Rational choice institutionalism defined institutions as the rules of the game which established the conditions for bounded rationality with political actors strategically following those rules in order to achieve their most preferred outcome (Koelble, 1995, p.241; Immergut, 1998, p.13; Lecours, 2000, p.512; Peters, 1999, p.47). Institutions which set parameters to choice provided certainty under conditions of uncertainty, thereby fostering cooperative, habitual, and predictive political behavior (Koelble, 1995, p.241; Peters, 1999, pp.47-8). In short, institutions either imposed constraints on political actors or offered them chances for action (Lecours, 2000, p.512).

Sociological institutionalism broadly defined institutions to include not only formal rules or procedures, but also cognitive frames, moral templates, symbol systems, and systems of meaning that guided the behavior of political actors (Hall and Taylor, 1996, p.947; Schmidt, 2006, p.107). Institutions influenced behavior by simultaneously specifying what one should do and what one could imagine oneself

doing in a given context (Hall and Taylor, 1996, p.948). They affected the strategic calculations, the underlying preferences and the identities of political actors that rational action was itself socially constituted (Hall and Taylor, 1996, p.948) and purposive, goal-oriented action was deemed acceptable according to the logic of appropriateness (Schmidt, 2006, p.107). Sociological institutionalism posited a process of institutional isomorphism when institutions became more homogeneous due to the adoption of formal rules promulgated by coercive authority, normative standards promoted by professionals, and legitimated practices of prominent institutions (DiMaggio and Powell, 1983, pp.150-3).

Historical institutionalism which built on old institutionalism “assigned importance to formal political institutions” (Hall and Taylor, 1996, p.937) but it also enriched the concept of institutions by talking about which institutions mattered and how they mattered (Hall and Taylor, 1996, p.937). It defined institutions as “formal or informal procedures, routines, norms, and conventions intrinsic to the organizational structure of the polity” (Hall and Taylor, 1996, p.938) that shaped the goals political actors pursued and structured power relations that favored some groups while demobilizing others (Thelen and Steinmo, 1992, p.2; Oliver and Massialos, 2005, p.10). Institutions were seen as “relatively persistent features of the historical

landscape” (Hall and Taylor, 1996, p.941) and one of the central forces structuring interactions and pushing policy development along a set of paths (Hall and Taylor, 1996, p.941). In brief, rational choice, sociological, and historical institutionalisms diverged on the definitions of institutions but were united on the importance of institutions in affecting political behavior (Koelble, 1995, p.232; Immergut, 1998, pp.5-6; Schmidt, 2006, p.101).

Among these three main strands of new institutionalism, historical institutionalism is chosen for examining healthcare financing reform in Shanghai and Hong Kong. Rational choice institutionalism is irrelevant because this study is not concerned with how political actors used institutions to maximize their utilities. Sociological institutionalism is not directly relevant because this study is not concerned with why the healthcare systems of Shanghai and Hong Kong become similar but why these two places follow distinct paths of health insurance reform. Historical institutionalism which primarily focuses on solving “empirically directed research questions relating to differences in outcomes through time and/or space” (Lecours, 2005, p.14) is the most appropriate theory to examine how institutions in Shanghai and Hong Kong respectively structure interactions and generate distinctive national trajectories of health insurance reforms over time.

3.3 Historical Institutionalism: Key Features

(a) Institutions Matter

Historical institutionalism has six distinctive features. Firstly, it emphasizes that institutions matter. All institutions “have organizational biases that channel the representation of interests” (Tuohy, 1999, p.108). They play a determinant role in distributing power among political actors in a given polity and shaping their strategies and goals in the decision-making process that in turn shape the political outcomes (Thelen and Steinmo, 1992, p.6; Koelble, 1995, p.236). Since institutions distribute power unevenly among different groups of political actors, they influence how political actors interpret and pursue their self-interests, define their goals, policy preferences and strategies based on their institutional position, institutional responsibilities and relationships with others (Koelble, 1995, p.236; Immergut, 1998, p.21). Institutions constrain or facilitate the structure of political opportunities for political actors (Hall and Taylor, 1996, p.941; Immergut, 1998, p.21) and create the vested interests (Béland, 2005b, p.34) by acting as filters that selectively favor particular goals political actors strive for or strategies to achieve these ends (Immergut, 1998, p.20). The asymmetries of political power caused by institutions privilege some groups of political actors at the expense of others, leading to some groups win while

others lose (Thelen and Steinmo, 1992, p.2; Hall and Taylor, 1996, p.941).

For example, Immergut (1992) examined how a nation's constitutional rules and electoral results produced different institutional constraints on the ability of executive governments to introduce the health insurance legislation in Switzerland, France and Sweden. She found that in Switzerland, "the constitutional right of voters to challenge legislation through referenda" (Immergut, 1992, p.68) led to decision-making moving from the executive and parliamentary arenas into the electoral arena (Immergut, 1992, p.74). This provided Swiss doctors with strategic opportunities to veto the health insurance legislation through referendum. In France, unstable parliamentary coalitions and the lack of party discipline impeded the executive government of the Fourth Republic from enacting the health insurance legislation (Immergut, 1992, p.74). However, the constitutional change which "allowed the executive to impose legislation without parliamentary ratification" (Immergut, 1992, p.72) led to the locus of decision-making shifting from the parliament to the executive that the executive government of the Fifth Republic was able to enact the health insurance legislation (Immergut, 1992, p.70). In Sweden, the executive dominance with stable parliamentary majorities "effectively constrained decision-making to the executive arena" (Immergut, 1992, p.67) that doctors had no veto points to block the health

insurance legislation. In brief, institutions play a crucial role in distributing power among political actors in a given polity and shaping their strategies and goals in the decision-making process that in turn shape the political outcomes (Thelen and Steinmo, 1992, p.6; Koelble, 1995, p.236).

(b) The Use of Calculus and Cultural Approaches to Affect Political Behaviors

Secondly, historical institutionalism assumes that institutions affect the behavior of political actors as mentioned in the calculus and cultural approaches (Hall and Taylor, 1996, p.940). The calculus approach assumes that institutions frame the actors' strategic behavior and reduce uncertainty by providing political actors with "information about the expected behavior of others" (Oliver and Mossialos, 2005, p. 10) through the existence of rules, "enforcement mechanisms for agreements, [and] penalties for defection" (Hall and Taylor, 1996, p.939). Political actors who are utility maximizer follow rules in order to maximize their personal gains (Steinmo, 2008, p.126). For example, the study of Immergut (1992) showed that institutions in Switzerland, France and Sweden respectively established different rules of the game for political actors to enact or to block policies (pp.58-9). Her study showed that different institutions provided political actors with different veto opportunities to influence political decisions (Immergut, 1992, pp.65-6). In Switzerland, direct

democracy provided veto points for doctors to use the referendum to block the health insurance legislation. In France, the constitutional change allowed the executive government to circumvent the parliamentary veto point and consequently enact the health insurance legislation. In Sweden, the executive dominance with stable parliamentary majorities provided no veto points for doctors to block the health insurance legislation.

As to the cultural approach, it assumes that institutions frame the ways in which actors see their world by providing “moral or cognitive templates for interpretations and action” (Hall and Taylor, 1996, p.939). Political actors follow the logic of appropriateness, established norms, routines, rules of thumbs or existing values when choosing their course of action (Hall and Taylor, 1996, p.939; Oliver and Mossialos, 2005, p. 11; Steinmo, 2008, p.126). In brief, historical institutionalism assumes that political outcome is best understood as a product of both interest maximizing and rule following (Steinmo, 2008, p.126).

(c) History Matters

Thirdly, historical institutionalism emphasizes that history matters. It takes history or time seriously, specifying sequences, tracing and analyzing processes over substantial

stretch of years to explain important political outcomes or real-world puzzles (Pierson and Skocpol, 2002, pp.695-8). History is not just a marker in time or a chain of independent events located in the past (Steinmo, 2008, p.128), but rather the contingent product of the interactions of multiple political actors and institutions operating in and influenced by broader political, economic and social contexts over time (Lecours, 2000, p.514; Pierson and Skocpol, 2002, p.706). Institutions are located in a causal chain that accommodates a role for other variables such as socioeconomic development and the diffusion of ideas (Hall and Taylor, 1996, p.942). As a result, political outcomes are attributed to the interaction of multiple variables that reflect the complex political situations in reality (Thelen and Steinmo, 1992, p.13; Immergut, 1998, p.19; Steinmo, 2008, p.128). Causal processes and outcomes in the social world occur slowly due to incrementalism and hence take a long time to add up to anything (Pierson and Skocpol, 2002, p.703). Casual processes involving chains with several links also require a longer time to work themselves out (Pierson and Skocpol, 2002, p.704). Therefore, by extending the time frame of social inquiry, historical institutionalism has the methodological advantages of increasing the number of observations available for examination, making more data available, contributing to causal inference by testing the arrow of causality through historical process tracing that cannot be achieved by simple correlation of analysis, sensitizing

researchers to period effects or temporal boundary conditions and allowing them to place particular events in a particular time without missing the overarching patterns (Pierson and Skocpol, 2002, pp. 698-9; Steinmo, 2008, p.135). In brief, historical institutionalism is able to “offer more accurate explanations for the specific events” it explores (Steinmo, 2008, p.127) through historical investigation on a broad time scale.

(d) The Emphasis on Path Dependency

Fourthly, historical institutionalism emphasizes path dependence that “preceding steps in a particular direction induce further movement along the same direction” (Pierson, 2000a, p.252). Self-reinforcing processes in institutions that “act as mechanisms of reproduction” (Lecours, 2005, p.10) make established institutions and their policies difficult to change once a path is established (Pierson, 2000b, p.75; Peters et al., 2005, p.1276). It means that established institutions favor the status quo and policy inertia. They “generate powerful inducements that reinforce their own stability and further development” (Pierson, 2000a, p. 255) and at the same time “find ways of defending existing patterns of policy” (Peters et al., 2005, p.1276). Policies also create feedback effects. They encourage political actors to “adapt in ways that lock in a particular path of policy development” (Pierson, 1994, p.42). The lock-in effects mean that policies

induce the emergence of elaborate economic and social networks that “greatly increase the cost of adopting once-possible alternatives and inhibit exit from a current policy path” (Pierson, 1994, p.42). Policies encourage political actors to make significant investments which are difficult to reverse (Pierson, 1994, p.45) or create strong incentives for political actors to “coordinate their activities with other social actors and adopt prevailing or anticipated standards” (Pierson, 1994, p.45). Important commitments made by political actors in response to certain types of government action greatly limit options for radical reforms or major policy changes in future (Pierson, 1994, p.43). As a result, individuals lock in previous policy decisions. According to Pierson (2000a), the high set-up costs of established institutions and policies, the learning effects which lead to investment in specialized skills, the coordination effects which deepen the relationships of individuals and institutions with others, the adaptive expectations which develop political and social identities, power asymmetries in which one set of political actors achieving a position of influence impose rules and preferences on another set, and the complexity and opacity of politics are reasons generating self-reinforcing processes that make the exit option increasingly unattractive over time (pp. 257-260).

For example, Wilsford (1994) argued that there was strong path dependency in

the U.S. to reform its healthcare system in a big way (p.251). The fragmented political institutions characterized by decentralized decision networks, vested interests that were well embedded in the current healthcare system, and the traditional philosophical underpinning of American healthcare system that healthcare was a private good acted as structural impediments to big and radically new changes proposed by the Clinton Plan (Wilsford, 1994, pp.271-4).

Besides, the conception of path dependence shows that the timing and sequence of particular event, process, choice or decision are crucial (Pierson and Skocpol, 2002, p.700; Oliver and Mossialos, 2005, p. 11) because the same event, process, choice or decision does not necessarily have the same impact at different stages of the path (Oliver and Mossialos, 2005, p. 11). Initial steps affect the outcomes of events occurring at a later point in time through self-reinforcement (Pierson, 2000a, p. 252; Pierson, 2000b, p.84; Pierson and Skocpol, 2002, pp.700-1). Self-reinforcement creates strong incentives for actors to stick to a specific path (Pierson, 2000a, p. 254) and generates irreversibility that plausible alternatives become increasingly distant and unreachable over time (Pierson, 2000b, pp.74-5; Pierson and Skocpol, 2002, p.701). When present-day political actors implement new policy, they have to “take into account the institutionalized policy legacy of decisions” (Béland, 2005b, p.34)

made by their predecessors decades or even centuries ago.

For example, Hacker (1998) emphasized the roles of “historical sequence, timing, and policy legacies” (p.80) in explaining the divergent trajectories of national health insurance programs in the UK, Canada, and the U.S. He argues that in the UK, the legacies of 1911 National Insurance Act which provided health insurance and sickness benefits to the wage-earners “forestalled the emergence of physician-friendly private [health] insurance” (Hacker, 1998, p.95) and “acclimated the public to state intervention in medicine” (Hacker, 1998, p.95) that subsequently led to the establishment of the NHS in 1948, which provided the public with free and universal healthcare services based on public provision.

In Canada, Hacker (1998) argued that the collapse of the Dominion-Provincial Conference of 1945 without agreeing upon the proposal for national health insurance led to the rapid growth of private health insurance plans and the efforts of federal government to subsidize the development of a technologically sophisticated private hospital system through postwar grants to the provinces (pp.96-7). Nevertheless, the federal aid fostered the passage of the provincial health insurance program in Saskatchewan in 1946 that provided the “government guarantee of medical insurance

to all its citizens” (Hacker, 1998, p.100). This spurred neighboring provinces to follow suit and eventually paved the way for passing a national health insurance legislation in 1966 with the establishment of “a provincially administered system of government health insurance based primarily on private provision” (Hacker, 1998, p.58).

In the U.S., Hacker (1998) found that the majority of population enrolling in physician-dominated private insurance plans, the building up of medical industry preceding the universal access to healthcare when the Hospital Construction Act was passed in 1946, and the initial implementation of health insurance programs of Medicare in 1965 for the elderly and disabled and Medicaid in 1966 for the poor that greatly increased the fiscal strains on public finance were three important reasons making the government incapable of enacting national health insurance legislation (pp.111-9). In brief, the study of Hacker (1998) shows that the complex interplay of forces --- historical sequence, timing and policy legacies--- play a crucial role in shaping subsequent healthcare policy developments in the UK, Canada and the U.S. and leading to lasting cross-national differences.

(e) The Importance of Policy Feedback from Previous Policy Choices

Fifthly, historical institutionalism emphasizes the role of policy feedback. Policy

feedback can be understood from three aspects: first, how resources and incentives provided by previous policies shape the formation of interest groups (Pierson, 1994, p.41); second, how information and meanings conveyed by previous policies shape the views and attitudes of citizens towards public policies (Pierson, 1994, p.45; Gusmano et al., 2002, p.734); and third, how the positive or negative feedback effect of previous policies shapes the development trajectory of policies. For the first aspect of policy feedback, this points to political feedback effects. Policy feedback creates vested interests. It provides resources and creates incentives that can facilitate, strengthen or inhibit the formation or expansion of interest groups (Pierson, 1994, pp.40-1). It gives interest groups “a reason to exit, facilitate or impede efforts to overcome collective-action problems, or provide access to considerable political resources” (Pierson, 1994, p.41). And it provides information for interest groups and affects their mind-sets and cognitive processes (Pierson, 1994, p.42). Interest groups which are beneficiaries of previous policies have strong motivation to mobilize in favor of the maintenance or expansion of the policies (Pierson, 1993, p. 599). Their activities would be easier if previous policies provide them with resources such as funding or having formal access to decision makers (Pierson, 1993, pp.601-2). For example, Pierson (1994) found that the fragmented and underdeveloped pension policy in the UK led to “a similarly fragmented and underdeveloped structure of

pensioner-interest representation” (p.47) that “were easily outmaneuvered by the Thatcher government in the struggle over pension retrenchment” (Pierson, 1994, p.47). On the other hand, the single and mature public pension programme in the U.S. “generated a strong and coherent base of political support” (Pierson, 1994, p.53) that the American elderly were easily mobilized to oppose the proposal for pension retrenchment (Pierson, 1994, p.71).

As to the second aspect of policy feedback, this points to the interpretive effects of previous policies (Pierson, 1993, p.610). Previous policies affect the cognitive processes of citizens (Pierson, 1993, p.610) through the conveyance of information and meanings. They affect how citizens perceive and interpret current policies and government’s policy choice (Pierson, 1994; Gusmano et al., 2002). Gusmano et al. (2002) identify three effects of public policies on public attitudes: “exposure, signaling, and experience” (p.734). The exposure model of policy feedback suggests that “the longer [the] citizens interact with a particular policy or institutions, the more ‘comfortable’ they become with that policy” (Gusmano et al., 2002, p.734). Emotional reactions play a particularly important role in shaping public attitudes toward public policies when “the public lacks detailed information about policy matters” (Gusmano et al., 2002, p.734). The signaling model of policy feedback refers to “elite influence

over public opinion” (Gusmano et al., 2002, p.735). It means that the public would “be most supportive of public policies in domains where there has been the most sustained set of elite messages favoring these policies” (Gusmano et al., 2002, p.735). And the experience model of policy feedback suggest that public support for a particular public policy is “based on [previous] personal experience with the relevant institutions” (Gusmano et al., 2002, p.749). Lessons drawn from personal experience are “interpreted through the lenses of conceptual frames and constructs that are most accessible through cultural experience” (Gusmano et al., 2002, p.735).

For example, Gusmano et al. (2002) argued that “the legitimizing effects of past public policy [were] rather narrow” (p.733) that public support for employer responsibility was limited to mainstream medical care (hospital and physician services) (Gusmano et al., 2002, p.733). Public support for employer responsibility did not extend to long-term care because there was little relevant public experience and no elite messages (Gusmano et al., 2002, p.761). And public support for employer responsibility in the treatment of substance abuse “was undermined by past evidence of threats to job security and civil liberties due to employer involvement” (Gusmano et al., 2002, p.761).

As to the third aspect of policy feedback, this points to the policy continuity or policy change. The positive or negative feedback effect of previous policies can shape the policy trajectory. While positive feedback effects emphasize how the self-reinforcing dynamics generated by past policies create path dependence and policy continuity (Skocpol, 1992; Pierson, 2000), negative feedback effects emphasize how negative socio-economic consequences induced by policies undermine “the political, fiscal or social sustainability of a particular set of policies” (Weaver, 2010, p.137).

(f) Using In-depth Case Studies as the Research Strategy

Sixthly, historical institutionalism uses small- to medium-n comparisons or in-depth case studies as the research strategy (Pierson and Skocpol, 2002, p.714; Steinmo, 2008, p.135) to “find interesting patterns to explain and to test the plausibility of causal hypotheses” (Skocpol, 1995, p.104). While its focus on important cases and big puzzles can “potentially suffer from the obvious dangers of selection bias” (Steinmo, 2008, p.135), historical institutionalism applies alternative strategies of causal inference to rigorously test the hypotheses in order to make good historical analysis (Pierson and Skocpol, 2002, p.714). By juxtaposing regions, time periods, and policy sectors, historical analyses turn “what appear to be one or a few national instances

into settings for many carefully compared cases” (Pierson and Skocpol, 2002, p.715).

And even within single case studies, historical analyses engage the case “at multiple [observation] points, thereby confronting explanatory propositions with multiple data points” (Steinmo, 2008, p.135). Historical institutionalism “seeks to establish historically grounded generalizations leading to middle-range theorizing” that explain particular phenomena (Lecours, 2000, p.515). The strength of historical institutionalism lies in its ability to explain policy continuities over time and policy variations and irregularities across countries (Thelen and Steinmo, 1992, p.10; Lecours, 2000, p.521). Features of historical institutionalism are summarized in **Table 9**.

3.4 The Approaches of Historical Institutionalism to Explain Change

While historical institutionalism is helpful in explaining different policy trajectories across countries and policy continuities within countries over times, it is criticized for being unable to deal with the question of institutional change (Thelen and Steinmo, 1992, p.14). Since historical institutionalism is “premised upon the enduring effects of institutional and policy choices made at the initiation of a structure” (Peters, 1999, p.68), it is more conducive to explaining institutional stability and policy persistence over time than to explaining institutional and policy change (Thelen and Steinmo,

1992, p.15; Peters, 1999, p.68; Peters et al., 2005, p.1278; Steinmo, 2008, p.129).

Besides, historical institutionalism is more structuralist because it conceives of institutions as sustained by and representing “systems of values, norms, and practices in society” (Peters et al., 2005, p.1278). Structures and norms tend to reinforce each other, resulting in strengthening the image of structural rigidity (Peters et al., 2005, pp.1278-9) that institutions are biased toward continuity.

But a review of available studies on historical institutionalism shows that historical institutionalism adopts some concepts or approaches to explain change, including punctuated equilibrium by Krasner (1984), the interplay of structure and conjuncture by Wilsford (1994), the accidental logic of history by Tuohy (1999), and institutional dynamism Thelen and Steinmo (1992). As illustrated below, the review of these concepts or approaches shows that the notion of institutional dynamism is more helpful in explaining change.

(a) Punctuated equilibrium and Critiques

In the mid-1980s, historical institutionalism explained change through punctuated equilibrium, a concept borrowed from evolutionary biology for politics by Krasner (1984). Punctuated equilibrium assumes that institutions remain in stability

(equilibrium) for a long period of time until they are punctuated by crises that bring about rapid institutional change and new policy trajectories, after which institutional consolidation and stasis set in again (Krasner, 1984, pp. 240-3). It means that the institutional equilibrium is not necessarily permanent because external shock can be the trigger of institutional change (Peters, 1999, p.68). It is the external shock causing the breakdown of old institutions and the creation of new ones (Krasner, 1984, p. 240).

Although the conception of punctuated equilibrium offers an explanation for institutional change, it fails to offer any priori criteria for determining when there is sufficient environmental pressure to generate an institutional change (Peters, 1999, p.69). As a result, the use of punctuated equilibrium to explain change risks being an explanation after the fact or being a tautological explanation which treats institutions as an independent variable to explain political outcomes during the period of stability and as a dependent variable when they break down because of external shock (Thelen and Steinmo, 1992, p.15; Peters, 1999, pp.68-9). It makes institutional change become “a product of fate” (Steinmo, 2008, p.129).

(b) The Interplay of Structure and Conjuncture and Critiques

In the early 1990s, Wilsford (1994) used the notions of structure and conjuncture to explain how their interplay facilitated or constrained healthcare reform in Germany, France, the UK, and the U.S. He argued that path dependence was not strictly about historical determinism but about historical contingency (Wilsford, 1994, p.275) because powerful and compelling conjunctures was a critical variable enabling political actor to override the inertia of the structural impediments to non-incremental change in policy path (Wilsford, 1994, pp.261-9). In his study, Germany, France and the UK were cases of changes in policy path while the U.S. was the case of path dependency because of the absence of a powerful conjuncture. Unfortunately, Wilsford (1994) vaguely defines the notion of conjunctures as “the fleeting comings together of a number of diverse elements into a new, single combination” (p.257) that raise the question of what the diverse elements are, what the composition of the diverse elements should be and when these diverse elements occur in order to create a conjuncture that is powerful and compelling enough for political actors to override the structural impediments to bring about big change.

In fact, his study showed that the conjunctural elements that allowed political actors to deviate from the original policy path varied among Germany, France and the UK. Wilsford (1994) found that in Germany, the conjunctural elements of high

healthcare spending, the fiscal crisis of German unification, the new, determined and dynamic Federal Minister of Health, and the party coalition on healthcare reform enabled the government to implement the Seehofer reform of 1992 that reduced prescription drug prices, extended the co-payment on prescription drugs and changed the hospital financing system from a per-bed, per-day basis to a global budget basis (pp.259-261). In France, he found that the conjunctural elements of the new austerity policy of 1983 and a new Director of Hospitals enabled the government to implement hospital financing reform in 1984 by introducing a system of anticipatory global budgeting (Wilsford, 1994, pp.263-4). In the UK, he found that the conjunctural elements of the strong leadership of Thatcher who centrally directed the reform process, the diffusion of the perception of a crisis in the hospital system and the new idea of introducing market forces into the healthcare system, the lack of unity in the medical profession, hospital managers who wanted to play a greater role in the decision-making of market players, and the absence of patients' opposition enabled the Thatcher government to implement National Health Service reform in 1991 that introduced the provider-purchaser split in healthcare (Wilsford, 1994, pp.268-9).

In brief, the study of Wilsford (1994) shows that a conjuncture can be the combination of political, economic, and ideational elements that leads to policy

change. He does not emphasize the importance of external shock like Krasner (1984) did in order to make change possible. However, the cross-national differences in the combination of the conjunctural elements without identifying a common set of conjunctural elements which bring about change reduce the explanatory power of Wilsford's (1994) approach. Other countries which are not examined by Wilsford (1994) can have a different combination of the conjunctural elements which make policy change possible. The vague definition of conjuncture is not helpful in understanding policy change.

Besides, it is problematic for Wilsford (1994) to argue that a conjuncture has to be powerful and compelling enough to bring about big change. As his empirical country case study shows, two conjunctural elements are powerful and compelling enough for the French government to implement healthcare reform while four and six conjunctural elements are respectively needed by the German and British government to implement healthcare reform. It shows that how powerful the conjuncture is does not depend on the sum of the number of diverse conjunctural elements. Also, it is difficult and problematic to argue that the conjuncture of France is more powerful than that of Germany and the UK to bring about policy change because there is no way one can measure the conjuncture.

Finally, Wilsford (1994) had a contradictory understanding of the functions of political institutions. On one hand, he argued that the conjunctures in Germany, France and the UK were powerful for political actors to override structural impediments to implement policy changes. On the other hand, he argued in the conclusion section that the centralization of decision process and hierarchical ordering commonly shared by the political institutions of Germany, France and the UK placed the top-most decision-agents in these countries in a more advantageous position to enforce healthcare reform (Wilsford, 1994, p.276). It means that instead of being an impediment, the institutional structures of Germany, France and the UK actually facilitated the change in healthcare policy path in face of conjuncture. The analysis of Wilsford's (1994) notions of structure and conjuncture shows that the approach is full of conceptual flaws and it is problematic to adopt these notions to explain institutional change.

(c) The Accidental Logic of History and Critiques

In the late 1990s, Tuohy (1999) used the accidental logic of history that referred to windows of opportunity created by broad political forces at critical moments in time to examine why major changes in healthcare policy took place in the UK but not in

the U.S. and Canada in the 1990s (p.6). She argued that a consolidated base of political authority for policy action and the commitments and willingness of key political actors to elevate the issue were two conditions necessary for creating a window of opportunity for policy change (Tuohy, 1999, pp.11-2). She also argued that “the timing of the opening of windows of opportunity for change” (Tuohy, 1999, p.123) is important.

Tuohy (1999) argued that the UK had major policy change in healthcare because the Thatcher government was a majority government in its third successive terms having both the mobilization of authority and political will to implement the internal market reforms that substantially changed the decision-making systems in healthcare from state-hierarchical to market-type mechanism (pp.241-2). She argued that the U.S. failed to implement universal health insurance reform in 1993 because the Clinton administration only had the political will but lacked the ability to mobilize authority on an extraordinary scale (Tuohy, 1999, p.106). The inability to mobilize authority was due to President Clinton lacking a strong popular mandate, his party’s lack of seats in the Senate to guard against the procedural maneuvers by the Republicans, and his inability to capitalize a bandwagon effect when the momentum behind the healthcare reform was strong due to his need to “address the mounting crisis over his

budgetary proposals” (Tuohy, 1999, p.79). Tuohy (1999) argued that both the federal and provincial government in Canada solidly endorsed and reaffirmed the prevailing “single payer system of national health insurance” (p.90) because federal-provincial relations being “dominated by the contentious debate about the appropriate degree of centralization/decentralization within the federation” (Tuohy, 1999, p.246) made the governments impossible to mobilize authority while the high political risk of tampering with the healthcare system which had major public support also prevented the governments from having political will to implements any healthcare reform (Tuohy, 1999, p.102).

Tuohy’s (1999) accidental logic of history is better than Krasner’s (1984) punctuated equilibrium and Wilsford’s (1994) notions of structure and conjuncture because it clearly and explicitly pointed out that the windows of opportunity for policy change were triggered by two political conditions--- the mobilization of political authority and the willingness of political actors to enact policy change--- and that the timing of opening these windows of opportunities is important to explain policy change. However, Tuohy (1999) fails to choose the right countries to apply the accidental logic of history to explain policy change because except the UK, both the U.S. and Canada represent the cases of path dependency when implementing

healthcare reform in the 1990s. She should have chosen countries which successfully implemented policy change in healthcare and then examined whether her use of accidental logic of history can offer a reasonable explanation of policy change in such countries. Besides, Tuohy (1999) fails to show that when the timing of opening the windows of opportunities would occur and excludes the possibilities that other contextual conditions or crises can open the windows of opportunities for policy changes. She limits the explanatory power of the accidental logic of history by solely regarding two political conditions as forces that create the windows of opportunity for change.

(d) Institutional Dynamism

The analyses of Krasner's (1984) punctuated equilibrium, Wilsford's (1994) notions of structure and conjuncture, and Tuohy's (1999) accidental logic of history show that these approaches fail to offer a clear and convincing explanation of institutional change. On the other hand, the analysis of 'institutional dynamism' developed by Thelen and Steinmo (1992) shows that this approach is conducive to providing a clearer way to understand about institutional and policy changes. Thelen and Steinmo (1992) use 'institutional dynamism' to identify four sources of institutional change that describe situations in which one "can observe variability in the impact of

institutions over time but within countries” (Thelen and Steinmo, 1992, p.16).

‘Institutional dynamism’ explains institutional and policy changes as an interaction between institutions and the broader political and socioeconomic context in which they operate. It examines how institutions mediate and filter politics in response to changes in broader political and socioeconomic context over time (Thelen and Steinmo, 1992, p.16).

According to Thelen and Steinmo (1992), the first source of institutional dynamism describes how the change in the political or socioeconomic context suddenly transforms previously latent institutions into salient arena of conflict and cooperation among political actors (p.16). The second source of institutional dynamism describes how the change in the political or socioeconomic context leads to existing institutions performing new tasks because new political actors emerge to pursue new goals through the existing institutions (Thelen and Steinmo, 1992, p.16).

The third source of institutional dynamism describes how the change in the political or socioeconomic context leads to changes in political outcomes because existing actors pursue new ideas, goals or strategies within the existing institutions (Thelen and Steinmo, 1992, pp.16-7). While the first three sources of institutional dynamism describe how the existing institutions produce different political outcomes in response

to shifting contextual conditions, the fourth source of institutional dynamism describes how the changes in the institutions lead to political actors adjusting their strategies to accommodate such institutional changes (Thelen and Steinmo, 1992, p.17). Drastic institutional changes such as the breakdown of old institutions and the creation of new institutions resulting from exogenous changes, and changes in institutional parameters resulting from political struggles or strategic maneuvering by political actors to enhance their own positions alter the institutional constraints in which political actors make their decisions (Thelen and Steinmo, 1992, p.17). It shows that how the changes in institutions reshape the perceived ideas and goals of political actors over time that political actors come to adjust their strategies to achieve those ideas and goals.

Although ‘institutional dynamism’ is not a theory of institutional change, it helps extend institutional analysis by identifying four sources of institutional change. Unlike Krasner’s (1984) punctuated equilibrium which regards institutional change simply as institutional breakdown and the creation of new institutions caused by the external shock and unlike Tuohy’s (1999) accidental logic of history which regards the political forces as the solely forces to open windows of opportunities, ‘institutional dynamism’ enriches the conception and understanding of institutional

change by showing how the changes in political or socioeconomic context reshape the meaning and functioning of existing institutions that policy changes can take place within existing institutions. Besides, it is clearer than Wilsford's (1994) notion of conjuncture which ambiguously says that the combination of a number of diverse elements can bring about policy change by telling researchers how to locate the sources of institutional change. Also, unlike Krasner's (1984) punctuated equilibrium which gives human agency no roles to play in institutional change, 'institutional dynamism' captures the dialectical interplay between institutions and agency. And it also explores the relationship between ideas and institutions. It shows that institutions are not the sole determinant of changes in political outcomes. Instead, it is the dynamic interaction of contextual conditions, ideas, actors, and institutions that structure particular political outcomes.

The dynamic interaction of contextual conditions, ideas, actors, and institutions that structure particular political outcomes deserve further illustration here. 'Institutional dynamism' shows that Thelen and Steinmo (1992) bring ideas and actors into institutional analyses to explain institutional change without undermining the important role played by institutions in affecting political outcomes. According to Thelen and Steinmo (1992), ideas cannot be discussed without pointing to actors

because ideas are articulated by actors and translated by actors into “language and slogans appropriate for political decision making” (Thelen and Steinmo, 1992, p. 24). Institutional structures define the channels and mechanisms for absorbing and diffusing new policy ideas and shaping “the interpretation and meaning behind those ideas” (Thelen and Steinmo, 1992, p.25). They can either facilitate or impede political actors in favor of new ideas to bring about policy switch. For example, political actors were institutionally better positioned in the UK than in the U.S. to promote New Right ideas that in turn led to policy change in work-welfare programs. It is because the centralized state with the government’s parliamentary majorities in the UK enabled the Thatcher government to make the new ideas go through the legislative process smoothly while the fragmented political system in the U.S. diluted new ideas through the need to forge compromise (Thelen and Steinmo, 1992, pp. 24-5). When there are changes in political or socioeconomic contexts, the important sources of support for old ideas can be eroded and the new ideas can become fully articulated to confront and challenge the old ideas that facilitate political actors to implement policy changes (Thelen and Steinmo, 1992, p.23). Nevertheless, the weakness of ‘institutional dynamism’ is that Thelen and Steinmo (1992) neither define the terms “ideas” and “actors” nor explain in any detail about how the roles of ideas and actors affect institutional change.

In recent years, Steinmo (2008) reasserts the importance of bringing ideas and actors into institutional analyses to understand institutional change because he argued that “institutional change is the product of changes in ideas held by [political] actors” (p.130). He does not propose any theory or model of institutional change in his recent study but seeks to briefly define what ideas are and identify what kinds of political actors have potentials to initiate institutional change. Steinmo (2008) defines ideas as “creative solutions to collective action problems” (p.131) and argues that institutional change can take place “when powerful actors have the will and ability to change institutions in favor of new ideas” (p.131). Steinmo (2008) does not elaborate further on who the powerful actors are or what criteria are adopted to determine whether the political actors have the will or ability to change institutions. But power is usually equated with position. Political actors who are in higher positions obtain more power. Besides, their power can come from legitimacy and majority support from society. Steinmo (2008) implies that powerful actors who have strong determination and ability can become promoters of new ideas and actors of policy change.

In similar fashion, Peters et al. (2005) argue for bringing ideas and actors into institutional analyses to understand institutional change more broadly. They argue that

two factors related to ideas appear to have interacted to make changes in policy or political outcomes possible (Peters, 2005, p.1291). The first factor is the perceived failure of the ideological basis of the existing policies (Peters, 2005, p.1291). The second factor is “the availability of new ideas to implement in place of those that were being questioned” (Peters, 2005, p.1293). Old ideas can be deeply entrenched in the existing institution that they have framing effects and consequently become “basic templates upon which other political decisions were made” (Steinmo, 2008, p.130). However, the equilibrium of existing institutions can be punctuated sharply by changes in political or socioeconomic conditions which provide the windows of opportunity for political actors to dismiss their core belief in existing institutions and pursue new ideas.

Besides, Peters et al. (2005) argue that while institutions “provide the structures and resources necessary for [new] ideas to change the course of policy” (p.1296), political actors are needed to become some form of agency to initiate change (Peters, 2005, p.1293). They argue that “powerful political leaders such as Reagan and Thatcher who challenged the existing order and offered alternatives” (Peters, 2005, p.1293) play an important role in initiating changes in political outcome. In brief, institutional change is a dynamic interaction in which contextual conditions, ideas,

and actors intersect with political institutions to produce changes in political outcomes.

3.5 Applying a Refined Theory of Historical Institutionalism into the Case Studies of Shanghai and Hong Kong

From the above, it shows that historical institutionalism contains six key features. They include: institutions matter; the use of both calculus and cultural approach to affect political behavior; history matters; the emphasis of path dependency; the importance of policy feedback from previous policy choices; and the use of in-depth case studies as the research strategy. But it shows that historical institutionalism is weak in explaining institutional and policy change. The existing approaches of Krasner's (1984) punctuated equilibrium, Wilsford's (1994) notions of structure and conjuncture, and Tuohy's (1999) accidental logic of history fail to offer a satisfactory explanation of institutional change. On the other hand, Thelen's and Steinmo's (1992) institutional dynamism can be a useful approach to explain institutional and policy change by identifying four sources of institutional changes and paying attention to the dynamic interaction among contextual conditions, ideas, actors and political institutions to produce such policy changes. Institutional dynamism shows that institutional studies are no longer restricted to explain status quo and institutional

stasis.

This study uses the theory of historical institutionalism to solve a real world puzzle about health insurance reform: why has Shanghai been able to implement health insurance reform from the mid-1980s onwards while Hong Kong has failed to do so? While Shanghai witnessed a revolution in healthcare financing in 2000, Hong Kong remains the status quo on healthcare financing. Recognizing that historical institutionalism itself is weak in explaining changes in policy path and pays insufficient attention to the roles of ideas and actors in shaping policy, this study has to refine historical institutionalism before it can be applied into the case studies of Shanghai and Hong Kong to respectively explain change in policy path and path dependency. This study argues that the dynamic interplay between contextual conditions, ideas, actors, political institutions, timing and sequences, path dependency, and policy feedback affect changes in healthcare policy path. In order to strengthen the analytical foundation and the explanatory power of historical institutionalism, this study refines historical institutionalism by bringing the approach of institutional dynamism, the roles of ideas and actors into the theory.

In this study, a refined theory of historical institutionalism will be adopted to

examine health insurance reforms in Shanghai and Hong Kong. This study will refine the theory of historical institutionalism by developing further from Thelen and Steinmo's (1992) version. On one hand, the researcher thinks that Thelen and Steinmo's (1992) 'institutional dynamism' can be helpful in explaining path change because it provides a clearer and more comprehensive perspective on identifying conditions under which path change can occur. She also agrees with Thelen and Steinmo (1992) that the roles of ideas and actors in 'institutional dynamism' can affect policy or path change. On the other hand, she finds that Thelen and Steinmo (1992) neither define the terms "ideas" and "political actors" nor explain in any detail about how the roles of ideas and political actors affect institutional change. Recognizing that the meaning of the term "ideas" is too loose, the researcher finds it necessary to sharpen the concept of ideas when refining the theory of historical institutionalism. As regards the roles of actors, the researcher thinks that healthcare financing reform is a complicated issue involving different political actors and stakeholders. She thinks that the refined version of historical institutionalism should identify different types of political actors and stakeholders and their roles in affecting the implementation of health insurance reform. As illustrated below, the researcher will develop further from Thelen and Steinmo (1992) by defining more clearly the term "ideas", highlighting five conditions under which new ideas can gain political prominences in detail, and

emphasizing the importance of identifying different types of political actors and stakeholders and examining their views on health insurance reform.

The refined theory of historical institutionalism will comprise seven explanatory elements: contextual conditions, ideas, actors, political institutions, timing and sequences, path dependency, and policy feedback. While contextual conditions, ideas and actors are three new elements adding to the theory of historical institutionalism, the rest are elements belonging to the traditional historical institutionalism. Although the researcher has added contextual conditions, ideas and actors into the theory, she argues that political institutions and history are the most important elements of the refined theory of historical institutionalism. Besides, she argues that adding these elements into the theory would not undermine the role of institutions in affecting policy outcomes. Instead, adding these elements into the theory only make the role of institutions in affecting policy outcomes more distinct. She argues that the relationship among contextual conditions, ideas, actors and institutions is closely linked. Firstly, the structure of political institutions can either facilitate or offset the contextual conditions. Secondly, political institutions play a determinant role in defining the channels and mechanisms for absorbing and diffusing ideas. Thirdly, political institutions play a determinant role in distributing power among political

actors and shaping their goals and strategies in the decision-making process. Therefore, the impact of contextual conditions, the role of ideas and actors on the health insurance reform process cannot be understood without linking them to the impact of political institutions.

The refined theory of historical institutionalism is helpful in examining health insurance reform in Shanghai and Hong Kong in more detail. Firstly, the approach of institutional dynamism identifies a range of contextual conditions which can generate the sources of institutional and policy changes. This study will examine whether broad changes in contextual conditions, namely political, economic or social context, occur when health insurance reform was respectively implemented and proposed in Shanghai and Hong Kong. It hypothesizes that Shanghai succeeds in implementing health insurance reform because there were changes in contextual conditions that created a window of opportunity for political institutions to deviate from the original path and set healthcare financing policy upon a new trajectory. On the other hand, it hypothesizes that Hong Kong fails to implement health insurance reform because of the absence of aforementioned contextual influences.

Secondly, the role of ideas is brought into the theory of historical institutionalism

to examine how it shapes health insurance reform in Shanghai and Hong Kong. Recognizing that the term “ideas” is poorly conceptualized in Thelen and Steinmo’s (1992) ‘institutional dynamism’, this study sharpens the concept of ideas by borrowing from the study of Campell (1998) and Hwang (2006), which identifies and clearly defines three types of ideational forces, namely programmatic ideas, policy paradigms and societal beliefs. Ideas matter in policy making (Campbell, 1998) because ideational forces either “favor significant policy change or reinforce existing institutional paths” (Hwang, 2006, p.16) through reproducing a dominant paradigm and producing frames which justify existing policy arrangements (Hwang, 2006, p.16). Ideas can range from programmatic ideas through policy paradigms to societal beliefs (Campbell, 1998; Hwang, 2006). Programmatic ideas are “technical and professional ideas that specify cause-and-effect relationships” (Campbell, 1998, p.386) and prescribe “precise, concrete, and policy-specific courses of action” (Campbell, 1998, p.389) to policy problems. Policy paradigms are “broad cognitive constraints on the range of solutions that actors perceive and deem useful for solving problems” (Campbell, 1998, p.389). Examples include the paradigmatic principles of neoclassical economics embraced by the major economics department in the U.S. during the 1970s and the early 1980s (Campbell, 1998, p.390). Societal beliefs are “assumptions held by large segments of the general public” (Campbell, 1998, p.390)

about “what is desirable or not” (Campbell, 1998, p.392). They constrain the normative range of solutions that policy makers view as politically acceptable and legitimate to the public (Campbell, 1998, p.385). In brief, programmatic ideas and policy paradigms are ideas at the cognitive level while societal beliefs are ideas at the normative level consisting of values and attitudes (Campbell, 1998, p.384).

Further, this study, by drawing insights from the study of Berman (2001) and Béland (2005a), highlights five conditions under which new ideas can achieve political prominence and in turn trigger path or policy change. Firstly, formal political institutions determine which actors are in a stronger position to promote a new idea or a policy alternative (Béland, 2005a, p.10). Secondly, new ideas must be championed by political actors who are “capable of persuading others to reconsider the way they think” (Berman, 2001, p.235) and “whose resources, power, and political longevity can enable an idea to get a better, longer, or more respectful hearing” (Berman, 2001, p.235). Thirdly, the time at which a political actor promotes a new idea or a policy alternative “is crucial in determining its level of political influence” (Béland, 2005a, p.10). Fourthly, “the fit or articulation between the idea and environment from which it emerges deserve attention” (Berman, 2001, p.236). Whether consolidation occurs depends on how the new idea or policy alternative fits with existing institutional

structures occupied by historically formed ideologies (Berman, 2001, p.236). Fifthly, the wide acceptance of a new idea or a policy alternative depends on its responsiveness to particular problems (Berman, 2001, p.236). If a new idea does not rise to political prominence and lead to policy change, it means that there is the persistence or institutionalization of old ideas (Berman, 2001, p.238). Ideas are institutionalized when they “have become accepted or instinctual parts of the social world” (Berman, 2001, p.239) and hence are simply viewed or accepted as natural or as part of objective reality (Berman, 2001, p.239).

This study will examine the role of ideas in shaping health insurance reform in Shanghai and Hong Kong. It hypothesizes that Shanghai succeeds in implementing health insurance reform because new idea(s) achieved political prominence. On the other hand, it hypothesizes that Hong Kong fails to implement health insurance reform because there were no favorable conditions giving new idea(s) wide political and public resonance.

Thirdly, the role of actors is brought into the theory of historical institutionalism to examine how different actors are engaged in the health insurance reform process in Shanghai and Hong Kong. This study will identify key actors involved in the

decision-making processes of health insurance reforms in Shanghai and Hong Kong. Besides, it will respectively examine how government officials, politicians, different stakeholders such as medical professionals, insurers and pharmaceutical companies, policy experts, scholars, and ordinary citizens view on health insurance reforms implemented in Shanghai and proposed in Hong Kong.

Fourthly, key political institutions creating “constraints and opportunities for those involved in policy-making” (Béland, 2005a, p.3) will be examined in Shanghai and Hong Kong. In this study, it will examine whether the design of political institutions in Shanghai and Hong Kong provide veto opportunities for interest groups to overturn political decisions in the health insurance reform process. It will examine whether the absence or presence of veto opportunities facilitate or impede the implementation of health insurance reforms in Shanghai and Hong Kong.

Finally, the importance of timing, path dependency, and policy feedback in shaping health insurance reform in Shanghai and Hong Kong will also be examined in this study. In brief, the refined theory of historical institutionalism will have stronger analytical and explanatory power after bringing the approach of institutional dynamism, the roles of ideas and actors into the theory. When presenting the

cross-case analysis in the conclusion chapter, the researcher will weigh up the importance of seven explanatory elements of the refined version of historical institutionalism.

No existing empirical studies have refined historical institutionalism before by bringing the approach of institutional dynamism, the roles of ideas and actors into the theory. Therefore, the current literature is not able to provide enough reference and data for this study. Interviews are conducted to collect data. The next chapter on research methodology and data collection will explain the methods of data collection in detail.

3.6 Conclusion

To conclude, this chapter briefly introduces the historical development of institutional theories in political science. It discusses the key features of historical institutionalism, its weakness in explaining institutional and policy changes, and its insufficient attention to the roles of ideas and actors in shaping policy. It examines how historical institutionalism is refined to increase its analytical and explanatory power to examine health insurance reforms in Shanghai and Hong Kong. The next chapter will outline the research methodology and data collection.

CHAPTER FOUR: RESEARCH METHODOLOGY AND DATA COLLECTION

4.1 Introduction

This chapter outlines the research methodology and the methods of data collection adopted in this study. It is divided into five sections. Section 4.2 examines the epistemological and ontological positions for choosing qualitative research and the case study method as the preferred research strategy in this study. Section 4.3 discusses three methods of data collection adopted in this study, including semi-structured interviews, documents and archival records. Section 4.4 talks about the methods adopted in analyzing data. Section 4.5 respectively reports fieldwork activities in Shanghai and Hong Kong. Section 4.6 gives a conclusion.

4.2 Research Strategy: Case Studies

Research methodology is the strategy governing “the choice and use of particular methods and linking the choice and use of methods to the desired outcomes” (Crotty, 1998, p.3). In social research, there are two representative research methodologies: quantitative and qualitative research (Sarantakos, 1993, pp.26-7). As mentioned in the previous chapter, this study uses historical institutionalism to examine health

insurance reforms in Shanghai and Hong Kong. Using case study as the research strategy is a key feature of historical institutionalism. The case study is a form of qualitative research. Qualitative research takes an inductive approach in which theory is generated out of research (Bryman, 2008, p.366). It holds an interpretivist epistemological position that the social world is understood through examining the interpretation of that world by individuals (Bryman, 2008, p.366). And it holds a constructionist ontological position that social meanings are outcomes of the interactions among individuals (Bryman, 2008, p.366). It puts emphasis on “the qualities of entities and on processes and meanings that are not experimentally examined or measured (if measured at all) in terms of quantity, amount, intensity, or frequency” (Denzin and Lincoln, 2000, p.8). It can give a holistic account to intellectual puzzles (Mason, 1996, p.6) by “reporting multiple perspectives, identifying the many factors involved in a situation, and generally sketching the larger picture that emerges” (Creswell, 2007, p.39).

Case study is the analysis of “persons, events, decisions, periods, projects, policies, institutions or other systems which are studied holistically by one or more methods” (Thomas, 2011, p.23). It is the preferred strategy when “how” or “why” questions are being asked about the subject of the inquiry (Thomas, 2011, p.4) and

when the researcher wants to cover contextual conditions which are believed to be highly pertinent to the phenomenon of study (Yin, 2003, p.13). The utility of the case study lies in studying process (Stoecker, 2006, p.330) and dealing with “the subtleties and intricacies of complex situation” (Denscombe, 2003, p.38) that “cannot easily be reduced to simple causal models or statistical tests” (David, 2006, p.XXVII). Yin (2003) argues that the case study focuses on “a contemporary set of events over which the investigator has little or no control” (p.9). However, Powell (2012) disagrees with Yin’s argument that case study cannot be historical and a focus should be on a contemporary set of events, “given that all case studies are historical because, the moment after an event occurs, it becomes ‘historical’” (p.43). The case which is the subject of the inquiry would be an instance of a class of phenomena providing “an analytical frame – an object – within which the study is conducted and which the case illuminates and explicates” (Thomas, 2011, p.23). According to Exworthy and Powell (2012), the scale of case study research in health policy has been significantly increased over the past 30 years, especially since the mid-1990s (p.8), based on “the results of a search of the databases Zetoc and Google Scholar using the term ‘case study health policy’” (Exworthy and Powell, 2012, p.8) (**See Table 10**).

The strength of the case study lies in its ability to develop “a more rounded,

richer, more balanced picture of [the] subject” (Thomas, 2011, p.4) “with many kinds of insights coming from different angles, [and] from different kinds of information” (Thomas, 2011, p.21). It pays attention to empirical details (Stoecker, 2006, p.331) and “allows for multiple facets of the phenomenon to be revealed and understood” (Baxter and Jack, 2008, p.544) “within its context using a variety of data sources” (Baxter and Jack, 2008, p.544). Data collected from multiple sources facilitates data validation (Denscombe, 2003, p.38) and “enhances data credibility” (Baxter and Jack, 2008, p.554).

Given the above considerations, the case study method is the best research strategy for this study because this study poses a question of why Shanghai has been able to implement health insurance reform from the mid-1980s onwards while Hong Kong has failed to do so. The implementation of health insurance reforms is a contemporary phenomenon over which the researcher has little or no control. In this study, Shanghai and Hong Kong represent two contrasting cases. It would be difficult to have a formal qualitative comparison between these two cases because they belong to diverse political and economic regime. In order to circumvent this problem, this study adopts the interpretive case study approach, which uses a theoretical lens as a unifying logic to compare these two cases. The theory of historical institutionalism is

used as the basis of case interpretation or a template with which to compare the empirical results of these two case studies. Through the lens of historical institutionalism, the researcher aims toward analytical generalization of the case study results. With a fundamental theoretical orientation, this study respectively presents a detailed case study analysis for Shanghai in Chapter Five and Six and for Hong Kong in Chapter Seven and Eight. In the conclusion chapter, this study uses a comparative perspective to present a cross-case analysis in order to gain insight into how and why these two places vary in the process, contexts and outcomes of health insurance reform. The process of implementing health insurance reform is complicated in these two places that each place respectively involves the dynamic interplay of forces, namely contextual conditions, ideas, actors, political institutions, timing and sequences, path dependency, and policy feedback. It requires the researcher to collect data from multiple sources in order to have a holistic account to the research questions examined.

4.3 Data Collection

Data collection “is an attempt to streamline a complex set of events into a set of manageable things for the researcher to analyze” (David and Sutton, 2004, p.203).

According to Yin (2003), data for case studies can come from six sources:

“documents, archival records, interviews, direct observation, participant-observation, and physical artifacts” (p.83). Since each data source has no complete advantages over the others but is highly complementary, a good case study would collect data from as many sources as possible (Yin, 2003, p.85). The “multiple sources of evidence essentially provide multiple measures of the same phenomenon” (Yin, 2003, p.99). As Baxter and Jack (2008) argue, each data source represents one piece of the puzzle “contributing to the researcher’s understanding of the whole phenomenon” (p.554). This convergence can achieve data triangulation which ensures completeness of findings and confirms the validity of the findings (Carpenter and Jenks, 2003, p.300). “Completeness provides breadth and depth to an investigation” (Carpenter and Jenks, 2003, p.300), offering the researcher “more rounded and complete accounts of social issues and processes” (Hakim, 1987, p.63) and “a more accurate picture of the phenomenon” (Carpenter and Jenks, 2003, p.300). There would be “less chance of making errors, or of drawing inappropriate conclusions” (Arksey and Knight, 1999, p.21). Confirmation occurs when the researcher uncovers the same information from more than one source (Carpenter and Jenks, 2003, p.300). The case study using multiple data sources is rated more highly in terms of its overall quality than that of using a single data source (Yin, 2003, p.99) because multiple data sources add rigor, richness, breadth and depth to the case examined (Denzin and Lincoln, 2000, p.5). In

order to provide more comprehensive and convincing research findings, this study uses multiple sources to collect data, in particular: (i) semi-structured interviews, (ii) documents and (iii) archival records.

(a) Semi-structured Interviews

An interview is “a purposeful conversation” (Bogdan and Biklen, 2007, p.103). It is “an interaction between the interviewer and interview subject in which both participants create and construct narrative versions of the social world” (Miller and Glassner, 1997, p.99). In this study, the researcher uses interviews as a data source because her ontological position suggests that “people’s knowledge, views, understandings, interpretations, experiences, and interactions are meaningful properties of the social reality” (Mason, 1996, p.39) while her epistemological position suggests that “a legitimate way to generate data on these ontological properties is to interact with people” (Mason, 1996, pp.39-40), accessing their accounts and articulations by talking and listening to them (Mason , 1996, pp.39-40).

There are three types of interviews: structured, semi-structured, and unstructured (Berg, 2007, p.92). Structured interview asks questions that are “predetermined both in content and in form” (Corbetta, 2003, p.271). Semi-structured interview asks

questions that are predetermined in the content but not in the form (Corbetta, 2003, p.272). Unstructured interview asks questions that are not predetermined in the content or the form (Corbetta, 2003, p.272). This study does not conduct structured interview because pre-established questions place “serious limitations on the objective of flexibility and adaptability to the specific situation analyzed” (Corbetta, 2003, p.269). This study also does not conduct unstructured interview because the interviewing process can be time-consuming and susceptible to digression. This study conducts semi-structured interviews because they provide the researcher with flexibility “in terms of the order in which the topics are considered” (Denscombe, 2003, p.167) and let her approach the world from the interview subject’s perspective “by adjusting the level of language of given scheduled questions or through unscheduled probes” (Berg, 2007, p.95). At the same time, semi-structured interviews let the interviewees develop their ideas, elaborate points of interests, speak more widely on the issues raised by the researcher and give open-ended answers (Denscombe, 2003, p.167). In brief, conducting semi-structured interviews has the advantages of giving both the researcher and interviewees ample flexibility and freedom to interact with each other, “while at the same time ensuring that all the relevant themes are dealt with and all the necessary information collected” (Corbetta, 2003, p.270).

This study adopts two types of sampling in order to choose prospective interviewees: purposive sampling and snowball sampling. Purposive sampling is used to choose prospective interviewees whom “have some special contribution to make” (Denscombe, 2003, p.172) and “have some unique insight [due to] the position they hold” (Denscombe, 2003, p.172). Snowball sampling is also used to locate interview subjects “with certain attributes or characteristics [of interest] necessary in the study” (Berg, 2007, p.44) by asking initial contacts if they can introduce other people possessing similar attributes or characteristics to the researcher to conduct interviews (Berg, 2007, p.44; Lofland et al., 2006, p.43).

In this study, the researcher conducted interviews with both elites and ordinary citizens in Shanghai and Hong Kong. Elites are people “exercising power and influence” (Arksey and Knight, 1999, p.122) and “held in high esteem” (Arksey and Knight, 1999, p.122). They include government officials, policy makers, legislators, and experts. Interviewing elites has three advantages. Firstly, elites “have special insight into the causal processes of politics, and interviewing them permits in-depth exploration of specific policies and political issues” (Beamer, 2002, p.87). The resulting information gathered from elite interviews offers the researcher “more

reliable and valid data for inferential purposes” (Beamer, 2002, p.87). Secondly, elite interviews “can shed light on the hidden elements of political action that are not clear from an analysis of political outcomes” (Tansey, 2007, p.767) or other sources. By interviewing elites, the researcher “can gain data about the political debates and deliberations that preceded decision making and action taking” (Tansey, 2007, p.767). Thirdly, elite interviews can “compensate for both the lack and limitations of documentary evidence” (Tansey, 2007, p.767) or help the researcher “distinguish the most significant or accurate documents from those that may be marginal or may present a selective accounts of events” (Tansey, 2007, p.767) if there is substantial documentation. Therefore, it is important to interview elites in order to gather rich detail about their attitudes and thoughts on specific policies or political issues (Tansey, 2007, p.766). The researcher also interviewed ordinary people because they are the users of medical services. They are directly affected by healthcare financing reforms implemented by the government. Therefore, it is important to understand about their attitudes and thoughts on healthcare financing reforms. Ordinary people are too large in number for the researcher to individually interview all of them. The researcher did not have enough time and money to get a representative sample. However, she could make use of the data collected from ordinary people interviewed to make inferences.

In this study, the researcher follows three key ethical principles when conducting interviews in order to avoid any harm to the interviewees: informed consent, right to privacy and protection from physical and emotional harm (Fontana and Frey, 2000, p.662). Informed consent “is a mechanism to show respect for the rights and welfare of research participants” (Arksey and Knight, 1999, p.130). In order to let the prospective interviewees make an informed decision about whether they agreed to be interviewed, the researcher sent them emails to introduce herself and clearly explain the nature, purpose and duration of the research to them. Besides, in order to protect the identity of the interviewees, the researcher ensured the confidentiality and anonymity of the interviewees by promising that their real names would not be used in the research report (Mason, 1996, p.56; Lofland et al., 2006, pp. 51-2). As Lofland et al. (2006) argue, the guarantee of confidentiality to the interviewees is “viewed both as an essential techniques for ‘getting in’, and once entrée has been accomplished, as a sacred trust” (pp.51-2). Another advantage of guaranteeing confidentiality to the interviewees is that “responses to [interview] questions may well be more frank” (Arksey and Knight, 1999, p.132). Also, the researcher did not use any tape or digital recorders to record interviews. Although she recognized that audio recording “aids the listening process and gives the opportunity of an unbiased record of the conversation” (Easterby-Smith et al., 2002, p.92), she did not use it because

audio recording would lead to interviewees' anxiety about confidentiality and the possibility of declining the research interview. As Bogdan and Biklen (2007) argue, some interviewees would worry that the recordings which contain their words "could come back to haunt them" (p.112) or "get them in trouble if, for example, they revealed something illegal they did" (p.112). Therefore, instead of tape recording any interviews, the researcher had note taking in order to capture the discussion happened during the interviews (Denscombe, 2003, p.175). The advantage of note taking is that it can cover the relevant information that audio recording would miss, including "the context of the location, the climate and atmosphere under which the interview was conducted...and comments on aspects of non-verbal communication" (Denscombe, 2003, p.175). In brief, the researcher follows these three key ethical principles in order to safeguard the proper interests of the interviewees who agreed to be interviewed.

In this study, the researcher recognized that sample of interviews in Shanghai and Hong Kong were not large and representative enough for quantitative analysis. Therefore, she did not claim that the semi-structured interviews in these two places were representative in that sense. The interviews were qualitative and revealed the opinions of key agents. Since the researcher recognized that the reliability of data

collected from interviews would be subject to the likely biases, knowledge and memory of informants, she cross-checked the data collected from semi-structured interviews with data collected from documents and archival records.

(b) Documents

A document is any material produced by individuals or institutions for providing information on a given social phenomenon (Corbetta, 2003, p.287). It “exists independently of the researcher’s action” (Corbetta, 2003, p.287) but the researcher can utilize it for cognitive purposes (Corbetta, 2003, p.287). In this study, the researcher also uses documents as a data source because her ontological position suggests that documents “act as some form of expression or representation of relevant elements of the social world” (Mason, 1996, p.72) that one “can trace or ‘read’ aspects of the social world through them” (Mason, 1996, p.72) while her epistemological position suggests that reading and interpreting documents “can provide or count as evidence” (Mason, 1996, p.73).

There are different kinds of documents, including books and journals, government publications, written reports of events, agendas, minutes of meetings, and newspaper articles (Denscombe, 2003, p.213-8; Yin, 2003, pp.85-6). They are “most

often available as texts (in a printed form), but they also have the form of an electronic file” (Flick, 2006, p.246). Denscombe (2003) argues that books and journals “should be the first port of call” (p.212) because they “contain the accumulated wisdom on which the research project should build, and also the latest cutting-edge ideas which shape the direction of the research” (Denscombe, 2003, p.212). Government publications provide a key source of documentary information, data and statistics which are authoritative, factual and objective because they are produced by the state with large resources and expert professionals (Denscombe, 2003, pp.216-7). Minutes of meetings in an organization are also useful documents because they record “issues raised at the meeting; the discussion of those issues; views of the participants; and actions to be taken” (Bryman, 2008, p.527). And newspaper articles can provide up-to-date information (Denscombe, 2003, p.214). In brief, documents provide an access to a set of events or processes, which the researcher cannot observe “(for example because they have already occurred, because they take place in private) without recourse to verbal descriptions and reconstructions” (Mason, 1996c, p.73). Although this study focuses on collecting qualitative data, it will also use quantitative data collected from documents as evidence to interpret, strengthen and support the arguments, and supplement information when qualitative accounts are lacking or incomplete (Gill and Popp, 2009). Some numerical data will be presented in the text

of this study. Tables of grouped numerical data will be placed in the appendices.

(c) Archival Records

Archival records are “non-current and inactive [records]” (University of Rochester, 2012) that are “not required to be retained in the office in which [they] originated or [were] received” (University of Rochester, 2012). However, they are permanently retained and preserved for their historical value (University of Rochester, 2012).

Archival records contain “information of enduring administrative, legal, fiscal, or cultural value to the creating institutions or to researchers” (Penn State University Libraries, 2011). They are generally seen by academic users and society as “passive resources to be exploited for various historical and cultural purposes” (Schwartz and Cook, 2002, p.1). Archival records can be letters, diaries, reports, service records, organizational records, survey data and other types of written documents as well as audiotapes, videotapes, computer tapes or disks, maps, drawings and photographs (Penn State University Libraries, 2011; The Massachusetts Historical Society, 2003; Yin, 2003, p.89). They can be obtained through open channels such as libraries free of charge and help save the time of the researcher to collect data. Most archival records are “produced for a specific purpose and a specific audience (other than the case study investigation)” (Yin, 2003, p.89). Nevertheless, they contain relevant elements of the

social world that can be utilized by the researcher for cognitive purposes. In this study, the researcher also uses archival records as a data source because like documents, archival records are available data providing the author with the opportunity to “study the past” (Corbetta, 2003, p.288; Singleton and Straits, 2005, p.355) and understand about social change (Singleton and Straits, 2005, p.356). Besides, it can provide useful figures in the past that cannot be accurately obtained from the interviewees who can only give an estimation of figures. In brief, this study makes use of semi-structured interviews, documents and archival records to collect data and to facilitate data validation.

4.4 Data Analysis: Coding

After data has been collected, it has to be analyzed. Data analysis is a transformative process that turns the raw data into findings or results (Lofland et al., 2006, p.195) by identifying “the presence or absence of meaningful themes, common and/or divergent ideas, beliefs and practices” (David and Sutton, 2004, p.191). In this study, the author uses coding to analyze data. Coding “organizes and conceptualizes the detailed components of data into patterns by use of symbols and labels” (Payne and Payne, 2004, p.36). It includes “two simultaneous activities: mechanical data reduction and analytic categorization of data into themes” (Neuman, 2003, p.442). According to

Basit (2003), coding “can be carried out by selecting segments of text using line numbering in the document, or by highlighting the specific quotation to be coded” (p.149). Symbols and labels used in coding are called codes that “are attached to chunks of varying-sized words, phrases, sentences or whole paragraphs, connected or unconnected to a specific setting” (Basit, 2003, p.144). The use of coding in data analysis has four advantages. Firstly, it reduces “mountains of raw data into manageable piles” (Neuman, 2003, p.442) so that a researcher can “quickly retrieve relevant parts of it” (Neuman, 2003, p.442). Secondly, it sorts the data “into various categories that organize it and render it meaningful from the vantage point of one or more frameworks or sets of ideas” (Lofland et al., 2006, p.200). Thirdly, it allows links to be made and highlights “key points within the vast of the overall data”(David and Sutton, 2004, p.195) in order to “find commonalities, differences, patterns and structures” (Basit, 2003, p.144). Fourthly, it allows the researcher to “communicate and connect with the data to facilitate the comprehension of the emerging phenomena” (Basit, 2003, p.152).

In this study, the researcher carries out coding manually. Based on the research questions of this study, the researcher identified several categories for coding. These categories include: (i) characteristics of healthcare financing system; (ii) reasons for

and purposes of healthcare financing reforms; (iii) contexts or pressures (e.g. political, economic, social, institutional, and ideological) which shape healthcare financing reforms; (iv) contents of healthcare financing reforms; (v) different views about healthcare financing reforms (e.g. positive/negative/both; happy/worried; advantages/disadvantages of the health insurance reform; and suggestions) from different groupings (e.g. government officials, former Legco member, scholars, members from medical profession or health-related organizations, social workers, insurance consultants and citizens).

4.5 Report on Fieldwork Activities

Fieldwork means how a researcher collects data “in a social setting that tries to reflect the naturally occurring order of events and subjective meanings of those being studied” (Payne and Payne, 2004, p.94). In order to collect data about health insurance reforms in Shanghai and Hong Kong, the researcher conducted fieldwork in these two places. Data was collected through doing interviews, looking at documents and archival records at libraries, on online database systems, and on the Internet.

(a) Fieldwork Activity about Shanghai Health Insurance Reform

The researcher conducted two rounds of fieldwork in Shanghai. The first round was

carried out from June 25, 2010 to July 8, 2010 while the second round was carried out from July 15, 2010 to August 4, 2010. Before conducting fieldwork in Shanghai, the researcher contacted some of the prospective interviewees either through personal contacts she had already established or by sending emails to them from April to May 2010 when she was still in Birmingham. As Denscombe (2003) argues, contacting the prospective interviewees in advance “allows both parties to arrange a mutually convenient time for the interview” (p.173). Some of the prospective interviewees were contacted by the researcher after arriving Shanghai through making personal calls and through personal contacts. In total, the researcher was able to interview 25 persons, including a government official, insurance consultants, pharmaceutical company workers, medical personnel, academic researchers and citizens. **Table 11** is a list of Shanghai interviewees containing information about a simple description of the interviewees, the date, time, and places of the interviews taking place.

Having good personal ties or *guanxi* in China can help increase the possibility of having more interview opportunities. The Chinese term *guanxi* refers to “an informal, particularistic personal connection between two individuals who are bounded by an implicit psychological contract to...[maintain] a long-term relationship, mutual commitment, loyalty, and obligation” (Chen and Chen, 2004, p.306). As an outsider,

the researcher had to made use of her *guanxi* with personal contacts in order to gain access to some prospective interviewees who are well-known scholars on healthcare financing reforms and who know about the operation of health insurance systems well. After getting informed consent from the prospective interviewees, the researcher called or emailed them to arrange a convenient time and place to have interviews with them. As Denscombe (2003) argues, the researcher needs to get a location for the interview that avoids disturbance and offers privacy (p.173).

The researcher was able to conduct face-to-face interviews with 23 interviewees. One of the face-to-face interviews was conducted in Hong Kong when a Hong Kong citizen who worked in Shanghai was unable to meet the researcher because he was not in Shanghai when the researcher was conducting fieldwork in Shanghai. The researcher had two telephone interviews because one of the interviewees was on a business trip in other part of China while another interviewee who was a government official was too busy to come out to meet the researcher. Telephone interviews have the advantages of saving time and money to set up individual meetings (Gillham, 2000, p.77) while offering “some of the virtues of the face-to-face interview...[such as] responsiveness and reflexivity” (Gillham, 2000, p.77).

In this study, 10 out of 25 interviewees in Shanghai were found through purposive sampling. The rest were introduced through snowball sampling which asked the subject interviewed to recommend people with a similar trait of interest. However, some of the interviewees which had the personal network were against the idea of snowball sampling. They refused to give the researcher any names because of different reasons. For example, Government Official 1 said that it was inappropriate for her to introduce any names because “medical insurance is a sensitive topic that involves many vested interests”.⁶ Professor 2 interviewed had good connection with government officials in healthcare related departments and bureau. However, he said that it was “politically incorrect” to introduce the researcher to meet them because he had already said enough.⁷ He also said that he would not have talked to the researcher if he did not have the title of professor.⁸ Doctor 1 interviewed said that health insurance was a sensitive topic involving unethical practices that he was suspicious of being stalked already and that he risked his life to be interviewed.⁹ He said that he did not want to get himself into trouble because asking his friends to be interviewed by the researcher was equal to telling his friends that he had already been interviewed by the researcher.¹⁰ Pharmaceutical Company Manager 1 and 2 interviewed also refused

⁶ Government Official 1 was interviewed on July 6, 2010 by phone.

⁷ Professor 2 was interviewed on July 1, 2010.

⁸ Professor 2 was interviewed on July 1, 2010.

⁹ Doctor 1 was interviewed on July 1, 2010.

¹⁰ Doctor 1 was interviewed on July 1, 2010.

to give any names who may agree to be interviewed because they said that they had answered every question raised by the researcher.¹¹ Asking them to introduce other names was equal to the researcher having unreasonable requests and showing sign of disrespect.¹²

Judging from the fact that health insurance is a sensitive topic to discuss in Shanghai, the researcher promised the interviewees not to disclose their real names in the study and would only had note taking during the interviews in order to erase the interviewees' anxiety, maintain trust and protect them from harm. The interviewees appreciated the researcher's ethical considerations. Knowing that the researcher would have note taking during the interviews, the interviewees were willing to speak slower so that the researcher could capture the discussion happened during the interviews in detail. They also promised the researcher that they were willing to have follow-up interviews or welcomed the researcher to contact them through phone calls or emails any time if the researcher had further questions to ask when tidying up the notes in future. 20 out of 25 interviews lasted for two to three hours. The researcher used Mandarin to communicate with the interviewees. She translated the interview

¹¹ Pharmaceutical Company Manager 1 and 2 was respectively interviewed on July 21, 2010 and August 1, 2010.

¹² Pharmaceutical Company Manager 1 and 2 was respectively interviewed on July 21, 2010 and August 1, 2010.

contents from Chinese into English. Interview notes were typed and stored in the notebook and backed up on a USB. There were also hardcopies of them for safe keeping. But the researcher made sure that the notebook, the USB and the storage space where the hardcopies were kept were secure and could not be accessed by other people. The researcher used at least one to two hours to type the note of every interview.

Apart from having interviews, the researcher also collected documents and archival records related to Shanghai health insurance. The researcher went to the library in Shanghai to borrow books related to Shanghai health insurance. The researcher also went to the university bookshops in Shanghai to buy books containing studies or surveys related to health insurance and healthcare system in Shanghai that were not available in the Shanghai library or Hong Kong university libraries. Documents and books about Shanghai health insurance that were available in Hong Kong were looked at and photocopied by the researcher when she had fieldwork in Hong Kong.

“Systematic searches for relevant documents are important in any data collection plan” (Yin, 2003, p.87). Documents related to health insurance reform in Shanghai

could be found in open channels, including university libraries in Hong Kong, public library in Shanghai, the Universities Service Centre for China Studies (USC) at the Chinese University of Hong Kong (CUHK),¹³ the websites of Shanghai Municipal Government (<http://www.shanghai.gov.cn>), Shanghai Municipal Human Resources and Social Security Bureau (<http://www.12333sh.gov.cn>), Shanghai Municipal Statistics Bureau (<http://www.stats-sh.gov.cn>), National Bureau of Statistics of China (<http://www.stats.gov.cn>), and Shanghai Bureau of China Insurance Regulatory Commission (<http://www.circ.gov.cn>). Newspaper articles on health insurance reform in Shanghai and useful articles or reports about health insurance reform in Shanghai could be found by searching Google website (www.google.com). Archival records related to health insurance reform in Shanghai could be found in the USC at the CUHK. Both the documents and archival records were able to provide useful facts and figures about health insurance reform in Shanghai, in particular figures from decade past, when the interviewees fail to provide figures or could only give an estimation of some figures due to poor memories.

¹³ The USC at the CUHK is “one of the most extensive and accessible Collection of a great variety of materials on contemporary China” (<http://www.usc.cuhk.edu.hk/Eng/Default.aspx>), including complete runs of “more than 250 provincial and national newspapers and close to 1,500 periodicals from the early 1950s; over 1300 constantly updated regional and statistical yearbooks” (<http://www.usc.cuhk.edu.hk/Eng/Default.aspx>). Besides, it also has a “large collection of provincial, city, county and village annals, including volumes on special topics” (<http://www.usc.cuhk.edu.hk/Eng/Default.aspx>) and books “with a focus on regional research data” (<http://www.usc.cuhk.edu.hk/Eng/Default.aspx>).

(b) Fieldwork Activity about Hong Kong Health Insurance Reform

The researcher conducted fieldwork in Hong Kong from mid-August 2010 to March 2011. Before conducting fieldwork in Hong Kong, the researcher contacted some of the prospective interviewees either through personal contacts she had already established or by sending emails to them from May to early June 2010 when she was still in Birmingham. Some of the prospective interviewees were contacted by the researcher after arriving Hong Kong through making personal calls and through sending emails. The researcher mainly relied on purposive sampling to find the prospective interviewees. The data collected in Hong Kong mainly through purposive sampling does not mean that they were better than that of Shanghai collected through purposive and snowball sampling. It is because using purposive or snowball sampling only means that the way to contact the prospective interviewees are different. Whether the data is better or not depends on the researcher asking the right and good questions and the interaction process between the researcher and the interviewees. Since the researcher grows up in Hong Kong, she is familiar with the context of Hong Kong and knows who can be the prospective interviewees. In total, the researcher was able to interview 25 persons, including a government official, civil servants, famous public figures who used to handle healthcare or health insurance issues, medical personnel, social workers, insurance consultants, scholars and citizens. **Table 12** is a list of Hong

Kong interviewees containing information about a simple description of the interviewees, the date, time, and places of the interviews taking place.

The researcher conducted two rounds of interviews. The reason for conducting the second round of interviews is due to the Hong Kong Special Administrative Region (HKSAR) governments' release of a new health insurance public consultation document in October 2010. The researcher conducted follow-up interviews with interviewees being interviewed before the release of the new health insurance public consultation document. She conducted follow-up interviews with 11 interviewees. However, eight out of 11 follow-up interviews were conducted from February to March 2011 because the interviewees needed more time to digest the new health insurance consultation document before they had follow-up interviews. That is one of the main reasons why the researcher needed a longer time to conduct fieldwork in Hong Kong.

For the first round of the interview, the researcher was able to conduct face-to-face interviews with 24 interviewees. She had to conduct a telephone interview with a citizen who was too busy to meet the researcher. For the second round of interviews, the researcher conducted face-to-face interviews with four interviewees and telephone

interviews with seven interviewees. As Berg (2007) argues, telephone interviews are “quite productive when they are conducted among people with whom the researcher has already conducted face-to-face interviews” (p.108).

Although health insurance is not a sensitive topic to discuss in Hong Kong but a widely debated topic and widely covered by the mass media, the researcher promised the interviewees not to disclose their real names in the study and would only have note taking during the interviews in order to erase the interviewees’ anxiety, maintain trust and protect them from harm. These ethical considerations are particularly important to some of the interviewees who are well-known public figures and scholars and those who work as the think tanks of the HKSAR governments. All the interviewees welcomed the researcher to contact them again if the researcher had further questions to ask in future. The researcher used Cantonese to communicate with the interviewees. She translated the interview contents from Chinese into English. Interview notes were typed and stored in the notebook and backed up on a USB. There were also hardcopies of them for safe keeping. But the researcher made sure that the notebook, the USB and the storage space where the hardcopies were kept were secure and could not be accessed by other people. The researcher used at least one to two hours to type the note of every interview.

Apart from having interviews, the researcher also collected documents and archival records related to Hong Kong health insurance. Documents related to healthcare financing reform in Hong Kong such as healthcare consultation documents, discussion paper, minutes of meetings related to healthcare financing reform can be found in open channels, including university libraries, the websites of the HKSAR government (www.gov.hk), Food and Health Bureau of the HKSAR (www.fhb.gov.hk), and the Legislative Council (www.legco.gov.hk). Newspaper articles on healthcare financing reform in Hong Kong could be collected from WiseNews (<http://libwisenews.wisers.net/wisenews/index.do?new-login=true>), which was a database providing access to local Chinese and English newspapers since 1998. The author could get access to WiseNews through the online library system of the CUHK. Since the database was large, key words in Chinese and English characters were inserted to narrow down the search. For example, key words such as “healthcare financing reform”, “health insurance”, “mandatory health insurance”, “health protection scheme”, and “voluntary health insurance” were inserted to narrow down the search in WiseNews. Archival records related to healthcare financing policy in Hong Kong could be found in university libraries.

Overall, the data collected through multiple sources which include semi-structured interviews, documents and archival records are rich and useful. Different sources of data are complementary to each other. Data triangulation not only helps facilitate data validation, but also helps form a more complete picture of the development of health insurance reform in Shanghai and Hong Kong and comes up with a more convincing research finding.

4.6 Conclusion

To conclude, this chapter provides an overview of the research methodology adopted in this study. It explains why qualitative research is adopted in this study by using case study research to respectively examine health insurance reform in Shanghai and Hong Kong in detail. Besides, it discusses the methods used to collect and analyze data. And it reported the fieldwork activities in Shanghai and Hong Kong. The next chapter will examine the healthcare system in Shanghai in the pre-reform era (1842 to 1976).

CHAPTER FIVE: SHANGHAI CASE STUDY: THE HISTORICAL

BACKGROUND

5.1 Introduction

This chapter briefly examines the historical development of the healthcare system in Shanghai and traces the performance of the institutional mechanisms established in the pre-reform era from 1842 to 1976. It provides important historical context necessary for understanding urban health insurance reform in Shanghai by showing that the establishment and institutionalization of public health and healthcare systems in Shanghai were the products of Western presence in China in the nineteenth century and by looking at the political and economic institutions in which the healthcare system was embedded in the pre-reform era (1949-1976). It is divided into four sections. Section 5.2 examines the governing institutions, the public health and healthcare systems in Shanghai in early years (1842-1937). Section 5.3 examines the political, economic, and healthcare systems in urban Shanghai during Mao's era (1949-1976). Section 5.4 discusses how the contextual conditions and political institutions shaped the development trajectory of healthcare in Shanghai. Section 5.5 gives a conclusion.

An overview of the development trajectory of public health and healthcare systems in Shanghai before 1976 shows that during the early years (1842-1937), the pace and scope of developing public health and healthcare in the foreign concessions was faster and better than that of the Chinese-administrated area. In the 1850s, the authorities in the foreign concessions emphasized the development of public health in order to turn Shanghai into a healthy place for economic growth. On the other hand, the Chinese authority of the old Chinese city in Shanghai did not start developing public health until 1905 when it regarded the development of public health as a way to counteract “the growth of foreign power” (Elvin, 1974, p.249). However, the Chinese authority lagged behind the foreign counterparts in developing public health because of the political turmoil, insufficient capital and the lack of well-trained personnel (Hsü, 2000; Nakajima, 2004; Peng, 2007).

Both the foreign and Chinese authorities in Shanghai played a negligible role in healthcare provision and left the tasks of building hospitals and offering medical treatment to missionaries, local elites and businessmen, Chinese-style practitioners and later private practitioners (Nakajima, 2004). It was not until the 1870s that the foreign authorities involved in healthcare provision by providing medical treatment for patients infected by venereal disease. Besides, they subsidized missionary

hospitals and financed summer disease hospitals because the medical treatment provided by these hospitals significantly reduced the financial burden on the foreign authorities (Nakajima, 2004, p.54). On the other hand, the Chinese authority did not involve in healthcare provision and financing until the early 1930s when the Nationalist government, which regarded foreign powers of the settlements as rivals, established hospitals to provide the general public with free or inexpensive medical care (Nakajima, 2004, p.147).

“After the Second World War, the foreign concessions were closed and Shanghai was returned to Chinese administration” (Wei, 1987, p.4). During Mao’s era, the state-run healthcare system in Shanghai performed well in the institutional configuration of the socialist planned economy. The work units in urban Shanghai were crucial institutions representing the CCP’s power to finance the healthcare of the population.¹⁴ They implemented the LIS and the GHS to provide urban employees with free healthcare financed by the state budget. The three-tiered medical institution network established in urban Shanghai was an efficient network making healthcare services more accessible to the majority of population. However, the state-run healthcare system in Shanghai came to malfunction after the PRC’s economic

¹⁴ The PRC’s administrative divisions include 22 provinces, five autonomous regions and four directly controlled municipalities (Beijing, Tianjing, Shanghai, Chongqing). Shanghai is the largest city in the PRC. It has 16 districts and one county. Each district consists of urban and rural areas.

transition to the market economy. The CCP was under great pressure to reform the healthcare financing system.

5.2 Early Years (1842-1937)

Shanghai is located at the mouth of Yangzi River, lying midway along the China coast (Yeung, 1996, pp.3-4). From the period 1842 to 1937, Shanghai was a semi-colony of the Western power opened to foreign settlements because of China's defeat in the First Opium War. The signing of the Land Regulations led to Britain, the U.S. and France obtaining settlement rights in 1845, 1848 and 1849 respectively (Lu, 1999, p.29). These foreign parties had the rights to buy, sell and lease properties, and the right to provide basic infrastructure conducive to international commerce in designated areas (MacPherson, 2002b, p.38). Under the principle of extraterritoriality, "foreign nationals were subject to the laws of their own countries and the jurisdiction of their own consuls" (Wei, 1993, p.17). In Shanghai, there were three separate administrative sectors: the International Settlement merged by the British and American settlements in 1863, the French Concession, and the old Chinese city (Hershatter, 1992; Lu, 1999; MacPherson, 2002b; Wei, 1987) (See **Diagram 1**).¹⁵ At first, the segregation policy

¹⁵ According to Fraser (1939), the area of the original British settlement was 138 acres in 1846 (p.45). While the Huangpu River was on the east side of the British settlement, the Defence Creek was the westerly limit of the settlement (Hart, 1890, p.218). The Suzhou and Yang-King-Pang Creeks were the northern and southern boundaries of the settlement (Hart, 1890, p.218). The American Settlement in Hongkou was "located on the north side of the Suzhou Creek" (Lu, 1999, p.29) and extended along the bank of the Huangpu River for about three miles in a northerly direction (Hart, 1890,

was adopted to exclude Chinese residence in the International Settlement and the French Concession. However, the policy was abandoned in 1854 because the outbreak of the Taiping Rebellion in 1853 led to about a million refugees fleeing to the foreign concessions (MacPherson, 2002b, p.38).¹⁶

(a) The Governing Institutions in Shanghai

The foreign concessions had their own governing institutions to address their needs and “provide a commercially viable, urban infrastructure” (MacPherson, 1990, p.42). They went “beyond the jurisdiction of the Chinese officials” (Wei, 1993, p.11). The International Settlement was governed by the Shanghai Municipal Council established in 1854 (Yu, 2010, p.59) while the French Concession was governed by *Conseil Municipal* (MacPherson, 2002b, p.38) established in 1862 (Camus, 2009, p.206). The Shanghai Municipal Council, which was elected by ratepayers, enjoyed administrative and legislative powers, as well as control over finance, taxation, the police and security (Wei, 1993, p.16; Wei, 1987, p.64). It was dominated by moneyed interests in

p.218). When the British and American settlements were merged in 1863, “the foreign area occupied 1, 309 acres” (Fraser, 1939, p.45). The area of the original French settlement was 164 acres in 1849 (Guo and Li, 1999). It was separated from the British settlement by the Yang-King-Pang Creek, and extended in a southerly direction to the walls of the Chinese city (Hart, 1890, p.218). And the area of the Chinese city comprised a territory of 204, 800 acres or 320 square miles (one square mile = 640 acres) with suburbs (Chamberlain, 1931, p.146; MacPherson, 1990, p.45). It was “surrounded by high walls with four entrance gates, which [were] guarded day and night and [were] closed after sunset” (Hart, 1890, p.220). With repeated expansion of the foreign concessions, the area occupied by the International Settlement reached 5,584 acres or 8.73 square miles while the area occupied by the French Concession reached 2,525 acres or 3.95 square miles in the early twentieth century (Guo and Li, 1999).

¹⁶ The Taiping Rebellion (1850-1864) was a domestic rebellion against the Qing dynasty, “raging over sixteen provinces and destroying more than 600 cities” (Hsü, 2000, p.221).

policy making because “stringent property qualifications for franchise in the International Settlement” (Wei, 1993, p.16) meant that major trading houses such as Jardine Matheson and Swire and “individuals with several domiciles commanded a multiple number of votes” (Wei, 1993, p.16).

On the other hand, the French government retained control over the French Concession through its consul in Shanghai and minister in Beijing (Wei, 1987, p.64). The French consul, who was the chief executive and administrator of the Concession government, was “the arbiter of all policies in the French Concession” (Wei, 1987, p.77). He held certain important powers, including appointing and dismissing employees of the Concession government, promulgating all laws, serving as ex-officio chairman of the *Conseil Municipal*, having the rights to veto council decisions and dissolve the council, calling the meetings of ratepayers and retaining control over the police (Wei, 1987, pp.79-80; Wei, 1993, p.19). The property qualifications for franchise in the French Concession was so stringent that only “landowners, or those paying annual rents of 1,000 francs or higher, had the right to vote” (Wei, 1987, p.80). Both the Shanghai Municipal Council and *Conseil Municipal* were responsible for constructing public work such as roads, bridges, jetties, street lights, providing education and public health services (MacPherson, 2002a; Major,

2010).

Meanwhile, until 1905, the Chinese administration in the old Chinese city remained substantially unchanged (Wei, 1987, p.81; Wei, 1993, p.20). It lacked “both a tradition of municipal government or of any perceived need for a modern urban infrastructure” (MacPherson, 1990, p.42). The local administrative official was the intendant assigned by the Qing government to oversee foreign trade, collect customs revenues and directly deal with the foreign consuls (Wei, 1993, p.20). But the Chinese administrative official gradually lost his power when Settlement authorities and foreign consuls assumed responsibilities for trade regulations and took away his right to collect customs duties (Wei, 1987, p.81; Wei, 1993, p.20). The decline of the Qing government’s power and China’s defeat in the First Sino-Japanese War (1894-1895) drove the Chinese political reformers to change the local administration in Shanghai (Wei, 1987, p.81).¹⁷ Being “apprehensive at the growth of foreign power and the loss

¹⁷ Before China’s defeat in the First Sino-Japanese War (1894-1895), the Qing government implemented the Self-Strengthening Movement (1861-1895) to modernize China after her repeated military defeats in the First and Second Opium War and foreign concessions. It was a reform campaign going under the rubric of “Western learning for [practical] application, Chinese learning for cultural essence (*Zhongxue wei ti, Xixue wei yong*)” (Shambaugh, 2010, p.94). According to Hsü (2000), the Self-Strengthening Movement can be divided into three periods (p.282). The first period (1861-1872) “stressed the adoption of Western firearms, machines, scientific knowledge, and the training of technical and diplomatic personnel” (Hsü, 2000, p.282). The second period (1872-1885) stressed “the development of profit-oriented enterprises such as shipping, railways, mining, and the telegraph” (Hsü, 2000, p.284). And the third period (1885-1895) stressed the military and naval build-up (Hsü, 2000, p.286). However, the Self-Strengthening Movement “barely scratched the surface of modernization” (Hsü, 2000, p.287) because of limited vision, the lack of coordination, technical backwardness, shortage of capital, psychological and social inertia (Hsü, 2000, pp.287-290). The failure of the Self-Strengthening Movement was confirmed by China’s defeat in the First Sino-Japanese War.

of sovereignty” (Elvin, 1974, p.249) and “keen observers of the [Settlements’] physical and institutional advances” (MacPherson, 1990, p.42), the Chinese authority established the Shanghai City Council in 1905 (Elvin, 1974, p.250), “modeled frankly on the Shanghai Municipal Council and paralleling its functions” (MacPherson, 2002b, p.39). The Shanghai City Council constructed roads and bridges, maintained public order, assessed and collected taxes, oversaw schools and charities, and provided public health service (MacPherson, 1996, p.501). In the Shanghai City Council, all the directors were “publicly selected by the local gentry and merchants” (Elvin, 1974, p.250). While consulting directors of the Consultative Assembly were responsible for making policies, managing general directors of the Executive Committee were responsible for carrying out the policies (Elvin, 1974, p.251). The Shanghai City Council, which was disbanded in 1914, was only “a short-lived national system of gentry democracy” (Elvin, 1974, p.250).

(b) Public Health and Healthcare Systems in Shanghai

(i) The Foreign Concessions

The authorities in the foreign concessions gave greater priority to develop free trade that most of the public expenditures were spent on capital works construction and police patrol to provide a convenient and safe environment for economic development

(Shi et al., 2001).¹⁸ It had little involvement in healthcare provision in order to save public expenditure and avoid tax increases. It mainly dealt with public health and the development of sanitary infrastructure that was “integral to their healthy survival, which in turn ensured grounds for economic growth” (MacPherson, 2002a, p.69). However, the amount of public expenditures spent on public health was small, which only accounted for about 6 per cent in the International Settlement in 1908 and about 2 per cent in the French Concession in 1906 (Shi et al., 2001).¹⁹ During the late nineteenth and early twentieth centuries, the sanitary infrastructure, “including water supply, sewage systems, and public latrines, could not keep up with the rapid population growth” (Nakajima, 2004, p.124) because of the accelerated pace of urbanization,²⁰ leading to the deterioration of the sanitary conditions in Shanghai (Cheung and Peng, 2007, p.97). Shanty towns, open night soil pots, polluted water due to ineffective drainage system, poor food-processing facilities, and untended refuse heaps (Nakajima, 2004, p.129) were the breeding grounds for epidemic diseases such as cholera, dysentery, hepatitis and typhoid fever (MacPherson, 2002a,

¹⁸ According to Shi et al. (2001), in 1908, the authorities in the International Settlement spent about 30 per cent of the public expenditures on police patrol and about 24 per cent of the public expenditures on capital works construction. In 1906, the authorities in the French Concession spent about 24 per cent of the public expenditures on capital works construction and about 16 per cent of the public expenditures on police patrol (Shi et al., 2001). Due to the lack of a complete set of data, the author was not able to provide the amount of public expenditures spent on police patrol and capital works construction in the International Settlement and the French Concession in the same year.

¹⁹ Due to the lack of a complete set of data, the author was not able to provide the amount of public expenditures spent on public health in the International Settlement and the French Concession in the same year.

²⁰ The population of Shanghai was between 100,000 and 300,000 during the first half of the nineteenth century (MacPherson, 2002a, p.2). By 1880, the population of Shanghai had reached 1 million (MacPherson, 2002b, p.38).

pp.69-73). In order to convert Shanghai into a healthy and habitable place, municipal councils in the foreign concessions implemented a series of sanitary measures, including extending the drainage, building a piped water supply system to provide pure water, providing adequate sewage disposal, building public latrines and providing rubbish bins (MacPherson, 1996, p.499; Cheung and Peng, 2007, p.97).

In the French Concession, the Office of Medical Affairs was established in 1858 to take charge of environmental sanitation and epidemic prevention (Nakajima, 2004, p.130). In the International Settlement, the Office of Hygiene was established in 1863 to take charge of general sanitation of the community such as trash disposal, vaccination (Nakajima, 2004, p.130) and the operation of the Public Health Laboratory for “constant chemical and bacteriological monitoring of the water supply” (MacPherson, 2002a, p.131). In 1898, the Office of Hygiene became the Health Department, which gradually institutionalized the management of environmental sanitation, epidemic prevention, food hygiene and health statistics in order to alleviate the pressure of public health brought by urbanization (Cheung and Peng, 2007, p.97). As Nakajima (2004) pointed out, the establishment of public health related institutions reflected the concept of ‘state medicine’, which originated in Britain in the nineteenth century with the central tenet that the state had the duty to

protect the health of the public by “[imposing] hygiene and sanitation regulations on private citizens for the public good” (p.130).

Since the authorities in the foreign concessions had little involvement in healthcare provision out of economic concerns, they left the tasks of building hospitals and offering medical treatment to missionaries, local elites and businessmen, Chinese-style practitioners and later private practitioners (Nakajima, 2004). Missionary hospitals which preached Christianity through free medical treatment were the first institutions providing the Chinese people in Shanghai with a chance to come in contact with Western medicine (Nakajima, 2004, p.35). By 1890, “western medicine had its roots well secured in Chinese soil and from that time onward there [had] been a constant forward development” (Allen, 1947, p.211). But missionary hospitals began to charge medical fees in the early twentieth century when they broadened their activities such as providing medical education and doing scientific research (Nakajima, 2004). Lester Hospital, St. Luke’s Hospital and St. Marie’s Hospitals were the earliest missionary hospitals respectively established in 1844, 1866 and 1907 in Shanghai and remain the leading hospitals nowadays (Nakajima, 2004, pp.36-48).²¹ Then, there were summer disease hospitals established by local elites

²¹ In 1844, Lester Hospital was established by William Lockhart, a medical missionary from the London Missionary Society. It was “colloquially referred to as the Chinese Hospital since it was devolved exclusively to serving the Chinese population” (MacPherson, 2002a, p.148). In 1870,

and businessmen “based on the Confucian principle of benevolence and the elite’s sense of responsibility” (Nakajima, 2004, p.52) to give free medical treatment and drugs to patients infected with communicable diseases such as cholera (Nakajima, 2004, p.52). These hospitals were staffed with Western-style practitioners and “provided treatment based on biomedicine” (Nakajima, 2004, p.53). For example, the Chinese Infectious Disease Hospital was established by local elites in 1920 to treat patients with gastrointestinal disease every summer and was the largest cholera-treatment center in Shanghai (Nakajima, 2004, pp.53-4). Also, there were the establishment of Chinese-medicine hospitals with Western management by the Chinese medical practitioners to “enhance the status of Chinese medicine and attracted patients”(Nakajima, 2004, p.61). For example, the Hubei (northern Shanghai) Guangyi Chinese Hospital and the Hunan (southern Shanghai) Guangyi Chinese Hospital were established by Ding Ganren, the central figure of the group of Chinese style doctors in 1918 to provide all out-patients with free medicine after paying a nominal fee (Nakajima, 2004, pp.66-8). These hospitals provided free inpatient rooms for the aged and the handicapped while they charged patients for the first- and

Lester Hospital was renamed as the Shandong Road Hospital for the Chinese in order to let the public identify the hospital in a better way (MacPherson, 2002a, p.157). From May 1844 to June 1845, Lester Hospital treated 10, 978 patients (Nakajima, 2004, p.37). In 1866, St. Luke’s Hospital was established by the American Episcopal Church in the Hongkou area (Nakajima, 2004, p.43). By the late nineteenth century, it was staffed with pharmacists and various specialists and was famous for doing surgery (Nakajima, 2004, pp.44-5). In 1907, St. Marie’s Hospital was established by Prosper Paris, who was a French Jesuit, on the Ruijin Road in the French Concession (Nakajima, 2004, p.48).

second-class inpatient rooms (Nakajima, 2004, pp.68-9). And there were private hospitals established by private practitioners in the 1930s to admit wealthy patients and charge them for medical treatment (Nakajima, 2004, p.71).

The authorities in the foreign concessions only began to involve in the provision of hospital services when the problem of prostitution led to the spread of venereal diseases becoming prevalent and a public problem in the 1870s (Henriot, 1992; Henriot, 2001; MacPherson, 2002a). From the mid-nineteenth to the mid-twentieth century, Shanghai attracted a large number of prostitutes to provide sexual services for the growing numbers of unattached businessmen, sailors, policemen and men in the army (Hershatter, 1992, p.251; MacPherson, 2002a, p.224). The infection ratio of venereal disease in the military and foreign constabulary was so high that it seriously compromised the effectiveness of the forces (MacPherson, 2002a, p.224).²² It drove the authorities of the two settlements to take up the moral responsibilities of preventing the spread of venereal disease (Henriot, 2001; MacPherson, 2002a). In 1877, the authorities of the two settlements jointly financed the establishment of the lock hospital to provide medical checks and treatment for diseased prostitutes

²² According to MacPherson (2002a), in 1862, the ratio of venereal disease per 1,000 men in British military records was 234.2, which was “exceedingly high and probably understated” (p.223). In 1870, “of the 37 men daily comprising the foreign constabulary, almost one half of their days (205 out of 541) were lost to sickness attributable to venereal disease” (MacPherson, 2004, p.224). It showed that the problem of venereal disease seriously affected the effectiveness of the military and police forces.

(Henriot, 2001, pp.279-280). In 1923, the authorities of the International Settlement established an evening clinic for venereal disease in the Shanghai General Hospital to provide medical treatment for diseased foreigners (Henriot, 2001, p.142).

While the authorities of the two settlements had little involvement in healthcare provision, they started subsidizing missionary hospitals and financed summer disease hospitals by the grants-in-aid although missionary hospitals also raised contributions from the church and from foreign and Chinese merchants while summer disease hospitals raised contributions from individuals and from tobacco, waterworks and electric companies (Nakajima, 2004). The Shanghai Municipal Council in the International Settlement subsidized Lester Hospital (Nakajima, 2004, p.39) while *Conseil Municipal* in the French Concession subsidized St. Marie's Hospital (Nakajima, 2004, p.48). Both the municipal governments financed the Chinese Infectious Disease Hospital because its medical treatment given to many poor patients significantly reduced the financial burden on two settlements (Nakajima, 2004, p.54).

(ii) The Chinese Administered Area in Shanghai

On the other hand, the Chinese administration in the old Chinese city did not pay attention to the development of public health until the establishment of the Shanghai

City Council in 1905. In the same year, the Sanitary Office was established under the jurisdiction of the police in the old Chinese city to manage urban sanitation and hygiene, namely street cleaning, epidemic prevention, garbage and night soil disposal, the provision of drainage and sewerage and forbidding the sale of unclean food (Peng, 2007, pp.89-104). However, there was little impact on improving the public health because of the political turmoil, insufficient capital and the lack of well-trained personnel (Hsü, 2000; Nakajima, 2004; Peng, 2007). After the downfall of the Qing dynasty in 1912, China entered the Republican era (1912-1927) that was neither united nor peaceful but “were characterized by moral degradation, monarchist movements, warlordism, and intensified foreign imperialism” (Hsü, 2000, p.493). The period of warlordism (1916-27) was the darkest period in Republican history that powerful warlords asserted political control in different regions (Jewell, 1983b, p.28) and plunged China into chaos and disorder (Hsü, 2000, p.482).

In 1927, the Nationalist Party under the leadership of Jiang Jieshi united China (Jewell, 1983b, p.28). In the same year, Jiang, who “had a strong sense of rivalry with the Westerners” (Nakajima, 2004, p.96), designated Shanghai as the ‘Special Municipality’ (MacPherson, 1990, p.47; MacPherson, 2002b, p.39). He announced the Greater Shanghai Plan, which called for “raising infrastructure standards in the

Chinese administered areas contiguous with the foreign settlements” (MacPherson, 2002b, p.39) and had the ultimate goal of uniting “the entire city under Chinese municipal government, thereby solving the long-standing loss of sovereignty” (MacPherson, 2002b, p.39) over two foreign concessions. In the aspect of healthcare, the Nationalist government established hospitals, health stations and clinics to provide the general public with free or inexpensive medical care (Nakajima, 2004, p.147).²³ It adopted “Western medicine as the state standard” (Nakajima, 2004, p.97) and gave the legal status to Western-style practitioners in 1930 (Nakajima, 2004, p.113) while suppressing the practice of traditional Chinese medicine and discriminating against Chinese-style practitioners (Chen, 1984a, p.23). However, the development of healthcare was unsatisfactory because the Nationalist government’s greater priority to military and political programmes limited government spending on healthcare (Yip, 1995, p.62). From 1928 to 1937, military appropriations accounted for an average of 44 per cent of total national expenditures (Yip, 1995, p.62). In 1929, 42 per cent of the total budget went to the military while only 0.1 per cent went to health services (Yip, 1992, p.404). The inadequate funding for healthcare adversely affected health planning and programmes (Yip, 1995, p.65).

²³ In 1934, the Nationalist government established Municipal Isolation Hospital for treating patients with communicable diseases and Municipal Hunan Hospital with 150 beds for serving Nanshi residents in Shanghai. From 1929 to 1936, only five health stations (Gaoqiao, Wusong, Jiangwan, Hunan and Hubei) were established to treat patients in district areas, which failed to meet the Nationalist government’s plan of establishing one station in each of the 17 districts in Shanghai because of insufficient funding and medical personnel (Nakajima, 2004, pp.147-8).

5.3 Mao's Era (1949-1976)

(a) The Political System: the Monopolistic Power of the CCP

“After the Second World War, the foreign concessions were closed and Shanghai was returned to Chinese administration” (Wei, 1987, p.4). The civil war between the Nationalist Party and the CCP from 1945 to 1949 culminated in the Communist victory in 1949 (Jewell, 1983b, p.61). The PRC was founded on 1 October, 1949 by the CCP under the leadership of Mao Zedong. Mao undertook the immediate task to rebuild the nation after the end of the Second World War and civil war (Leung and Nann, 1995, p. 19). He unequivocally announced his “lean to one side” foreign policy towards the Soviet Union, a country which had the same ideological affinity with socialism and could provide the PRC with aid and protection to forestall Western intervention (Hsü, 2000). The Soviet model of socialism provided the CCP with “the direction for state organization and a strategy of industrial development” (Leung and Nann, 1995, p. 20). During Mao's era, the CCP established a central planning system that “emphasized public ownership and welfare, mass-based collectivism and egalitarianism” (Chen, 2001, p.456).

(b) The Work Unit: a Pivotal Institution between the CCP and the People in

Urban China

Under the planned economy, the CCP, which was “the supreme organizing force and final legitimate authority” (Hiller, 1983b, p.134) in the PRC, controlled all decisions regarding “production, personnel (appointments, promotion, and transfer), finance, and welfare” (Leung and Nann, 1995, p. 59). In urban China, all organizations where people worked were generally classified as “*danwei*”, which literally meant work unit (Gu, 1999, p.69). According to Gu (2001b), the work units were further divided into three categories based on the nature of the work: (1) enterprise units which engaged in profit-making businesses; (2) non-profit units which included cultural, educational, scientific and healthcare organizations; and (3) administrative units, i.e. governmental organs (p.92). During Mao’s era, the work unit was not simply a place where people worked (Leung and Nann, 1995, p. 57). In fact, it was a pivotal institution between the CCP and the people that implemented state policies and constructed a socialist society (Leung and Nann, 1995, p. 56). Apart from functioning as an economic institution which guaranteed permanent employment known as the “iron rice bowl” (Duckett, 1997, p.262; Leung, 1998, p.619; Gu, 1999, p.70), the work unit also functioned as a welfare delivery institution providing comprehensive, generous and non-contributory welfare benefits from housing, education, social security to healthcare for employees, and subsidies from food, meals, haircut to transportation (Leung, 1994, p.343; Leung

and Nann, 1995, pp. 57-8; Duckett, 1997, p.262; Gu, 1999, p.70). The employment-based welfare benefits were regarded as a social wage necessary to compensate for low wages (Leung and Nann, 1995, p. 61; Leung, 1998, p.618). Nevertheless, the work unit served an even more important purpose: the purpose of political control. Politically speaking, the dependency of employees on the work unit for livelihood and welfare benefits meant that they were subject to the influence and control of the CCP (Leung, 1994, p.344). The CCP, through the work unit, “provided economic and social security in return for the workers’ political compliance and allegiance” (Gu, 1999, p.70). It was conducive to nation building and economic recovery (Leung and Nann, 1995, p. 55).

(c) Healthcare System in Urban Shanghai

When the CCP came to power, the PRC was “the sick man of Asia” (Pearson, 1995, p.89).²⁴ Under Mao’s leadership, the CCP “made health a priority and included a right of access to health care in its constitution” (Bloom, 2005, p.25). The healthcare

²⁴ In 1949, the PRC had enormous health problems caused by poverty, infectious diseases, years of wars against Japan and civil war (Wilenski, 1976, p.7). There were a number of indicators showing that the PRC was the sick man of Asia, including the maternal mortality rate being about 1.5 per cent (Wilenski, 1976, p.7); infant mortality ranging up to “200 deaths in the first year of life per 1,000 live births” (Wilenski, 1976, p.7), and about 30 per cent of children dying before the age of five (Wilenski, 1976, p.7). Besides, there were high infection rates of parasitic diseases in central and south China. For example, there were about 10.5 million people being infected with schistosomiasis and the infection rate of malaria was 50 per cent (Lampton, 1977, p.14). There were also hookworm, kala-azar, and contagious diseases such as cholera, plague, and smallpox (Lampton, 1977, p.14). And there was venereal disease, “with prevalence rates of 3 to 5 per cent in the cities [of the PRC] and rates running as high as 10 per cent among the frontier people” (Lampton, 1977, p.14).

system was “a major pillar of state socialism” in China (Gu, 2001a, p.197). The CCP established health administrative organs from the central down to local governments at various levels in order to “strengthen management and leadership over medical service” (Chen, 1984, p.80). The Ministry of Health (MOH) in Beijing was the central health authority established on 1 November, 1949 (Chen, 1984b, p.60). Its lower tier was provincial, municipal, district, and county bureaux of health. Bureaux of health at each level was “answerable to the government at the same level” (Tang and Meng, 2004, p.21) and followed the professional instructions from the higher-level bureau of health (Sun, 1993, p.55).

(i) Healthcare Financing System

After the Second World War, more than 96 per cent of Shanghai residents had to pay medical expenses from their pocket (Zhang and Shao, 1998, p.114). When Mao came to power, he implemented free healthcare for certain employees of the work units and social groups as a welfare benefit, which alleviated the financial burden of those who enjoyed the benefit when seeking medical treatment. In urban China, free healthcare was “a central part of the employment-based welfare programme” (Leung and Nann, 1995, p. 57) to ensure a healthy workforce. Following the model of the Soviet Union, the CCP implemented two types of free healthcare programmes targeting different

types of employees: the LIS and the GHS.

The LIS was implemented in urban China after the promulgation of *the Labour Insurance Regulations* in February 1951 (Li, 2009, p.33). It provided employees in SOEs and the collective enterprises with free outpatient and inpatient services financed by the enterprise's welfare fund before 1953 and later by the company payroll after 1953 (Zhang and Shao, 1998, p.114). It also covered the dependents of the LIS beneficiaries who were half-subsidized by the enterprises for their health expenditures and the costs of prescribed drugs (Dong, 2003, p.224). But the enterprise's welfare fund "was actually financed from fiscal appropriations" (Gu, 2001a, p.200) because the enterprise units had to submit all their realized profits to the central government which in turn "made a unified state plan for resource allocation" (Gu, 2001a, p.200). Although the CCP during Mao's era used the term 'insurance' to describe the free healthcare it provided for employees of SOES and the collective enterprises, the LIS was not actually an insurance scheme in the real sense because it involved no premium contributions and no insurance institutions to manage the Schemes (Gu, 2001a, pp.200-201).²⁵ According to Zhang and Shao (1998),

²⁵ The Chinese term "*laobao yiliao*" adopted by the CCP to describe free healthcare provided for employees of SOEs and collective enterprises literally meant 'Labour Insurance Scheme' (LIS) after translation. It shows that the CCP during Mao's era had a different interpretation of the word 'insurance' from the West. On the other hand, the Chinese term "*gongfei yiliao*" adopted by the CCP to describe free healthcare provided for government employees, army veterans and university students literally meant 'Government-funded Healthcare Scheme (GHS)' after translation. However,

employees joining the LIS rose from 1.07 million in 1958 to 2.37 million in 1965, which accounted for 14.3 per cent and 21.7 per cent of Shanghai's population respectively (p.115).

The GHS was implemented in urban China after the issue of *the Instructions of Implementing the Publicly-funded Healthcare Scheme* in 1952 (Li, 2009, p.34). It covered government employees and retirees, army veterans, university and college students, staff in the cultural, education, health and science sectors, and retirees from these sectors (Grogan, 1995, p. 1074; Cheung, 2001, p.65; Gu, 2001a, p.200). The GHS beneficiaries were only required to pay outpatient registration fees and could enjoy free medical treatment that was directly financed by each level of government through the state budget (Zhang and Shao, 1998, p.116; Liu et al., 2004, p.39). The central government set the per capita GHS budget and appropriated the GHS budget to each level of government through the Ministry of Finance (Liu and Yi, 2004, p.31).

a review of current literature shows that the term 'insurance' is commonly adopted by Chinese and Western scholars to describe these two types of free healthcare schemes. For example, Grogan (1995) and Yu and Ren (1997) adopted the terms 'Government Insurance System' and 'Labor Insurance System' to describe the healthcare financing system in the PRC in the 1950s. Dong (2003, 2008) and Tang and Meng (2004) adopted the terms 'Government Insurance Scheme' and 'Labour Insurance Scheme' to describe the healthcare financing system in the PRC in the 1950s. Liu et al. (2004) adopted the terms 'Government Insurance Program' and 'Labor Insurance Program' to describe the healthcare financing system in the PRC in the 1950s. Ye (2010) adopted the terms 'Government Health Insurance' and 'Labor Health Insurance'. Duckett (2001) adopted the terms 'insurance for public employees' and 'labour insurance system' to describe the healthcare financing system in the PRC in the 1950s. In another study, Duckett (2004) adopted the terms 'public health insurance' and 'labour insurance'. Based on literal translation, this study would still adopt the term 'Labour Insurance Scheme' (LIS) to describe free healthcare provided for employees of SOEs and collective enterprises while adopting the term 'Government-funded Healthcare System (GHS)' to describe free healthcare provided for government employees, army veterans and university students.

According to Zhang and Shao (1998), employees joining the GHS rose from 98,000 in 1952 to 329,000 in 1965, which respectively accounted for 1.7 per cent and 3.0 per cent of Shanghai's population (p.116). Besides, the insurance funding of the GHS in Shanghai rose from RMB 1.08 million in 1952 to about RMB 9 million in 1965 (Zhang and Shao, 1998, p.116). Also, the annual insurance funding of the GHS per capita rose from RMB 22.14 in 1952 to RMB 27.33 in 1965 (Zhang and Shao, 1998, p.116).

(ii) Healthcare Delivery System

The CCP, "[i]n parallel with the institutional configuration of a planned economy" (Gu, 2001a, p.201), nationalized hospitals that were previously run by foreign medical missionaries or privately run by local elites and businessmen. All the hospitals were directly under state control and "were classified as non-profit work units" (Gu, 2001a, p.201). They were directly supervised and managed by the MOH or the lower-tier of provincial, municipal, district, and county bureaux of health, depending on their locations (Cheung and Gu, 2004; Tang and Meng, 2004). Hospital employees were fully paid by the state according to standard salary scales regulated by the central government.

The CCP established the three-tiered medical institution network in urban areas covering the medical needs of the population (Wong et al., 1996, p.409). Each tier was assigned a defined service area and was managed by a corresponding health administrative department. The first-tiered medical institutions were street-level/sub-district hospitals, neighborhood health stations and enterprise health stations providing the primary and preventive care for the employees and retirees of small collectively-owned enterprises and their families (Dong, 2003, p.225; Cheung and Gu, 2004, p.39). The second-tiered medical institutions were district and enterprise-level hospitals providing both inpatient and outpatient services for the employees and retirees of large and medium-sized collectively-owned enterprises, and the employees of district and street-level government agencies, and middle-to-primary schools (Dong, 2003, p.225; Cheung and Gu, 2004, p.39). The third-tiered medical institutions were municipal hospitals and university-affiliated hospitals providing specialist care and complex treatments for the employees and retirees of SOEs, municipal-level government agencies, veteran cadres, and university staff (Dong, 2003, p.225; Cheung and Gu, 2004, p.39) (**See Diagram 2**).

Besides, the CCP established the three-tiered wholesale drug stations in urban China for distributing drugs to medical institutions. It established the first-tiered

wholesale drug station at provincial level, the second-tiered wholesale drug station at municipal level, and the third-tiered wholesale drug station at county level (Bao, 2008, p.76). Only the three-tier stated-owned wholesale drug stations could distribute drugs to hospitals (Bao, 2008, p.76). The CCP strictly regulated the drug prices but allowed medical institutions to add a 15 per cent markup over the wholesale prices (Bao, 2008, p.77). The 15 percent retail markup was treated as revenues to compensate for the consultation and treatment fees that were set below costs by the CCP (Bao, 2008, p.85).

In Shanghai, the Shanghai Municipal Health Bureau (SMHB) was an administrative department of the MOH. It was responsible for implementing national healthcare policies into Shanghai and monitoring the local public health. “By 1956, all Shanghai hospitals were directly under state control” according to Cheung and Gu (2004, p.39). In 1958, the three-tier medical institution networks were established in urban Shanghai (Zhang and Shao, 1998, p.84). By the end of 1965, urban Shanghai had 340 hospitals, 1,514 clinics (Chinese and Western medicine) and 2,417 health stations (Zhang and Shao, 1998, p.84). It had 31,671 hospital beds and 2.9 hospital beds per 1,000 people (Zhang and Shao, 1998, p.84). According to Zhang and Shao (1998), the hospital outpatient visits in Shanghai rose from about 4.05 million in 1950

to about 63 million in 1965 (p.84).

From 1949 to 1976, the CCP under the leadership of Mao established a state-run healthcare system characterized by the public provision of healthcare through a three-tiered urban medical institution network and the finance of healthcare through the state budget in urban areas. The state-run healthcare system enabled the CCP to make healthcare accessible to the majority of the population. During the first three decades after its introduction in the 1950s, the state-run healthcare system improved the health status of the PRC's population, leading to an increase in the average life expectancy, a decrease in infant mortality, and a decrease in the prevalence of infectious diseases (Hsiao, 1995a, p.1047).

In the late 1970s, however, the PRC's transition from the socialist planning economy to the market economy adversely affected the free healthcare system. In urban Shanghai, the economic reform led to both the enterprise units and the local government bearing a heavy financial burden of financing the LIS and GHS. The collapse of the LIS and GHS compelled the central government to implement urban health insurance reform.

5.4 Discussion

As outlined in Chapter Three, historical institutionalism emphasizes that history matters. It takes history or time seriously, specifying sequences, tracing and analyzing processes over substantial stretch of years to explain important political outcomes or real-world puzzles (Pierson and Skocpol, 2002, pp.695-8). History is the contingent product of the interactions of multiple political actors and institutions operating in and influenced by broader political, economic and social contexts over time (Lecours, 2000, p.514; Pierson and Skocpol, 2002, p.706). An overview of the historical development of public health and healthcare systems in Shanghai shows that the establishment and institutionalization of public health and healthcare systems in Shanghai “linked inseparably with Western imperialism” in the nineteenth century (Jewell, 1983a, p.24). The political and military weaknesses of the Qing government led to foreign influence extending to Shanghai. Both the public health and healthcare systems in Shanghai were the products of Western presence in China and the interactions between the West and the Chinese when China was opened to “widespread Western business, military and missionary penetration” (Jewell, 1983a, p.3) after her defeat in the First Opium War.

The authorities in the foreign concessions took advantage of the unequal treaties

to dominate the control over Shanghai. They had their own governing institutions dominated by moneyed interests that favored free trade. Since the beginning of the open trade in Shanghai, the authorities in the foreign concessions prioritized economic development. They involved in developing public health out of a pragmatic and economic concern that a clean environment was conducive to doing trade business. On the other hand, the Chinese authority did not appeal for the development of public health until 1905 when it feared the growth of foreign power would further intrude on China's sovereignty. But the Chinese authority lagged behind the foreign counterparts in developing public health because of lacking political stability, financial resources and manpower.

The authorities in the foreign concessions had little involvement in healthcare provision in order to save public expenditure and avoid tax increases. Missionaries, local elites and businessmen, Chinese-style practitioners and later private practitioners were main healthcare providers and hospital founders that provided free medical treatment for the mass. The missionary hospitals which were the first institutions introducing Western medicine to Shanghai stimulated the Chinese elites to establish hospitals based on the principle of benevolence, and the Chinese-style practitioners to establish hospitals for enhancing the status of Chinese medicine (Nakajima, 2004,

p.61). The establishment of hospitals in Shanghai laid down the foundation of building a modern healthcare system during Mao's era.

As outlined in Chapter Three, historical institutionalism emphasizes that institutions matter. Institutions play a determinant role in distributing power among political actors in a given polity and shaping their strategies and goals in the decision-making process that in turn shape the political outcomes (Thelen and Steinmo, 1992, p.6; Koelble, 1995, p.236). The historical overview of the healthcare system in urban Shanghai during Mao's era showed that the political and economic institutions of the PRC significantly affected the establishment of the healthcare system in urban Shanghai. The centralized political system gave the CCP leverage to completely control the planning and development of healthcare services. It directly used political power to coordinate healthcare programmes with economic plans. "In parallel with the institutional configuration of a planned economy" (Gu, 2001a, p.201), the CCP nationalized hospitals and established a three-tiered medical institution network in urban Shanghai to deliver healthcare services to its population. Besides, it used the work units to finance the healthcare of urban populations. The work units were pivotal institutions between the CCP and people implementing state policies and constructing a socialist society in urban Shanghai. They represented the CCP's power

with political, economic and welfare delivery functions.

Under the socialist planned economy, the work units in urban Shanghai provided employees with lifetime employment and generous and comprehensive welfare benefits, including healthcare. The work units implemented the LIS and GHS to benefit urban employees “who were not constrained financially in their pursuit of demands for health care” (Hiller, 1983a, p.98). Both the LIS and GHS beneficiaries enjoyed free healthcare financed by the state budget. Under the market economy, however, the work units and the Shanghai municipal government lost the financial capacity to sustain the dual system of the LIS and GHS. The collapse of the LIS and GHS put great pressure on the central government to reform the healthcare financing system.

5.5 Conclusion

To conclude, a historical overview of the development of public health and healthcare systems in Shanghai shows that the establishment and institutionalization of public health and healthcare systems in Shanghai were the products of Western presence in China in the nineteenth century after China’s defeat in the First Opium War. During Mao’s era, the state-run healthcare system in urban Shanghai performed well in the

institutional configuration of the socialist planned economy. While the LIS and GHS provided free healthcare for urban employees, the three-tiered medical institution network provided an efficient network for the majority of population to access healthcare. However, the state-run healthcare system in urban Shanghai came to malfunction after the PRC's economic transition to the market economy. The CCP was under great pressure to reform the healthcare financing system. These issues will be pursued in detail in the following chapter.

CHAPTER SIX: SHANGHAI CASE STUDY: HEALTH INSURANCE

REFORM

6.1 Introduction

This chapter examines why the Shanghai municipal government, when implementing health insurance reform, was able to significantly deviate from the established policy path by replacing the free healthcare system with a new contributory health insurance system. It is divided into five sections. Section 6.2 examines three phases of urban health insurance reform in Shanghai. Section 6.3 examines the reasons for Shanghai witnessing a revolution in healthcare financing. Section 6.4 examines the views of different stakeholders, citizens, scholars, and the government official on changes brought by the new health insurance reform. Section 6.5 discusses the findings and implications. Section 6.6 gives a conclusion.

The refined theory of historical institutionalism comprises seven explanatory elements: contextual conditions, ideas, actors, political institutions, timing and sequences, path dependency, and policy feedback. When it is adopted to examine urban health insurance reform in Shanghai, it focuses on how the complex interplay of forces, namely contextual influences, ideas, actors, political institutions, timing and

sequences, path dependency, and policy feedback, shaped urban health insurance reform process.

Having looked at urban health insurance reform through the lens of historical institutionalism, this study argues that the case of Shanghai is an example of institutional change in which the Shanghai municipal government successfully implemented health insurance reform in 2000 by replacing the free healthcare system with a new contributory health insurance system. It argues that the implementation of urban health insurance reform and big change in healthcare financing policy path was possible because of (1) changes in political and economic contexts due to the new political leader of the CCP coming to power, (2) ideological shift from egalitarianism to pro-market policies, (3) policy feedback which accelerated the pace of collapse of the free healthcare system, (4) the authoritative political institutions with the strong influence of the CCP and a highly centralized decision-making structure, (5) the dominance of the political leader and key bureaucratic stakeholders from different ministries in urban healthcare insurance reform process, (6) new ideas being championed by the political leader and key bureaucratic actors, and (7) the decentralization power given to the local governments to implement urban health insurance reform. This study argues that it is the dynamic interplay of these forces

enabling the Shanghai municipal government to implement urban health insurance reform without any impediments.

6.2 Phases of Urban Health Insurance Reform in Shanghai

During Mao's era, the free healthcare system which was financed by the state budget functioned well and improved the health conditions of the PRC's population. As shown in a later section, in the post-Mao period, however, the free healthcare system was plagued with inefficiency and rising costs, thereby imposing unbearable financial burdens on both the central government and enterprise units. This compelled the central government from the mid-1980s to reform the free healthcare system "through a series of local trials, and on this basis in 1998 announced a new national programme" (Duckett, 2001, p.290). Following the direction of healthcare reform indicated by the central government, the Shanghai municipal government from the mid-1980s gradually implemented urban health insurance reform through three phases: (1) the exploration phase (1984-1988); (2) the experimental phase (1994-1996); and (3) the implementation phase (1998-2001).

(a) The Exploration Phase (1984-1988)

In Shanghai, the first phase of health insurance reform was "marked by explorative

experimentation in search for a direction” (Leung, 1998, p.625). The Shanghai municipal government and other local governments were “encouraged [by the central government] to experiment with different solutions” (Leung, 1998, p.624) to solve the problem of rising healthcare costs in their jurisdiction. From 1984 to 1986, the Shanghai municipal government implemented a co-payment scheme in selected enterprise units and selected districts, whereby the LIS and GHS beneficiaries who received a reserve payment from the municipal government were required to pay 10 per cent of the outpatient charges out-of-pocket, with an upper limit (RMB 20) set for the out-of-pocket payment (Zhang and Shao, 1998, pp.115-6).²⁶ In January 1988, the Shanghai municipal government implemented the co-payment scheme in the entire city (Zhang and Shao, 1998, p.116). At the same time, it implemented the experimental measures of allocating a fixed amount of healthcare funds to work units for self-management (Zhang and Shao, 1998, p.116; Cheung and Gu, 2004, p.43) and placing a year-round budget under the custody of hospitals which “took full responsibility for the health care of the work-units’ employees” (Gu, 2001a, p.209) in order to control the growth of healthcare expenditures.

²⁶ The co-payment scheme was first implemented in selected enterprise units in June 1984 and then extended to selected districts in June 1986 (Zhang and Shao, 1998, p.116). For the LIS beneficiaries of enterprise units selected to join the co-payment scheme, they were given a medical reserve payment amount to RMB 3 to 8 every month for paying medical and prescription fees (Zhang and Shao, 1998, p.115). As to the GHS beneficiaries in districts selected to join the co-payment scheme, they received different amount of medical reserve payments according to different age ranges. According to Zhang and Shao (1998), GHS beneficiaries aged 35 or below received RMB 8 every year (p.116). Those aged between 36 and 50 received RMB 10 every year while those aged 51 or above received RMB 12 every year (Zhang and Shao, 1998, p.116).

However, the initial reform in Shanghai was small-scale, piecemeal and incremental. It was limited to certain funding adjustments to reduce the moral hazard on the demand and supply side without involving any institutional transformation of the existing free healthcare system (Gu, 2001a, p.209). Hence, it made slow progress and had little effect on cost containment (Zhang and Shao, 1998, p.115), with urban healthcare expenditures in Shanghai growing at an annual rate of about 30 per cent from 1983 to 1992 (Wang, 2008, p.233).

(b) The Experimental Phase (1994-1996)

The second phase of health insurance reform began in November 1994 when the central government selected the cities of Zhenjiang in Jiangsu province and Jiujiang in Jiangxi province (the two *jiangs*) to implement a pilot study of health insurance model (Gu, 2001a, p.209; Liu et al., 2004, p.43; Tang and Meng, 2004, p.32; Wong et al., 2006, p.16). The “two-*jiang* model” consisted of the MSA and the SPF, requiring both the work units and employees to make mandatory contribution. Employers were required to contribute 10 per cent of their total annual payroll while employees were required to contribute 1 per cent of their annual salary. These contributions went into the MSA and the SPF from which to draw to pay for medical expenses (**See Diagram**

3). In 1996, the central government extended the “two-*jiang* model” to 57 cities. But local governments were given considerable room to modify the model which could “better meet their local needs and socioeconomic condition” (Liu et al., 2004, p.45).

In Shanghai, the pilot health insurance model implemented by the Shanghai municipal government was different from the “two-*jiang* model” in terms of the funding structure, the source of finance, and the contribution rate. In May 1996, the Shanghai municipal government implemented a hospitalization insurance scheme for enterprise employees (Cheung and Gu, 2004, p.45; Tang and Meng, 2004, p.33), which only established the SPF and required the work units to make mandatory contribution to the insurance scheme. The work units paid 4.5 per cent of their total annual payroll to a health insurance fund which in return, covered 85 per cent of the employees’ inpatient expenses that exceeded the threshold of RMB 1,500 for the first-tiered hospitals, RMB 2,000 for the second-tiered hospitals, and RMB 2,500 for the third-tiered hospitals (Cheung and Gu, 2004, p.45; Wong et al., 2006, p.46). The remainder would be paid by the work units and employees (Cheung and Gu, 2004, p.45). The insurance scheme was then extended to cover outpatient and emergency services of enterprises’ incumbent and retired employees.²⁷ The hospitalization

²⁷ Interview with Professor 5.

insurance scheme was facilitated by a hospital revenue cap policy introduced in July 1994.²⁸ Being the pioneer of the hospital revenue cap policy, the Shanghai municipal government set the annual allowable growth rate of hospital revenues and hospital drug revenues every year to match the annual growth rate of GDP.²⁹ Revenues in excess of the cap would be fully taxed by the government.³⁰ The Shanghai model had significant implication for the pilot urban insurance reform in the PRC because it showed that a parallel measure to constrain hospital revenues was necessary in order to make the health insurance scheme more effective.³¹ The hospital revenue cap acted as an effective cost control mechanism on the supply side and facilitated the implementation of the health insurance scheme.³² Hence, the Shanghai model became one of the pilot models gaining national recognition in the experimental phase (Liu et al., 2004, p.50).³³

²⁸ Interview with Professor 5. The studies of Liu et al. (2004) and Wong et al. (2006) were few of the studies mentioning the Shanghai model. However, while the former did not talk about the hospital revenue cap policy in detail, the latter did not mention the hospital revenue cap policy at all. In the PRC, the Shanghai model is famous for the combination of the hospital insurance scheme with the hospital revenue cap policy. The implementation of the hospital revenue cap policy was the main contribution made by the Shanghai model. The details of the hospital revenue cap policy provided by Professor 5 during the interview are conducive to understanding about the Shanghai model and filling the research gap of the current literature.

²⁹ Interview with Professor 5. According to Shanghai Statistical Yearbook 2010, the average annual growth rate of GDP in Shanghai from 1991 to 2009 was 12 per cent (Shanghai Municipal Statistics Bureau, 2011).

³⁰ Interview with Professor 5.

³¹ Interview with Professor 5.

³² Interview with Professor 5.

³³ Like the Shanghai model, the Shenzhen model and the Hainan model gained national recognition because of their contributions to the pilot urban health insurance reform in the PRC. The Shenzhen model was praised for its heterogeneity in tailoring three different insurance plans to meet the needs of three different population groups, including employees and retirees with permanent residence of Shenzhen, temporary residents at work and the unemployed, and retired senior government officials and disabled veterans (Liu et al., 2004, p.50). The Hainan model was praised for its 'block design' in which the individual MSA only paid for outpatient services and the SPF only paid for inpatient care

(c) The Implementation Phase (1998-2001)

The third phase of health insurance reform began in December 1998 when the central government decided to establish a new health insurance system across the country (Gu, 2001a, p.211; Gu and Zhang, 2006, p.58; Wong et al., 2006, p.17). In order to pursue a nationwide urban health insurance reform, the State Council promulgated a landmark decree known as *the Decision of the State Council Concerning the Establishment of the Basic Medical Insurance System for Urban Employees* (hereafter “*the 1998 Decree*”) (The State Council, 1998), which required all urban work units and their employees to participate in the Basic Medical Insurance System (hereafter the BMI System). Based on the “two-*jiang* model”, the BMI system consisted of the individual MSA and the SPF,³⁴ requiring both the work units and employees to make mandatory contribution.³⁵ The work units and their employees should respectively contribute 6 per cent and 2 per cent of their total wage bill as annual insurance premium.³⁶ The Ministry of Labor and Social Security (MOLSS) was established to “take charge of the urban health insurance and its reform” (Tang and Meng, 2004, p.34). *The Drug Catalogue for National Basic Medical Insurance* (hereafter “*the*

(Liu et al., 2004, p.49). The independent operation of and the service-specific use of the individual MSAs and the SPFs had a better contribution to cost containment (Liu et al., 2004, p.53).

³⁴ Please refer to Section One and Section Three of *the 1998 Decree*.

³⁵ Please refer to Section Two of *the 1998 Decree*.

³⁶ Please refer to Section Two and Section Seven of *the 1998 Decree*.

Drug Catalogue”) was issued since 2000 to specify both Western medicines and Chinese proprietary medicines that were eligible for reimbursement by the BMI.³⁷ Medicines specified in *the Drug Catalogue* were essential medicines which were cost-effective, safe, and efficacious.³⁸

According to *the 1998 Decree*, the local government could modify the national BMI system in accordance with local circumstances while following the basic principle that the BMI system consisted of the individual MSA and the SPF.³⁹ On October 20, 2000, the Shanghai municipal government, in accordance with *the 1998 Decree*, promulgated Order No. 92 --- *the Measures of the Shanghai City on the Basic Medical Insurance for Urban Employees* (hereafter “*the Shanghai BMI Measures*”) (Shanghai Municipal Government, 2000a; Shanghai Municipal Government, 2000b) --- to institutionalize the BMI System in Shanghai. The BMI System in Shanghai became effective on December 1, 2000 (Shanghai Municipal Government, 2000b). The new BMI System implemented in Shanghai was different from the national BMI system introduced by *the 1998 Decree* in terms of the work unit’s contribution rate,

³⁷ Please refer to Section Five of *the 1998 Decree*. In order to make sure that the insured participants could buy drugs at affordable prices, the MOLSS collaborated with the MOH and the Ministry of Finance in formulating *the Drug Catalogue*. *The Drug Catalogue* had two categories: Category A and Category B. Category A medicines were completely reimbursed by the BMI. Category B medicines were partially reimbursed by the BMI and patients were required to pay certain percentage of the fees.

³⁸ Pharmaceutical Company Manager 1 was interviewed on July 21, 2010. Pharmaceutical Company Manager 2 was interviewed on August 1, 2010.

³⁹ Please refer to Section One and Section Seven of *the 1998 Decree*.

funding structure, and payment structure. Firstly, the new BMI system implemented in Shanghai required the work units to contribute 10 per cent of their total wage bill as annual insurance premium, which was four per cent higher than the national model introduced in *the 1998 Decree*. Secondly, the funding structure of the BMI system implemented in Shanghai consisted of the individual MSA, the SPF and the LAMI fund. However, the national model only consisted of the individual MSA and the SPF. Thirdly, the new BMI system implemented in Shanghai had a complicated three-tiered payment structure that did not appear in *the 1998 Decree* (See **Table 14 and Table 15**).

Besides, a comparison of the new BMI System in Shanghai and the old LIS-GHS system shows that the former was significantly different from the latter in terms of coverage, the source of finance, funding structure, payment structure, the use of healthcare services and administrative agency.

Firstly, the new BMI system in Shanghai had a wider coverage than the old LIS-GHS system because the former compulsorily required employees and retirees of all the urban work units, including private enterprises, foreign investment enterprises

and private non-enterprise entities, to join the scheme.⁴⁰ Retired employees could join the BMI System without paying any insurance premiums.⁴¹ Secondly, the new BMI system had a more diversified sources of finance than the old LIS-GHS system. It was financed by mandatory contribution from both the work units and their employees⁴² while the old LIS-GHS system was financed by the state budget.

Thirdly, the new BMI system had a funding structure consisting of the individual MSA and the SPF,⁴³ which did not exist in the old LIS-GHS system. While the individual MSAs covered general outpatient and emergency medical expenses, and the prescribed drug charges,⁴⁴ the SPFs covered the inpatient charges (including inpatient observation in emergency rooms).⁴⁵ Besides, the local additional medical insurance fund (hereafter the LAMI fund) was also established to supplement the BMI System in Shanghai (See **Diagram 4**).⁴⁶ For the BMI, the work units and their employees should respectively contribute 10 per cent and 2 per cent of their total wage bill as annual insurance premium.⁴⁷ For the LAMI fund, the work units should contribute 2 per cent of their total wage bill as annual insurance premium.⁴⁸ All the

⁴⁰ Please refer to Article 2 of the *Shanghai BMI Measures*.

⁴¹ Please refer to Article 5 of the *Shanghai BMI Measures*.

⁴² Please refer to Article 5 and Article 6 of the *Shanghai BMI Measures*.

⁴³ Please refer to Article 9 of the *Shanghai BMI Measures*.

⁴⁴ Please refer to Article 22 of the *Shanghai BMI Measures*.

⁴⁵ Please refer to Article 25 and Article 26 of the *Shanghai BMI Measures*.

⁴⁶ Please refer to Article 15 of the *Shanghai BMI Measures*.

⁴⁷ Please refer to Article 5 and Article 6 of the *Shanghai BMI Measures*.

⁴⁸ Please refer to Article 6 of the *Shanghai BMI Measures*.

employees' contributions were deposited in their individual MSAs.⁴⁹ 30 per cent of the work units' contributions went into the individual MSAs in different proportions depending on the age of the insured participants, with the remaining money going to the SPFs.⁵⁰ Retirees received higher proportion (See **Table 13**).⁵¹

Fourthly, the new BMI system in Shanghai had a complicated payment structure which did not exist in the old LIS-GHS system. A three-tier payment system was adopted in Shanghai to pay the general outpatient and emergency medical expenses, with the individual MSA being the first tier, out-of-pocket being the second tier, and the LAMI fund being the third tier.⁵² Besides, payment thresholds and ceilings were set for the SPF to pay the medical expenses of inpatient stay and emergency room stay.⁵³ The SPF covered inpatient charges which were above the payment threshold or below the ceilings, with the remainder paid by the individual MSA or self-payment.⁵⁴ Different age groups enjoyed different degree of medical insurance

⁴⁹ Please refer to Article 11 of the *Shanghai BMI Measures*.

⁵⁰ Please refer to Section Two of the *Implementation Scheme of Shanghai City for the Decision of the State Council Concerning the Establishment of the Basic Medical Insurance System for Urban Employees* (Shanghai Municipal Government, 2000a). Please also refer to Article 11 of the *Shanghai BMI Measures*.

⁵¹ Please refer to Article 11 of the *Shanghai BMI Measures*.

⁵² Please refer to Article 22 and Article 23 of the *Shanghai BMI Measures*.

⁵³ Please refer to Article 25, Article 26 and Article 27 of the *Shanghai BMI Measures*. For the incumbent employees, the payment threshold of the SPFs was 10 per cent of the employees' average annual salary of Shanghai in the previous year (EAASSP), whereas the ceiling was four times the EAASSP. For the retirees, the payment threshold of the SPFs ranged from 5 to 10 per cent of EAASSP, with the older retirees enjoying lower payment threshold. The ceiling was four times the EAASSP.

⁵⁴ Please refer to Article 26 and Article 27 of the *Shanghai BMI Measures*.

coverage (See Table 14 and Table 15). Retirees enjoyed better medical insurance coverage than incumbent employees.

Fifthly, the BMI participants who were given a medical insurance certificates, had to seek medical treatment at designated medical institutions and buy prescription drugs at designated medical institutions or designated retail pharmacies.⁵⁵ Sixthly, the Shanghai Municipal Medical Insurance Bureau was the administrative agency established to supervise and administer the operation of the BMI System.⁵⁶ **Diagram 5** illustrated the operation of the BMI System in terms of cash flows and the relationships between the work units, employees, medical insurance agency, and medical institutions in Shanghai.

In brief, the Shanghai municipal government abolished the institutional demarcations between the LIS and GHS by turning the free healthcare system into a mandatory contribution system. The institutional design of the new BMI System represented a vast improvement over the old LIS-GHS system in terms of coverage, the sources of finance, funding structure, payment structure and the use of healthcare services.

⁵⁵ Please refer to Article 19 and Article 20 of the *Shanghai BMI Measures*.

⁵⁶ Please refer to Article 2 of the *Shanghai BMI Measures*.

6.3 Reasons for Being Able to Reform the Funding Structure of Healthcare

The overview of the development trajectory of urban health insurance reform showed that since the mid-1980s, Shanghai had entered into the era of health insurance reform.

The Shanghai municipal government implemented urban health insurance reform in a gradual manner. This study argues that Shanghai was able to implement urban health insurance reform because of seven reasons: (1) changes in political and economic contexts due to the new political leader of the CCP coming to power, (2) ideological shift from egalitarianism to pro-market policies, (3) policy feedback which accelerated the pace of collapse of the free healthcare system, (4) the authoritative political institutions with the strong influence of the CCP and a highly centralized decision-making structure, (5) the dominance of the political leader and key bureaucratic stakeholders from different ministries in the healthcare insurance reform process, (6) new ideas being championed by the political leader and key bureaucratic actors, and (7) the decentralization power given to the local governments to implement urban health insurance reform. Some of these forces, as illustrated below, are interrelated with each other.

(a) Contextual Influences, New Political Leadership, and Ideological Shift

Historical institutionalism argues that changes in contextual conditions, namely political, economic or social context, can generate the sources of institutional and policy changes. The change in the political or socioeconomic context would lead to existing institutions performing new tasks because new political actors emerge to pursue new goals through the existing institutions (Thelen and Steinmo, 1992, p.16). This point was picked up by Professor 1, Professor 5, Professor 6 and Researcher 1, who shared the view that changes in political and economic contexts due to the rise of the new political leader were the source of institutional dynamism creating the windows of opportunity to change the path of urban healthcare financing policy in the PRC.⁵⁷ They argued that the economic reform initiated by the new political leader Deng Xiaoping since 1978 had badly and deeply affected the operation of the free healthcare system and challenged the prevailing belief in healthcare, thereby providing a conjunctual moment for the urban healthcare financing policy to move into a new trajectory.⁵⁸ According to Professor 6, “the picture of urban health insurance reform in Shanghai would be incomplete without taking the change in political leadership and the economic modernization into account”.⁵⁹

The argument made by the interviewees warrants a discussion here with the help

⁵⁷ Interviews with Professor 1, Professor 5, Professor 6 and Researcher 1.

⁵⁸ Interviews with Professor 1, Professor 5, Professor 6 and Researcher 1.

⁵⁹ Interview with Professor 6.

of literature. The change in the political context and the change in the economic context were empirically intertwined. It was the change in the political context triggering the change in the economic context. Deng Xiaoping, who was the successor to Mao, was regarded as the paramount leader of the PRC from 1978 to 1992 and the architect of the PRC's reform and opening up (Joseph, 2010b, p.154). When Deng came to power in 1978, he undertook the foremost task of rebuilding the ruined economy caused by the Cultural Revolution (1966-1976),⁶⁰ which was a political upheaval and anti-capitalist movement that lasted for 10 years (Sidel and Sidel, 1982). He hoped to restore the CCP's credibility and consolidate his authority through improving people's living standards and the delivery of the economic goods (Leung, 1998, p.619; Saich, 2004, pp.241-2). In order to achieve these political goals, Deng embraced new ideas and pursued new economic goals. He believed in the ideas that the introduction of market forces into the economy, the Four Modernizations (Hsü, 2000, p.803)⁶¹ and the aspects of capitalism "such as the profit motive and private ownership of businesses" (Joseph, 2010b, p.155) could be the driving forces for the economic advancement in the PRC. He embraced the dictum 'to get rich is glorious'

⁶⁰ The Cultural Revolution (1966-1976) was described as "10 lost years" of the PRC, a period during which the entire country was plagued with political chaos and the economy and society was seriously damaged. It was instigated by Mao to attack and purge bureaucratic elites who deviated from the socialist path (Lucas, 1982). The impact of the Cultural Revolution on the healthcare system dated from Mao's criticism of the MOH in the "June 26th Directive" in 1965 for its urban biases and becoming "the Urban Ministry of Health" (Lucas, 1982, p.123; Sidel and Sidel, 1982, p.4). By June 1967, Mao removed Minister of Health and his six vice-ministers from office. He also instructed that medical resources should be shifted to the countryside.

⁶¹ Deng was committed to the Four Modernizations of "agriculture, industry, science and technology, and national defence" (Hsü, 2000, p.803) when implementing the economic reform.

(Saich, 2004, p.242) and the slogan ‘let some people get rich first’ (Joseph, 2010b, p.154). On the other hand, he denounced Mao’s egalitarian principle of “everyone eating from the same pot” (Leung, 1998, p.619) “as a dangerous notion that retarded economic growth” (Saich, 2004, p.60). His goal was to modernize the PRC through implementing the economic reform. The ideological shift from egalitarianism to pro-market policies during Deng’s era influenced urban healthcare financing policy in the 1980s and worsened the free healthcare system afterwards.

As Professor 1, Professor 2, Professor 3 and Professor 5 said during their interviews, the economic reform implemented since 1978 had transformed the PRC’s economic system from the socialist planning economy to the market economy.⁶² While it was undeniable that Deng’s economic reform brought rapid development and growth to the PRC, it simultaneously brought adverse effects to the free healthcare system in the PRC.⁶³ As illustrated below, fiscal decentralization, the financial responsibility system, the relaxation of price controls, enterprise reform, and Open Door Policy were the main components of the economic reform causing the free healthcare system to malfunction and collapse afterwards.⁶⁴

⁶² Interviews with Professor 1, Professor 2, Professor 3, and Professor 5.

⁶³ Interviews with Professor 1, Professor 2, Professor 3, and Professor 5.

⁶⁴ Interviews with Professor 2, Professor 3, Professor 5, and Professor 6.

(b) Policy Feedback from Economic Reform, the LIS and GHS

Historical institutionalism argues that policy feedback provides resources and creates incentives that can facilitate, strengthen or inhibit the formation or expansion of stakeholder interests (Pierson, 1994, pp.40-1). In Shanghai, policy feedback from the economic reform implemented since 1978 and the LIS and GHS implemented since the early 1950s accelerated the pace of collapse of the free healthcare system. The argument of policy feedback can be elaborated by combining interview data and literature. Under the economic reform, “the central government’s decision to decentralize the fiscal system put health spending decisions in the hands of local government” (Duckett, 2011, p.36). Local governments could decide how much money to allocate to their local hospitals (Tang and Meng, 2004, p.27). Since they gave a higher priority to developing the local economy than developing the local healthcare (Tang and Meng, 2004, p.27), they moved towards a cost recovery policy in hospital financing (Pearson, 1995, p.108) by significantly reducing the subsidies to hospitals (Tang and Meng, 2004, p.27). At the same time, they implemented a financial responsibility system which gave hospitals greater financial autonomy but required them to generate revenues on their own and be responsible for their profits and losses.⁶⁵ Under the financial responsibility system, bonuses were awarded to

⁶⁵ Interview with Professor 2.

hospital staff for their hard work and quality of care (Henderson, 198, p.206). The financial responsibility system created stronger incentives for both the hospitals and doctors to earn more revenues through different sources and to charge patients substantially greater than the actual cost. It created the new problem of supplier-induced demand (SID), which was a moral hazard from the supply-side.⁶⁶

As Professor 2, Professor 1 and Researcher 1 said during their interviews, SID was prevalent among hospitals in Shanghai during Deng's era.⁶⁷ It was because government and enterprises units that acted as third party payers were incapable of adopting any mechanisms to restrict the profit-seeking behavior of medical institutions (Tang and Meng, 2004, p.26). It led to hospitals and doctors prescribing unnecessary or expensive drugs, doing unnecessary diagnostic tests and therapies, performing unnecessary surgeries and procedures, prolonging inpatient stay and increasing patient charges whenever they saw fit.⁶⁸ For example, Henderson (1989) found that having higher charges for patients entitled to the GHS boosted the income of all Shanghai hospitals "by one-third of their total yearly allocation from the Ministry of Health" (p.207). Hsiao (1995a) found that the average cost of drug for appendectomy patients entitled to either LIS or GHS were two times higher than that

⁶⁶ Interviews with Professor 2 and Professor 6.

⁶⁷ Interviews with Professor 2, Professor 1, and Researcher 1.

⁶⁸ Interviews with Professor 2, Professor 1, and Researcher 1.

of patients having no entitlement to free healthcare in a Shanghai hospital (p.1053). Another example was that foreign advanced medical equipment and imported drugs were commonly used by hospitals and doctors in Shanghai to earn more profits although cheap and simple cure for patients was available.⁶⁹ It resulted in hospitals in Shanghai importing more foreign advanced medical equipment than needed.⁷⁰ For example, in 1986, a survey conducted by the MOH showed that medical equipment level at municipal, district, and street-level hospitals in Shanghai was higher than that of the average medical equipment level among seven provinces and two cities (Zhang and Shao, 1998, p.110) (See **Table 16**).⁷¹ While advanced medical equipment, if being used properly, could modernize healthcare and increase service quality, it was used by hospitals and doctors as a tool for generating profits.⁷²

The problem of SID was especially serious in third-tiered medical institutions where people were attracted to seek better medical care.⁷³ It became more severe when price control was relaxed in the early 1980s to give hospitals more room to increase charges for different medicines, hospital services and medical equipment.⁷⁴

⁶⁹ Interviews with Professor 2, Professor 1, and Researcher 1.

⁷⁰ Interview with Professor 2.

⁷¹ In 1986, seven provinces surveyed by the MOH surveyed were Liaoning, Jilin, Jiangsu, Fujian, Hubei, Sichuan, and Shaanxi. The two cities surveyed were Beijing and Shanghai.

⁷² Interview with Professor 2.

⁷³ Interviews with Professor 2, Professor 1, Researcher 1, Government Official 1, and Armed Police Officer 1.

⁷⁴ Interviews with Professor 1 and Professor 5.

Healthcare became a commodity to be bought and sold, and was available to those who could afford it. As Professor 2 said during the interview, hospitals and doctors would not regard SID as an unethical practice but “a strategy to survive in the changing economic environment”.⁷⁵ On the other hand, the local government turned a blind eye to the practice of SID because prohibiting the practice would only lead to hospitals asking for money from the government.⁷⁶ In brief, policy feedback from fiscal decentralization, the financial responsibility system and the relaxation of price controls created strong incentives for hospitals and doctors to charge patients substantially greater than the actual cost in Shanghai.

The new problem of SID arising out of economic reform drastically escalated the healthcare expenditures of citizens in Shanghai. It further worsened the free healthcare system in Shanghai that had long been plagued with the problem of moral hazard from the demand side. Policy feedback from the LIS implemented since the early 1950s provided free outpatient and inpatient services for employees in SOEs and the collective enterprises and their dependents while policy feedback from the GHS provided free medical treatment for government employees and retirees, army veterans, university and college students, staff in the cultural, education, health and

⁷⁵ Interview with Professor 2.

⁷⁶ Interviews with Professor 2 and Government Official 1.

science sectors, and retirees from these sectors (Grogan, 1995, p. 1074; Cheung, 2001, p.65; Gu, 2001a, p.200). Beneficiaries' entitlements to the LIS and GHS to generous medical benefits led to the problem of moral hazard from the demand side, which caused unnecessary waste of medical resources and money.⁷⁷ As Professor 2 said during the interview, "the non-contributory nature of the LIS and GHS improperly encouraged people entitled to these schemes to over-utilize healthcare service".⁷⁸ Both the LIS and GHS beneficiaries were not cost conscious when seeking healthcare because they were not responsible for their abusive behavior.⁷⁹ Besides, the free healthcare system in Shanghai was plagued with the problem of having too many retired people using the system.⁸⁰ Enterprise units and the government had to pay the medical bills for their retired workers.⁸¹ The older the enterprise units were, the more retired workers they had, and the heavier the financial burden they had to bear (Gu, 2001b, p.98; Yu and Ren, 1997, p.447).⁸² Retired workers usually had higher healthcare expenditures due to having more illnesses and poorer health, thereby causing tremendous financial burden on both the government and enterprise units.⁸³

⁷⁷ Interviews with Professor 2, Professor 5, Researcher 1, Researcher 2, Insurance Company Manager 2, and Citizen 3.

⁷⁸ Interview with Professor 2.

⁷⁹ Interviews with Professor 6, Insurance Company Manager 2, and Citizen 5.

⁸⁰ Interviews with Professor 1, Professor 2, Professor 6, and Government Official 1.

⁸¹ Interviews with Professor 1, Professor 2, and Professor 6.

⁸² Shanghai had become the first ageing city in the PRC since 1979 (Li and Zhu, 2010, p.36; Zhang, 2004) when the segment of its population aged 65 and above first accounted for 7.2 per cent, which fit the United nation's definition of ageing society as one with 7 per cent or more of its population being aged 65 and above (Zhang, 2004). The longer the retired employees lived, the heavier financial burden the enterprise units bore.

⁸³ Interviews with Professor 1, Professor 2, and Professor 6.

When the new problem of SID arose, it worsened the free healthcare system at a faster pace in Shanghai by drastically escalating the healthcare expenditures. It ended up imposing unmanageable financial burdens to the enterprise units, the central and local governments.

Also, policy feedback from the enterprise reform imposed greater financial pressure for enterprise units to pay the medical expenses of LIS beneficiaries. The implementation of enterprise reform made the enterprise units become responsible for paying the healthcare expenditures of their employees. In order to increase enterprise units' efficiency and their responsiveness to market forces, the central government decentralized both administration and responsibility to the enterprise units (Gu, 2001c, p.133) which became "responsible for all their economic decisions, as well as their return of a profit or loss" (Hsü, 2000, p.850). On one hand, the enterprise units enjoyed the autonomy to make decision with respect to production plans, personnel management (recruitment, promotion, dismissal), salaries, bonuses, distribution of profits, capital allocation and utilization (Hsü, 2000, p.855; Gu, 2001c, p.134; Saich, 2004, p.255). On the other hand, they became responsible for paying employees' welfare expenditures through self-financing because the central government ceased to distribute fiscal appropriations to enterprise units' welfare funds (Gu, 2001c, p.134).

They used their profits to pay the healthcare expenditures of LIS beneficiaries.⁸⁴

However, the rapid increase in healthcare expenditures led to enterprise units, in particular the SOEs, having a big drain on profits which could have been used to reinvest in their businesses.⁸⁵ It also damaged the financial viability of enterprise units and impaired their competitiveness in the market economy.⁸⁶ Enterprise units became weaker players in the market.

The rapid increase in healthcare expenditures adversely affected enterprise units' ability to pay medical bills for their employees entitled to the LIS. Enterprise units which barely earned a profit or had little profit left only paid part of the medical expenses for their employees (Grogan, 1995, p.1079). Besides, those which used contract-based system to hire employees only paid part of the medical expenses for their employees or did not pay any medical expenses for their employees at all.⁸⁷ Also, enterprise units which were financially insolvent became incapable of paying the medical expenses for their employees (Yu, 1998, p.9).

Policy feedback from the LIS only allowed employees of SOEs and collective enterprises and their dependents to enjoy the entitlement to free medical benefits.

⁸⁴ Interview with Professor 2 and Professor 6.

⁸⁵ Interviews with Professor 2 and Professor 5.

⁸⁶ Interviews with Professor 2 and Professor 5.

⁸⁷ Interview with Insurance Company Manager 2.

Hence, employees who were laid off from SOEs and collective enterprises under the economic reform lost their entitlement to the LIS (Dong, 2003, p.225). Besides, policy feedback from the LIS that only required SOEs and collective enterprises to provide LIS for their employees exacerbated the problem of employees being ‘underinsured’ and ‘uninsured’ because private enterprises emerged and prospered under the enterprise reform and foreign enterprises under the Open Door Policy did not need to provide any LIS for their employees.⁸⁸ As Professor 6 said during the interview, employees being ‘underinsured’ and ‘uninsured’ were particularly serious in Shanghai because Deng’s adoption of Open Door Policy had the preference for channeling foreign investment to Shanghai in the mid-1980s.⁸⁹ While the continued growth of foreign and private enterprises sped up the pace of economic development in Shanghai, it concurrently deepened the problem of employees having ‘no health insurance coverage’.⁹⁰

⁸⁸ Interview with Professor 6. Since Professor 6 regarded both the LIS and GHS as ‘insurance’ programmes, he used ‘underinsured’ to reflect the situation of employees only having part of their medical expenses paid by their work units while using ‘uninsured’ to reflect the situation of employees having no work units to pay for their medical expenses.

⁸⁹ Interview with Professor 6. Under the economic reform, Deng implemented Open Door policy, which unprecedentedly opened up the PRC to foreign capital, technology, and investment for economic advancement. It led to the establishment of four special economic zones (SEZs) in 1980, including Shenzhen, Zhuhai, Shantou and Xiamen. Besides, there was the opening of 14 coastal cities in 1984, including Beihai, Dalian, Fuzhou, Guangzhou, Qingdao, Qinhuangdao, Lianyungang, Nantong, Ningbo, Shanghai, Tianjin, Wenzhou, Yantai, and Zhanjiang (Yeung et al., 2009, p.225). In June 1985, Deng announced that foreign investment should be channeled specially to four of the biggest coastal cities which included Shanghai, Tianjin, Guangzhou, and Dalian (Grogan, 1995, p.1075).

⁹⁰ Interview with Professor 6.

Transferring the responsibility of financing the LIS to the enterprise units did not help relieve the central government's financial burden of healthcare. It was because policy feedback from the GHS that the central government's responsibility for financing the GHS through the state budget remained unchanged⁹¹ although under economic reform it decentralized the financing of the GHS to local governments which could determine the per capita GHS budget "based on local budgets and the previous use rates of health care services" (Liu and Yi, 2004, pp.31-2). Then, the GHS budget was allocated to the work units of GHS beneficiaries to manage (Liu and Yi, 2004, p.31). Any deficits had to be met by the work units "using their operating budget and/or other self-raising fund" (Liu and Yi, 2004, p.31). As Insurance Company Manager 2 said during the interview, since the work units of GHS beneficiaries such as government departments and universities were not profit-making institutions, they hardly had money drawn from other sources to meet the deficits when their employees' healthcare expenditures exceeded the GHS budget.⁹² Therefore, the so-called self-raised funds actually were seeking financial help from the local government which in turn set a higher per capita GHS budget.⁹³ When the economic reform proceeded, work units seeking financial help from the local government became more frequent, which increased the financial burden of both the

⁹¹ Interviews with Professor 2 and Professor 6.

⁹² Interview with Insurance Company Manager 2.

⁹³ Interview with Insurance Company Manager 2.

local and central governments.⁹⁴

Indeed, policy feedback from the economic reform implemented since 1978 and the LIS and GHS implemented since the early 1950s created many problems, including drastic increase in healthcare expenditures, the moral hazard from the demand side, imposing greater financial pressure for enterprise units and central government to pay the medical expenditures of their employees, and exacerbating the problem of employees being ‘underinsured’ and ‘uninsured’. It accelerated the pace of collapse of the free healthcare system in Shanghai and compelled the government to implement urban health insurance reform.

The collapse of the free healthcare system in Shanghai was due to unstable and insufficient financial support for paying the rising healthcare expenditures. In the 1980s, both the enterprise units and the government found the financial burden of medical expenses unbearable when there was a continued growth in the number of LIS and GHS beneficiaries and a continued growth in healthcare expenditures. In Shanghai, from 1978 to 1989, the number of employees joining the LIS rose from about 3.6 million to about 5.5 million, which respectively accounted for about 33 per

⁹⁴ Interview with Insurance Company Manager 2 and Insurance Company Manager 1.

cent and about 43 per cent of Shanghai's total population (Zhang and Shao, 1998, p.115). As to the number of employees joining the GHS, it rose from 498,000 in 1980 to 769,000 in 1985, which respectively accounted for about 4 per cent and 6 per cent of Shanghai's total population (Zhang and Shao, 1998, p.116). The total number of LIS and GHS beneficiaries would be more if retired employees were also taken into account.⁹⁵ At the same time, both the overall LIS and GHS expenditures and the average annual LIS and GHS expenditure per beneficiary continued to increase drastically because of the problems of SID, moral hazard from the demand side and having too many retired employees using the free healthcare system. According to Zhang and Shao (1998), the LIS expenditure rose from RMB 120 million in 1978 to RMB 1,560 million in 1989 (p.115). The average annual health insurance expenditure per LIS beneficiary rose about five times, from about RMB 55 in 1978 to about RMB 283 in 1989 (Zhang and Shao, 1998, p.115). As to the GHS expenditure, it rose for about eight times, from RMB 19.7 million in 1980 to about RMB 152.6 million in 1990 (Zhang and Shao, 1998, p.116). The average annual health insurance expenditure per GHS beneficiary rose from about RMB 40 in 1980 to about RMB 198

⁹⁵ No interviewees were able to give the exact or estimated number of retired population enjoying either the LIS or GHS before urban health insurance reform took place in Shanghai. However, Shanghai Statistical Yearbook 2000 showed that there were 952,400 retired employees of enterprise units in 1980, with 673,900 employees retiring from SOEs and 278,500 employees retiring from collective enterprises (Shanghai Municipal Statistics Bureau, 2000). In 1990, the number of retired employees of enterprise units drastically rose to about 1.6 million, with 1.1 million employees retiring from SOEs and 424,200 employees retiring from collective enterprises (Shanghai Municipal Statistics Bureau, 2000). Since enterprise units were responsible for paying the medical bills of their retired employees, they bore heavy financial burden.

in 1990 (Zhang and Shao, 1998, p.116).

The alarming trend of soaring healthcare expenditures became irreversible in Shanghai and in other places within the PRC. A continued drain on the state budget and profits weakened the financial capacity of both the government and enterprise units to sustain the free healthcare system. The problem of employees paying their medical expenses out-of-pocket at point of consumption became serious. In Shanghai, the number of patients having self-pay medical treatments rose from 6 per cent in 1980 to 10 per cent in the late 1980s (Zhang and Shao, 1998, p.114). Those who failed to have self-payment delayed getting needed healthcare or failed to access healthcare.⁹⁶ It showed that the free healthcare system which functioned well in the socialist planning economy did not perform well within the new institutional configuration of the market economy (Gu, 2001a, p.199). Without unstable and insufficient financial support, the free healthcare system began to collapse. It compelled the central government to reform the free healthcare system.

(c) The Authoritative Political Institutions

Historical institutionalism argues that political institutions play a determinant role in

⁹⁶ Interviews with Professor 6 and Hong Kong Citizen 1.

constraining or facilitating the structure of political opportunities for political actors in a given polity (Hall and Taylor, 1996, p.941; Immergut, 1998, p.21) and shaping their strategies and goals in the decision-making process that in turn shape the political outcomes (Thelen and Steinmo, 1992, p.6; Koelble, 1995, p.236). In the PRC, the authoritative political institutions with the strong influence of the CCP and a highly centralized decision-making structure enabled the central government to implement a nationwide urban health insurance reform in 1998 without any political impediments. As Professor 2, Professor 5, Professor 6 and Researcher 2 said during their interviews, the CCP was the locus of political power in the PRC and never faced any political opposition which challenged its role as the ruling party since the establishment of the PRC in 1949.⁹⁷ The CCP claimed that it represented the interests of the people and was able to act in the best interest of the state.⁹⁸ Being a non-democratic state, the PRC had a centralized political system without any separation of executive, legislative and judicial powers that the CCP enjoyed the monopoly on setting national goals and policy making, including the monopoly on setting healthcare goals and making healthcare policy.⁹⁹ It adopted a top-down decision-making model which only allowed the political leaders, senior and high-ranking ministerial officials to participate in the process of formulating health insurance policy behind closed door

⁹⁷ Interviews with Professor 2, Professor 5, Professor 6, and Researcher 2.

⁹⁸ Interviews with Professor 2, Professor 5, Professor 6, and Researcher 2.

⁹⁹ Interviews with Professor 2, Professor 5, Professor 6, and Researcher 2.

and left no room for public participation or policy opposition.¹⁰⁰ As Citizen 1, Citizen 2, Citizen 5, Citizen 7 and Armed Police Officer 1 said during their interviews, the CCP was the strong authoritative voice in the PRC while the voices from the public and non-state actors were weak that citizens' open criticism of the CCP and its policies was deemed risky.¹⁰¹

The argument made by the interviewees warrants a discussion here with the help of literature. The written Constitution legitimized the power of the CCP (Christiansen and Rai, 1996, p.83) and vested the CCP with full authority (Gu, 2009, p.227). Over the past six decades, the CCP had ensured its position as the dominant political institution in the PRC by providing political, ideological and organizational leadership (Townsend and Womack, 1986, p.89). It exercised its leadership functions, ensured its control over government operations and sustained the strong party-state by dominating and penetrating all levels of government from provinces, cities, counties to townships (Duckett, 2011, p.14; Gu, 2009, p.132; Guo, 2003, p.55; Townsend and Womack, 1986, p.89) and by emphasizing "thought control and reinforcing the party line" (Gu, 2009, p.132). Leading party cadres at various levels concurrently occupied the highest posts in local government institutions (Li, 2010, p.166) and established

¹⁰⁰ Interviews with Professor 2, Professor 5, Professor 6, and Researcher 2.

¹⁰¹ Interviews with Citizen 1, Citizen 2, Citizen 5, Citizen 7, and Armed Police Officer 1.

party cells within government entities to oversee all activities (Duckett, 2011, p.14; Gu, 2009, p.132). It was the CCP that made policy (Joseph, 2010a, p.13) and the state or government that operated “merely as the executor of decisions made by the party” (Li, 2010, p.166). Policy making “remained relatively closed” (Duckett, 2011, p.15) and had “little open public debate or lobbying” (Duckett, 2011, p.15). The general public “retained the mentality of deference and dependence” (Guo, 2003, p.110), which was conducive to stabilizing and reinforcing the legitimacy of the CCP rule (Guo, 2003, p.110).

(i) The Roles of the Central Committee and the State Council

Concerning the top-down decision-making model, attention needed to be paid to the roles played by the Central Committee of the CCP and the State Council. The Central Committee was the highest authority within the CCP containing the leading figures of the PRC, including president of the PRC and premier of the State Council. It was “the most important representative body in the PRC” (Townsend and Womack, 1986, p.91) having “the power to make decisions on major policies of a nationwide character” (Wang, 2002, p.406).¹⁰² The State Council, which consisted “almost entirely of high-ranking party members” (Townsend and Womack, 1986, p.101), was the highest

¹⁰² Please refer to Article 15 of the Constitution of the People’s Republic of China (1982).

executive organ and the command headquarter (Wang, 2002, pp.92-3) exerting leadership over the ministries, bureaux, commissions and committees (Saich, 2004, p.133), and was responsible for administering and coordinating the government's programmes at the provincial and local levels (Wang, 2002, pp.92-3). The Central Committee and the State Council had close relationship when formulating health insurance policy.¹⁰³ While the Central Committee indicated the direction of healthcare reform should proceed, the State Council established leading small groups (*lingdao xiaozu*) or small groups (*xiaozu*) to propose policies, implement pilot experiments of health insurance reform, and give suggestions to the Central Committee based on the results of the pilot experiments.¹⁰⁴ Once the Central Committee approved the healthcare policy option it chose, the State Council would administer various ministries below it to actualize the healthcare reform.¹⁰⁵

Indeed, the close relationship of the Central Committee and the State Council was reflected in the timeline of urban health insurance reform in the PRC. Since the mid-1980s, the Central Committee's emphasis on implementing the economic reform had led to accelerating the pace of implementing health insurance system reform¹⁰⁶

¹⁰³ Interviews with Professor 2, Professor 5, Professor 6, and Insurance Company Manager 2.

¹⁰⁴ Interviews with Professor 2, Professor 5, Professor 6, and Insurance Company Manager 2.

¹⁰⁵ Interviews with Professor 2, Professor 5, Professor 6, and Insurance Company Manager 2.

¹⁰⁶ For more details, please refer to *the Notification of the Key Points of 1989 Economic Reform Made by the State Commission for Restructuring Economic Systems* (Chinese Version).

because the free healthcare system was in bad condition and acted as an institutional impediment to further enterprise reforms and economic reforms (Gu, 2001a, p.197). During the three years from 1985 to 1987, the average annual growth rate of healthcare expenditures in the state sector reaching about 25 per cent “compelled the central government to put health reform on the policy agenda” (Gu, 2001a, p.208). In March 1988, the State Council established a Research Small Group on Health Insurance System Reform to draft a proposal on reforming the GHS and LIS (Gu, 2001a, p.208; Wong et al., 2006, p.16). However, the pilot reform based on the suggestions of the Research Small Group “could not reverse the national tendency of soaring [healthcare] expenditure” (Gu, 2001a, p.209). This in turn compelled the Central Committee to initiate a new round of pilot health insurance reform.

In May 1992, the State Council established a Small Group on Healthcare System Reform to conduct a comprehensive study on reforming the GHS and LIS (The State Council, 1992). In November 1993, the Third Plenary Session of the Fourteenth Central Committee of the CCP decided on a health insurance system for urban employees based on a contribution system consisting of the individual MSA and the SPF (The Fourteenth Central Committee of the CCP, 1993).¹⁰⁷ In November 1994,

¹⁰⁷ Please refer to *the Decision of the Central Committee of the CCP Concerning the Establishment of the Socialist Market Economy* (Chinese Version).

the State Council commenced the pilot experiments of health insurance reform in the two *jiangs* (Gu, 2001a, p.209; Liu et al., 2004, p.43; Tang and Meng, 2004, p.32; Wong et al., 2006, p.16).¹⁰⁸ Based on the Central Committee's decision to accelerate the urban health insurance reform, the State Council decreed in May 1996 that all provincial government should implement the experimental health insurance reform based on the "two-*jiang* model" (The State Council, 1996). At the same time, the State Council established a Leading Small Group on the Pilot Spots of Health Insurance System Reform for Urban Employees to deal with the extension of experimental health insurance reform in "57 cities in 27 provinces" (Yu, 1998, p.2).

In January 1997, the Central Committee and the State Council jointly issued *the Decision of the Central Committee of the CCP and the State Council Concerning Public Health Reform and Development*, which talked about the necessity of reforming the health insurance system for urban employees and expanding the health insurance coverage so as to provide the basic medical protection for urban employees (The Central Committee of the CCP and the State Council, 1997). In order to pursue a nationwide urban health insurance reform, the State Council on December 14, 1998 promulgated *the 1998 Decree* (The State Council, 1998), which required all urban

¹⁰⁸ For more details, please refer to *the Approval of the Proposal for Pilot Health Insurance System Reform for Urban Employees in Zhenjiang in Jiangsu Province and Jiujiang in Jiangxi Province* (Chinese Version) issued by State Council on November 18, 1994.

work units and their employees to participate in the BMI System.

(ii) Leading Small Groups, Their Key Participants and the Bargaining Process

The role of leading small groups or small groups of the State Council needs further elaboration here. Most of the current Chinese and English literature about healthcare reform in the PRC seldom mentioned the existence of leading small groups or contained detailed information or discussion about the nature of leading small groups.

During the interview, except Professor 2, Professor 5, Professor 6 and Insurance Company Manager 2, most of the interviewees had difficulty in giving a detailed description about the role or nature of leading small groups of the State Council in healthcare policy making process. This was due to the fact that being the important institutions, leading small groups or small groups did not officially appear on the organizational chart of the CCP and were “largely hidden from public view” (Lieberthal, 2004, p.217). The policy making process was not transparent in the PRC and there were limited official documents disclosed to the public. While this could be understood as one of the characteristics of policy making in the PRC, this could also meant that one was not easy to grasp the understanding of leading small groups well. Nevertheless, the work of Lieberthal (2004), Hai and Fook (2005) and Miller (2008) were few of the current literature offering insights about the nature of leading small

groups in the PRC.

In fact, leading small groups or small groups were not new institutions used by the Chinese leadership for policy making (Hai and Fook, 2005, p.2). First created in 1958 in the Central Committee and later in the State Council and People's Liberation Army (Miller, 2008, pp.2-3), leading small groups or small groups were informal bodies being used as a complement to "reduce the workload of already burdened (and often elderly) decision makers" (Hai and Fook, 2005, p.2). They dealt with "major and complex issues which cut across geographic and bureaucratic lines" (Hai and Fook, 2005, p.2), ranging from politics and laws, party affairs, culture and education, economic affairs, science and technology to foreign affairs (Miller, 2008, pp.8-21). They were "a bridge between the top leaders of the political system and the major bureaucracies" (Lieberthal, 2004, p.216) and a coordination mechanism to straddle different ministries in policy deliberation so that various views could be tapped to make the best recommendation and cooperation among ministries could be ensured during policy implementation (Hai and Fook, 2005, pp.1-2). In brief, leading small groups or small groups were "the trouble-shooter, problem-solver and arbitrator" (Hai and Fook, 2005, p.2) of the Chinese leadership.

Leading small groups or small groups of the State Council played a crucial role in formulating health insurance policy because there were about 20 ministries containing certain degrees of responsibilities for healthcare in the PRC.¹⁰⁹ “Nine dragons harnessing floods” (*jiu long zhi shui*) was the Chinese idiom adopted by Professor 2 and Insurance Company Manager 2 interviewed to describe this complex institutional arrangement for healthcare.¹¹⁰ Since healthcare was a complicated issue in the PRC and involved multi-institutions, leading small groups or small groups of the State Council served as ad hoc committees where heads or representatives of various ministries gathered together to exchange ideas, monitor the progress of pilot health insurance reform experiments and tried to reach a consensus on health insurance reform proposal.¹¹¹ For example, the Research Small Group on Health Insurance System Reform established in March 1988 included the directors and heads of the State Commission for Restructuring Economic Systems, Ministry of Health, Ministry of Labor, Ministry of Finance, State Pharmaceutical Bureau, the Organization Department of the Central Committee of China, All China Federation of Trade Unions and the People’s Insurance Company of China (Gu, 2001a, p.208). Under the leadership of the State Council, the Research Small Group “recommended that medical costs [should] be borne jointly by the employer and the employees”

¹⁰⁹ Interviews with Professor 2, Professor 5, Professor 6, and Insurance Company Manager 2.

¹¹⁰ Interviews with Professor 2 and Insurance Company Manager 2.

¹¹¹ Interviews with Professor 2, Professor 5, Professor 6, and Insurance Company Manager 2.

(Wong et al., 2006, p.16) and Dandong, Siping, Huangshi and Zhuzhou should be chosen as the pilot cities to implement the experimental reform (Gu, 2001a, p.208; Wong et al., 2006, p.16).

As to the Small Group on Healthcare System Reform established in May 1992, it comprised the directors and heads of seven government entities and a national trade union federation led by the CCP, including the State Commission for Restructuring Economic Systems, Ministry of Health, Ministry of Labor, Ministry of Personnel, Ministry of Finance, Price Bureau, Medical Bureau and All China Federation of Trade Unions, to conduct a comprehensive study on reforming the GHS and LIS (The State Council, 1992). Under the direct leadership of the State Council, the Small Group used about six months to regularly discuss the current situation, problems, steps and experience of health insurance reform and conduct pilot health insurance reform experiments by using different reform models in different provinces, autonomous regions, municipalities and counties in order to formulate a reform proposal (The State Council, 1992). Also, the Leading Small Group on the Pilot Spots of Health Insurance System Reform for Urban Employees established in May 1996 comprised the representatives of different ministries and related authority such as the State Commission for Restructuring Economic Systems, Ministry of Health, Ministry of

Labor and Ministry of Finance to lead, guide, supervise, coordinate and evaluate the health insurance reform experiments based on the *two-jiang* model in pilot spots.¹¹²

The policy making process within the leading small groups or small groups of the State Council was a process involving bargaining among members of different ministries.¹¹³ This was attributed to the fact that the division of authority among the ministries was not clear, the ministries operated largely independently on a daily basis, had different interests to defend, and saw the way to reform the free healthcare system from different angles and perspectives.¹¹⁴ Professor 2 and Professor 5 who had close relationship with the health-related authority felt uncomfortable disclosing the bargaining process within the leading small groups in detail because the information was sensitive and was related to top leadership. Thus, they were unwilling to go through each commission or ministry participating in the leading small groups or small groups of the State Council. Nevertheless, Professor 2, Professor 5, Professor 6 and Insurance Company Manager 2 interviewed mentioned the positions of four key political institutions when formulating health insurance policy. They were the State Commission for Restructuring Economic Systems, the Ministry of Health, the

¹¹² Interviews with Professor 2, Professor 5, Professor 6, and Insurance Company Manager 2. For more details, please refer to *the Opinion on Expanding the Pilot Spots for Reforming Health Insurance System for Urban Employees* (Chinese Version) issued by the State Commission for Restructuring Economic Systems, Ministry of Finance, Ministry of Labor and Ministry of Health in April 1996.

¹¹³ Interviews with Professor 2 and Professor 5.

¹¹⁴ Interviews with Professor 2 and Insurance Company Manager 2.

Ministry of Finance and the Ministry of Labor respectively.

The State Commission for Restructuring Economic Systems, which was established in early 1982 to study and guide the overall economic reform and to coordinate the interests of all parties to ensure the smooth implementation of economic reform, emphasized efficiency and favored less government involvement in healthcare financing.¹¹⁵ The Ministry of Health, which was responsible for managing hospitals, favored protecting the interests of hospitals and doctors and wanted to ensure that health insurance reform would not affect the incomes earned by hospitals and doctors.¹¹⁶ The Ministry of Finance, which was responsible for managing and supervising the public expenditures of the central government, had a fiscally conservative position.¹¹⁷ It favored balancing the fiscal budget of the central government and reducing the government's financial burden caused by escalating healthcare expenditures and shrinking the government's role in financing healthcare.¹¹⁸ The Ministry of Labor, which was responsible for managing the LIS, was eager to reduce the financial burden of enterprises and favored cost-sharing and

¹¹⁵ Interview with Professor 6 and Insurance Company Manager 2. According to Lieberthal and Oksenberg (1988), the commissions "are at a higher bureaucratic level than are ministries" (p.63). They "take a more comprehensive view of things than do the more narrowly focused line ministries" (Lieberthal and Oksenberg, 1988, p.63). In 1998, the institutional reform led to the State Commission for Restructuring Economic Systems becoming the Office of Restructuring Economic Systems. In 2003, the Office of Restructuring Economic Systems was merged with State Economic and Trade Commission and became National Development and Reform Commission.

¹¹⁶ Interviews with Professor 2, Professor 5, Professor 6, and Insurance Company Manager 2.

¹¹⁷ Interview with Professor 5.

¹¹⁸ Interview with Professor 5.

risk-pooling measures.¹¹⁹ From the above, it showed that the commission and ministries took divergent positions on health insurance reform and represented different interests which appeared to be in conflict with each other. It was not easy to reach a consensus on health insurance option which could satisfy all the commissions and ministries involved without making any compromises. It implied that there were even more differences when there were 20 ministries involving in healthcare. As Professor 5 and Professor 6 said during their interviews, disagreement among ministries over health insurance policy was unavoidable.¹²⁰ Competing policy options, conflicting perspectives and conflicting interests among ministries often led to time-consuming discussion, heated debates, or even impasse.¹²¹ Nevertheless, since the commissions and ministries knew that the Central Committee was the final decision-maker while their tasks were to propose policy options to the Central Committee, they would find ways to reconcile their differences and find common ground to peacefully co-exist.¹²²

The closed policy-making process within the leading small groups or small groups of the State Council showed that the leading small groups were confined to a small circle of senior officials from different ministries only. Other stakeholders or

¹¹⁹ Interviews with Professor 6 and Insurance Company Manager 2.

¹²⁰ Interviews with Professor 5 and Professor 6.

¹²¹ Interviews with Professor 5 and Professor 6.

¹²² Interviews with Professor 5 and Professor 6.

interest groups in health insurance reform such as employers/work units, employees, patients, doctors, pharmaceutical companies and insurance companies barely had a chance to voice out their opinions.¹²³ As Professor 1, Professor 2, Professor 5, Professor 6 said during their interviews, scholars and experts on health insurance were sometimes invited to meet the members of the leading small groups of the State Council for joining the discussions.¹²⁴ Their opinions could be served as useful reference for the leading small groups.¹²⁵ However, they may not decisively influence the formulation of health insurance policy.¹²⁶ Insurance Director 1 and Insurance Company Manager 2 interviewed also said that representatives of the insurance companies were sometimes invited to meet the government officials of the leading small groups of the State Council.¹²⁷ However, the opinions given by the representatives of the insurance companies were not influential and could be rejected immediately during the meeting.¹²⁸ Doctor 1 and Doctor 2 interviewed said that the culture of doctors expressing opinions on health insurance policy did not exist and doctors liked them did not have the enthusiasm for expressing opinions on healthcare issues.¹²⁹ Citizen 1, Citizen 3, Citizen 4 and Citizen 6 interviewed said that the government did not consult their opinions on health insurance reform, but they did not

¹²³ Interviews with Professor 5, Professor 6, Insurance Company Manager 2, and Insurance Director 1.

¹²⁴ Interviews with Professor 1, Professor 2, Professor 5, and Professor 6.

¹²⁵ Interviews with Professor 1, Professor 2, Professor 5, and Professor 6.

¹²⁶ Interviews with Professor 1, Professor 2, Professor 5, and Professor 6.

¹²⁷ Interviews with Insurance Company Manager 2 and Insurance Director 1.

¹²⁸ Interviews with Insurance Company Manager 2 and Insurance Director 1.

¹²⁹ Interviews with Doctor 1 and Doctor 2.

bother to express their opinions because they did not think that their opinions carried any weight.¹³⁰

It shows that the closed policy-making process did not give stakeholders outside the leading small groups or small groups of the State Council an equal footing to participate in policy formulation and discussion. Scholars and representatives of insurance companies could only express their opinions on health insurance reform at the invitation of government officials. On the other hand, both the doctors and citizens were indifferent to expressing opinions on health insurance reform because they did not think their opinions were influential enough to shape the health insurance policy. In the PRC, the authoritative political institutions with the strong influence of the CCP and a highly centralized decision-making structure did not provide any veto opportunities for non-bureaucratic stakeholders in healthcare insurance reform or interest groups to affect policy proposals or policy results. Non-bureaucratic stakeholders or interest groups did not have any leverage over healthcare financing policy making. In brief, the closed policy-making process gave the central government an advantage in formulating and choosing urban health insurance reform policy it favored in the absence of voices of other stakeholders.

¹³⁰ Interviews with Citizen 1, Citizen 3, Citizen 4, and Citizen 6.

(d) New Ideas being Championed by the Political Leader and Key Bureaucratic

Actors

Historical institutionalism argues that ideational forces matter in policy making because they “favor significant policy change or reinforce existing institutional paths” (Hwang, 2006, p.16). In the PRC, the new ideas of individual MSA, the SPF, co-payment, individual responsibility and social solidarity were championed by the political leader and key bureaucratic actors from different ministries that a new mandatory health insurance system replaced the free healthcare system in Shanghai. As Professor 5 and Professor 6 said during their interviews, these new ideas could achieve political prominence because they fitted into the market-oriented economic context well and were believed to be a solution to the intractable problems of moral hazard from the demand side and rising healthcare expenditures.¹³¹ On the other hand, the old ideas of free healthcare and egalitarianism were regarded as one of the root causes of rising healthcare expenditures and impediments to further promote economic reforms.¹³² The collapse of the free healthcare system provided an opportune time for the political leader and key bureaucratic actors to promote and endorse new ideas.¹³³ The highly centralized decision-making structure and closed

¹³¹ Interviews with Professor 5 and Professor 6.

¹³² Interviews with Professor 5 and Professor 6.

¹³³ Interviews with Professor 5 and Professor 6.

policy-making process favored the political leader and key bureaucratic actors adopting these new ideas without facing any stiff opposition.¹³⁴ As a result, these new ideas gained political prominence and were adopted in urban health insurance reform.¹³⁵

In fact, the new health insurance model adopted by the Central Committee showed that the leading small groups of the State Council did not generate the health insurance option from scratch but by borrowing international experience. The new model which combined the individual MSA and the SPF was a new mandatory health insurance system replacing the work-unit-based free healthcare system. The institutional design of the new insurance model showed that the individual MSA was similar to the Medisave Scheme in Singapore in 1984 while the SPF and the mandatory contribution from both the work units and employees was similar to the sickness fund of the social insurance scheme in Germany. As Professor 5 and Professor 2 said during their interviews, the “two-*jiang* model” had a funding framework based on the compulsory medical savings scheme in Singapore and borrowed the German experience to form the institutional framework of the new health insurance model.¹³⁶ This was similar to the findings of Yip and Hsiao (1997)

¹³⁴ Interviews with Professor 5 and Professor 6.

¹³⁵ Interviews with Professor 5 and Professor 6.

¹³⁶ Interviews with Professor 5 and Professor 2.

and Cheung (2001) that the “two-*jiang* model” patterned after the Singapore’s Medisave Scheme and the finding of Gu and Zhang (2006) that the Singaporean funding arrangement was “incorporated into the German-style institutional framework of social insurance” (p.58). Professor 5 and Professor 2 interviewed said that it was common for governments to borrow experience from other countries when they implemented reform.¹³⁷ Since the PRC had become an open economy in the late 1970s, it was understandable for the leading small groups of the State Council to look at international experience for reference.

Nevertheless, the institutional design of the new health insurance model showed that the leading small groups of the State Council did not directly copy the health insurance models from Singapore and Germany because the political, economic and social contexts of the PRC were different from that of Singapore and Germany. The path-dependent logic had played a role in shaping the design of the new health insurance model in the PRC. The Singapore’s compulsory medical savings scheme emphasized self-reliance and had the advantages of increasing cost consciousness and reducing the moral hazard on the demand side. However, the leading small groups of the State Council did not follow the contribution requirements of the Medisave

¹³⁷ Interviews with Professor 5 and Professor 2.

Scheme, which required the work units and employees, including the self-employed, to equally contribute 6 to 8 per cent of their earnings as insurance premium (Hsiao, 1995b, p.261). Instead, they excluded the self-employed to participate in the health insurance reform and required the work units and employees to respectively contribute 10 per cent and 1 per cent of their total wage bill as insurance premium. In fact, the practice of excluding the self-employed and having the work units bearing higher contribution rate reflected the institutional legacies of the past that the health insurance benefit was work-unit based and the work units assumed the financial responsibility to pay for employees' medical expenses. As a result, the State Council, when implementing the health insurance reform, excluded the self-employed who did not belong to any work units from participating in urban health insurance reform. Besides, although the work units no longer responsible for paying the full amount of the employees' medical expenses, they were required to pay a higher insurance premium rate.

The German institutional framework of social insurance adopted by the leading small groups of the State Council emphasized social solidarity and redistributive financing and had the advantage of providing a risk pool to insure the enterprise employees against catastrophic illnesses. The insurance pool that was absent in the

work units in the past could prevent the work units from running deficits or being bankrupt due to paying medical expenses for their own employees. It could also prevent the employees from being underinsured or uninsured because of work units having fiscal difficulties in paying their medical expenses. In brief, the institutional design of the new health insurance model showed that the leading small groups of the State Council carefully designed the health insurance model during the policy-making process.

(e) Implementing Urban Health Insurance Reform in a Decentralized Manner

As mentioned before, historical institutionalism argues that political institutions play a determinant role in facilitating or constraining the structure of political opportunities for political actors (Hall and Taylor, 1996, p.941; Immergut, 1998, p.21) to strive for particular goals or strategies to achieve these ends (Immergut, 1998, p.20). In the PRC, the central government's delegation of power to the local governments increased the enthusiasm of the Shanghai municipal government to implement urban health insurance reform. During Deng's era, while the CCP still centralized the political and policy making powers in its hands, it decentralized the administrative power to the local governments to implement policy reforms. For healthcare, local governments were encouraged to implement variations based on national health insurance model to

reflect different needs and socioeconomic conditions of local governments.¹³⁸

Decentralization increased the autonomy, discretion, efficiency, enthusiasm, flexibility, incentives, initiatives and support of local governments for implementing health insurance reform.¹³⁹ As Professor 2 and Government Official 1 said during their interviews, the Shanghai municipal government benefited from the decentralized power to experiment with the Shanghai model to constrain growth of healthcare expenditures.¹⁴⁰ Its successful experience in 1996 gained recognition from the central government and this boosted its activism and confidence to implement urban health insurance reform in 1998.¹⁴¹ Knowing that it was a role model in health insurance reform, the Shanghai municipal government spent much time and effort to carefully consider the contribution rate and the payment structure of the BMI scheme and develop lengthy instructions on the use of BMI.¹⁴² According to Shanghai Statistical Yearbook 2010, there were about 3.6 million BMI participants in 2000 (Shanghai Municipal Statistics Bureau, 2011), covering only about 22 per cent of Shanghai population.¹⁴³ In 2008, the BMI System covered about 41 per cent of Shanghai population, including about 4.5 million working participants and about 3.2 million retired participants (Shanghai Municipal Statistics Bureau, 2009).

¹³⁸ Interviews with Professor 2 and Professor 6.

¹³⁹ Interviews with Professor 1, Professor 2, Professor 5, and Professor 6.

¹⁴⁰ Interviews with Professor 2 and Government Official 1.

¹⁴¹ Interviews with Professor 2 and Government Official 1.

¹⁴² Interview with Government Official 1.

¹⁴³ According to Shanghai Statistical Yearbook 2010, the year-end resident population in Shanghai was about 16.08 million.

In brief, using historical institutionalism to examine urban health insurance reform in Shanghai shows that Shanghai succeeded in implementing health insurance reform since the mid-1980s because of seven reasons: (1) changes in political and economic contexts due to the new political leader of the CCP coming to power, (2) ideological shift from egalitarianism to pro-market policies, (3) policy feedback which accelerated the pace of collapse of the free healthcare system, (4) the authoritative political institutions with the strong influence of the CCP and a highly centralized decision-making structure, (5) the dominance of the political leader and key bureaucratic stakeholders from different ministries in the healthcare insurance reform process, (6) new ideas being championed by the political leader and key bureaucratic actors, and (7) the decentralization power given to the local governments to implement urban health insurance reform.

6.4 Different Views on the Changes Brought by Health Insurance Reform

The implementation of health insurance reform in Shanghai could affect stakeholders in many aspects: citizens' access to, affordability of and demand for healthcare, healthcare providers' capacity of and efficiency in healthcare delivery, insurers' profits and their freedom of action. As illustrated below, different stakeholders who

had different interests and expectations toward health insurance reform responded differently to the change in policy path. This section will examine the views of former LIS and GHS beneficiaries, BMI participants, non-BMI participants, doctors, pharmaceutical company managers, private insurance managers and director, a government official, scholars and researchers on health insurance reform in Shanghai. Their views reflected policy feedback.

(1) Former LIS or GHS beneficiaries

Former LIS or GHS beneficiaries who had become BMI participants were against the changes brought by health insurance reform because the BMI System went against their vested interests embedded in the pre-existing free healthcare system. They were discontent with the government's decision of replacing the free healthcare system with a contribution-based BMI System and regarded the new BMI System as an unpopular institutional change. Citizen 3 who used to enjoy the GHS for more than two decades said in the interview that BMI participants like her were reluctant to give up free healthcare benefits enjoyed for decades.¹⁴⁴ She complained that the implementation of the new BMI System went against her expectations of having the government to continuously pay for her medical bills.¹⁴⁵ She found herself

¹⁴⁴ Interview with Citizen 3.

¹⁴⁵ Interview with Citizen 3.

“experiencing psychological imbalance” because she kept asking about herself why the government abandoned its responsibility to pay her medical expenses and she was left to pay her own medical bills.¹⁴⁶ She said she missed the old days and did not like the new ideas of deductibles and co-payment.¹⁴⁷ Like other parents in Shanghai, she felt pity for her daughter who never had a chance to enjoy free healthcare.¹⁴⁸ And she worried that medical expenses would increase the financial burden of her daughter who was a young BMI participant obtaining less favorable medical coverage. Professor 4 who used to enjoy the GHS was dissatisfied with the implementation of the new BMI System because she no longer enjoyed free healthcare and had to pay for her medical expenses nowadays.¹⁴⁹ She perceived herself as “a victim rather than beneficiary” because as a patient with chronic illnesses, she had to “spend more money on long-term medication for high blood pressure and heart disease”.¹⁵⁰ Besides, she found the complicated instructions on the use of the individual MSA and the SPF inconvenient, annoying and confusing.¹⁵¹ Both Citizen 3 and Professor 4 interviewed felt disappointed that they were not as lucky as retired cadres, old Red Army and disabled military personnel, whose rights to continuously enjoy free healthcare were guaranteed by *the 1998 Decree* and thus were not affected by the

¹⁴⁶ Interview with Citizen 3.

¹⁴⁷ Interview with Citizen 3.

¹⁴⁸ Interview with Citizen 3.

¹⁴⁹ Interview with Professor 4.

¹⁵⁰ Interview with Professor 4.

¹⁵¹ Interview with Professor 4.

changes brought by urban health insurance reform.¹⁵² These special groups of people could still obtain medical services and drugs without any restrictions, with their medical expenses paid by the BMI fund.¹⁵³ For example, the grandmother of Citizen 1 interviewed was a retired veteran cadre enjoying free healthcare.¹⁵⁴ She could stay at Shanghai Cancer Hospital of Fudan University, which was one of the three best municipal hospitals in Shanghai,¹⁵⁵ to receive colorectal cancer treatment which cost from RMB 300,000 to RMB 1 million.¹⁵⁶ Her privilege of enjoying free healthcare freed the parents of Citizen 1 interviewed from paying the expensive medical bill.¹⁵⁷

(2) BMI Participants

BMI participants interviewed disliked the changes brought by urban health insurance reform because they did not find the new BMI System useful or fair. During the interview, BMI participants shared the view that they were dissatisfied with the new BMI scheme.¹⁵⁸ Citizen 1, Citizen 2, Citizen 4, Citizen 5, and Citizen 7 who were in their late twenties, and Citizen 6 and Researcher 2 who were in their early thirties said in their interviews that the BMI System was not quite useful to them because the

¹⁵² Interviews with Citizen 3 and Professor 4. Section Six of *the 1998 Decree* stated that the medical benefits of retired cadres, old Red Army and disabled military personnel remained unchanged.

¹⁵³ Interviews with Citizen 3 and Professor 4.

¹⁵⁴ Interview with Citizen 1.

¹⁵⁵ Shanghai Cancer Hospital of Fudan University, together with Zhongshan Hospital of Fudan University, and Huashan Hospital, were three best municipal hospitals in Shanghai.

¹⁵⁶ Interview with Citizen 1.

¹⁵⁷ Interview with Citizen 1.

¹⁵⁸ Interviews with Citizen 1, Citizen 2, Citizen 4, Citizen 5, Citizen 7, Citizen 6, and Researcher 2.

standard premium rate for urban employees was too low that the money saved in the individual MSAs was insufficient to use.¹⁵⁹ They said that money deposited into the individual MSAs could last longer if it was used to pay for the outpatient expenses in the second-tiered medical institutions where doctors prescribed less expensive drugs that could be reimbursed by the BMI.¹⁶⁰ But the practice of “using drug sale to feed hospitals” (*yi yao yang yi*) was so common in the third-tiered medical institutions in Shanghai that the individual MSAs would be depleted quickly when profit-minded doctors prescribed more drugs than necessary or do unnecessary examinations.¹⁶¹ It was an open secret that hospitals and doctors received kickbacks and red pocket money from pharmaceutical companies in exchange for prescribing expensive drugs.¹⁶² As Citizen 6 said during the interview, he felt upset about a doctor in a municipal hospital prescribing expensive and unnecessary drugs to treat his hacking cough, which included antibiotics, painkillers, and vitamins.¹⁶³ He ended up throwing all the unnecessary drugs away.¹⁶⁴ Sometimes, BMI participants could not use the individual MSAs at all but ended up paying out-of-pocket when expensive or imported drugs prescribed were excluded from *the Drug Catalogue* for

¹⁵⁹ Interviews with Citizen 1, Citizen 2, Citizen 4, Citizen 5, Citizen 7, Citizen 6, and Researcher 2.

¹⁶⁰ Interviews with Citizen 1, Citizen 2, Citizen 4, Citizen 5, Citizen 7, Citizen 6, and Researcher 2.

¹⁶¹ Interviews with Citizen 1, Citizen 2, Citizen 4, Citizen 5, Citizen 7, Citizen 6, and Researcher 2.

¹⁶² Interviews with Citizen 1, Citizen 2, Citizen 4, Citizen 5, Citizen 7, and Citizen 6.

¹⁶³ Interview with Citizen 6.

¹⁶⁴ Interview with Citizen 6.

reimbursement.¹⁶⁵ Besides, money deposited into the individual MSAs was definitely insufficient to pay for the inpatient expenses which were usually expensive.¹⁶⁶

Since all the employees insured were charged at the same premium wage regardless of wage level, those who had a lower-paid job were less advantageous than their counterparts who earned higher wages because the former only had small amount of money deposited into the individual MSAs and could hardly afford their medical bills if they became seriously ill.¹⁶⁷ Citizen 2 who was a manager said during the interview that her individual MSAs had accumulated about RMB 3,000 after working for five year.¹⁶⁸ But her friends who had lower-paid jobs only accumulated about RMB 1,200 to RMB 1,500 after working for five year.¹⁶⁹ Medical expenses became her friends' principal worry that her friends restrained consumption in order to save for future medical expenses.¹⁷⁰ Besides, young and healthy BMI participants did not find the BMI System useful because they seldom had medical treatment that money would only accumulate in the individual MSAs.¹⁷¹ As Citizen 5 and Citizen 7

¹⁶⁵ Interviews with Citizen 1, Citizen 2, Citizen 5, and Citizen 6. According to *the 2009 Drug Catalogue*, 349 Western medicines and 154 Chinese proprietary medicines belonging to Category A could be completely covered by the BMI while 791 Western medicines and 833 Chinese proprietary medicines belonging to Category B could be partially covered by the BMI (The Ministry of Human Resources and Social Security of China, 2009, p.1). *The 2009 Drug Catalogue* is the third version of drug catalogue. The second version was published in 2004.

¹⁶⁶ Interviews with Citizen 1, Citizen 2, Citizen 5, and Citizen 6.

¹⁶⁷ Interviews with Citizen 1 and Citizen 2.

¹⁶⁸ Interview with Citizen 2.

¹⁶⁹ Interview with Citizen 2.

¹⁷⁰ Interview with Citizen 2.

¹⁷¹ Interviews with Citizen 5 and Citizen 7.

said in their interviews, if the premium contribution was not mandatory, they could have spent the money on elsewhere such as buying digital products, clothes, or renting an apartment.¹⁷²

In addition, the BMI participants interviewed thought that the BMI System was an unfair health insurance system because of the problems of age disparity and free healthcare enjoyed by retired cadres, old Red Army and disabled military personnel.¹⁷³ Citizen 1, Citizen 4 and Citizen 5 interviewed said that they were unfairly treated because retirees who did not pay premium could enjoy better and higher medical coverage than incumbent employees who paid premiums (**See Table 14 and Table 15**).¹⁷⁴ In particular, older retirees could enjoy lower self-payment rate, higher LAMI coverage for their outpatient and emergency medical expenses, and higher SPF coverage for their inpatient expenses.¹⁷⁵ Besides, most of the BMI participants interviewed were upset by free healthcare enjoyed by retired cadres, old Red Army and disabled military personnel.¹⁷⁶ It was because the medical expenses of these special groups of people that were financed by the state budget in the past were financed by the BMI fund nowadays.¹⁷⁷ As Citizen 1, Citizen 2, Citizen 5, Citizen 6

¹⁷² Interviews with Citizen 5 and Citizen 7.

¹⁷³ Interviews with Citizen 1, Citizen 2, Citizen 4, Citizen 5, Citizen 6, Citizen 7, and Researcher 2.

¹⁷⁴ Interviews with Citizen 1, Citizen 4, and Citizen 5.

¹⁷⁵ Interviews with Citizen 1, Citizen 4, and Citizen 5.

¹⁷⁶ Interviews with Citizen 1, Citizen 2, Citizen 5, Citizen 6, and Citizen 7.

¹⁷⁷ Interviews with Citizen 1, Citizen 2, Citizen 5, Citizen 6, and Citizen 7.

and Citizen 7 said during their interviews, they opposed pooling their risks with retired cadres, old Red Army and disabled military personnel because similar to retired employees, these special groups of people quickly depleted the SPFs in the BMI System, thereby leaving little money or no money for the younger incumbents like them to pay their medical bills (See Table 17).¹⁷⁸ Citizen 7 interviewed argued that health insurance reform became meaningless when young incumbents in Shanghai replaced the government to pay the medical expenses of these special groups of people.¹⁷⁹ She questioned whether the BMI fund would still be sustainable to finance the healthcare of young incumbents in future.¹⁸⁰ Citizen 2 interviewed also argued that the BMI scheme failed to assure any medical security she deserved in the long run.¹⁸¹ As Citizen 1, Citizen 2, Citizen 5, Citizen 6 and Citizen 7 said during their interviews, their sense of powerlessness grew and intensified because it should be the government's responsibility rather than that of young incumbents to pay the

¹⁷⁸ Interviews with Citizen 1, Citizen 2, Citizen 5, Citizen 6, and Citizen 7. According to the data of Shanghai Municipal Medical Insurance Statistical Yearbook 2005 reproduced from Wang (2008), the average medical expenses of the insured urban employees of the BMI rose from about RMB 382 in 2001 to about RMB 1,017 in 2005 (p.302). The growth rate was about 166 per cent. The average medical expenses of the insured retirees of the BMI rose from about RMB 3,297 in 2001 to about RMB 4,564 in 2005 (Wang, 2008, p.302). The growth rate was about 38 per cent. The average medical expenses of the retired veteran cadres of the BMI rose from about RMB 14,122 in 2001 to about RMB 26,104 in 2005 (Wang, 2008, p.302). The growth rate was about 85 per cent. Shanghai Municipal Medical Insurance Statistical Yearbook 2005 was not available in libraries in Shanghai or in Hong Kong. It was also not available online. The author cited the data of Shanghai Municipal Medical Insurance Statistical Yearbook 2005 from the study of Wang (2008) who reproduced the data.

¹⁷⁹ Interview with Citizen 7.

¹⁸⁰ Interview with Citizen 7.

¹⁸¹ Interview with Citizen 2.

medical bills of retired cadres, old Red Army and disabled military personnel.¹⁸²

However, the existing government policy did not seem to give them any choice to choose or to quit the BMI scheme.¹⁸³ They thought that it was unrealistic to pin their hopes on the BMI System having enough money to pay their medical bills when they retired.¹⁸⁴

Since the BMI participants interviewed did not find the new health insurance system useful and fair, they used different means to ensure medical security or save money. These included joining the individual commercial health insurance scheme, using the group commercial health insurance provided by the companies they worked for, practising self-medication, using the medical insurance certificates of their parents or grandparents, and delaying in seeking medical treatment. Besides, some work units in Shanghai committed fraud in order to reduce or deny health insurance benefits to employees. Citizen 2 interviewed planned to join the individual commercial health insurance scheme after getting married because she thought that the BMI System was unable to insure her against catastrophic illness.¹⁸⁵ She thought that the individual commercial health insurance could be “a safety net to provide

¹⁸² Interviews with Citizen 1, Citizen 2, Citizen 5, Citizen 6, and Citizen 7.

¹⁸³ Interviews with Citizen 1, Citizen 2, Citizen 5, Citizen 6, and Citizen 7.

¹⁸⁴ Interviews with Citizen 1, Citizen 2, Citizen 5, Citizen 6, and Citizen 7.

¹⁸⁵ Interview with Citizen 2. According to Insurance Company Manager 1 and 2 interviewed on July 20, 2010 and Insurance Director 1 interviewed on July 29, 2010, commercial health insurance required a participant to contribute premium on his/her own and mainly covered the medical expenses of critical illness and hospitalization.

better and extra financial protection against medical expenses resulting from a major illness in future”.¹⁸⁶ Citizen 1, Citizen 4, Citizen 5, Citizen 6, and Citizen 7 interviewed said that they sometimes used the group commercial health insurance which was an employee benefits to cover more expensive medical expenses.¹⁸⁷ In brief, some of the BMI participants interviewed joined the individual commercial health insurance scheme or the group commercial health insurance for getting extra financial protection against soaring medical costs.

Meanwhile, Citizen 2, Citizen 5 and Citizen 7 interviewed practiced self-medication by taking over-the-counter (OTC) drugs which did not require a doctor’s prescription or left-over medicines from family members.¹⁸⁸ Both OTC drugs and left-over medicines could save money because the former was cheaper than prescribed drugs and could be easily bought at pharmacies while the latter did not require one to spend extra money to buy them.¹⁸⁹ As Citizen 2, Citizen 5 and Citizen 7 said during their interviews, they self-medicated with a combination of drugs based on their own judgment or lay advices obtained from parents, spouses, friends, or staff

¹⁸⁶ Interview with Citizen 2.

¹⁸⁷ Interviews with Citizen 1, Citizen 4, Citizen 5, Citizen 6, and Citizen 7. According to Insurance Company Manager 1 and 2 interviewed on July 20, 2010 and Insurance Director 1 interviewed on July 29, 2010, the group commercial health insurance was an employee benefits provided by some private foreign companies or big state-owned enterprises to attract and retain good staff. They said that the group commercial health insurance covered the medical expenses of outpatient illnesses, hospitalization and critical illnesses.

¹⁸⁸ Interviews with Citizen 2, Citizen 5, and Citizen 7.

¹⁸⁹ Interviews with Citizen 2, Citizen 5, and Citizen 7.

from pharmacies.¹⁹⁰ Depending on the severity of the symptoms, they would take a heavier dose of OTC drugs or left-over medicines for faster relief without doctors' instructions.¹⁹¹

Besides, Citizen 1, Citizen 2 and Citizen 4 interviewed used the medical insurance certificates of their parents or grandparents when seeking medical treatment at hospitals in order to get better medical coverage and save money.¹⁹² Although both Citizen 1 and Citizen 2 mentioned that they opposed pooling their risks with retired cadres, they admitted that it was better for them to use their grandmothers' and parents' medical insurance certificates because they could enjoy higher LAMI and SPF coverage.¹⁹³ Citizen 1 admitted that using her grandparents' medical insurance certificate "was not a right thing to do".¹⁹⁴ However, she was not afraid of getting caught because she and her family members were familiar with the doctors.¹⁹⁵ Citizen 4 interviewed said that the staff at hospitals did not match the identity of a patient with the name printed on the medical insurance certificate as long as the patient paid his/her medical bills.¹⁹⁶ Citizen 2 and Citizen 6 interviewed said that some of their friends who did not have a well-paid job would simply borrow their parents' or

¹⁹⁰ Interviews with Citizen 2, Citizen 5, and Citizen 7.

¹⁹¹ Interviews with Citizen 2, Citizen 5, and Citizen 7.

¹⁹² Interviews with Citizen 1, Citizen 2, and Citizen 4.

¹⁹³ Interviews with Citizen 1 and Citizen 2.

¹⁹⁴ Interview with Citizen 1.

¹⁹⁵ Interview with Citizen 1.

¹⁹⁶ Interview with Citizen 4.

relatives' medical insurance certificates when seeking medical treatment.¹⁹⁷ Some of their friends who wanted to accumulate more money in their individual MSAs would simply delay in seeking medical care until their health conditions deteriorated or having more serious symptoms such as severe pain.¹⁹⁸

Some of the BMI participants interviewed said that urban health insurance reform created the problem of work units' fraud which reduced or denied health insurance benefits to employees.¹⁹⁹ As Citizen 1, Citizen 5, and Hong Kong Citizen 1 said during their interviews, running a business in Shanghai was not an easy task because of high operation costs.²⁰⁰ Work units were required to compulsorily contribute four insurance premiums for their employees, including health insurance, pension insurance, unemployment insurance, and work injury and maternity insurance.²⁰¹ The total contribution rates of these four types of social insurance for work units were equal to about 40 per cent of the total wage bill.²⁰² In order to reduce or escape premium contribution, some work units willfully falsified the total number

¹⁹⁷ Interviews with Citizen 2 and Citizen 6.

¹⁹⁸ Interviews with Citizen 2 and Citizen 6.

¹⁹⁹ Interviews with Citizen 1, Citizen 5, and Hong Kong Citizen 1.

²⁰⁰ Interviews with Citizen 1, Citizen 5, and Hong Kong Citizen 1.

²⁰¹ Interviews with Citizen 1, Citizen 5, and Hong Kong Citizen 1.

²⁰² Interviews with Hong Kong Citizen 1 and Citizen 1. According to the Central People's Government of the People's Republic of China (2010), in Shanghai, the total contribution rates of these four types of social insurance for work units were equal to 37 per cent of the total wage bill. Work units had to respectively contribute 12 per cent, 22 per cent, 2 per cent and 1 per cent of the total wage bill to health insurance, pension insurance, unemployment insurance, and work injury and maternity insurance (The Central People's Government of the People's Republic of China, 2010).

and the identity of the employees and the payroll records.²⁰³ Hence, employees had less amount of money in their health insurance account than what they originally deserved.²⁰⁴ However, these employees were discouraged from pursuing a legitimate claim because there was no health insurance legislation to deal with work units' fraud in Shanghai.²⁰⁵ Even if the health insurance legislation to deal with insurance fraud existed, these employees "would usually keep quiet about this unfair treatment in order to keep their jobs".²⁰⁶ On the other hand, some work units used a lump sum cash payment to employees as a substitute for premium contribution.²⁰⁷ As Citizen 2 and Citizen 5 said during their interviews, some employees, in particular those who were healthy, did not resist this practice and even favored the practice because the lump sum cash payment was like increasing their salary and could be used in a more flexible way.²⁰⁸ The support from employees led to work units' fraud going undetected.²⁰⁹

(3) Non-BMI Participants

Armed Police Officer 1 interviewed was a non-BMI participant because armed police officers in the PRC got free healthcare in military hospitals financed by government

²⁰³ Interviews with Citizen 1, Citizen 5, and Hong Kong Citizen 1.

²⁰⁴ Interviews with Citizen 1, Citizen 5, and Hong Kong Citizen 1.

²⁰⁵ Interview with Citizen 5.

²⁰⁶ Interview with Citizen 5.

²⁰⁷ Interviews with Citizen 2 and Citizen 5.

²⁰⁸ Interviews with Citizen 2 and Citizen 5.

²⁰⁹ Interview with Citizen 5.

subsidies.²¹⁰ He said that since the amount of government subsidies received by military hospitals was limited, the quality of the medical services and the attitudes of doctors and nurses were poorer.²¹¹ In order to seek better medical care, he and other armed police officers sometimes would go to municipal hospitals.²¹² Without the individual MSAs, they had to pay out-of-pocket.²¹³ However, he had bad experience of paying unreasonably expensive fees for minor ailments at municipal hospitals.²¹⁴ He thought that the government should initiate some measures to restrain the profit maximizing behaviors of hospitals and doctors.²¹⁵

(4) Doctors

The doctors interviewed had mixed views about urban health insurance reform. Doctor 1 interviewed did not like urban health insurance reform because the BMI System was full of disparities when insurance coverage varied among participants according to age.²¹⁶ Besides, the BMI System did not promote equal access to healthcare, leading to the poor having difficulties in seeing doctors when they were sick.²¹⁷ As Doctor 1 said during the interview, the Shanghai municipal government

²¹⁰ Interview with Armed Police Officer 1.

²¹¹ Interview with Armed Police Officer 1.

²¹² Interview with Armed Police Officer 1.

²¹³ Interview with Armed Police Officer 1.

²¹⁴ Interview with Armed Police Officer 1.

²¹⁵ Interview with Armed Police Officer 1.

²¹⁶ Interview with Doctor 1.

²¹⁷ Interview with Doctor 1. Charity organizations in Shanghai implemented medical charity card scheme which partially or fully covered the medical expenses of vulnerable people when seeking

did not bear the financial responsibility of funding the BMI System so that it could spend the money on projects that could facilitate the economic growth.²¹⁸ He argued that the implementation of health insurance reform was all about money.²¹⁹ The Shanghai municipal government's financial involvement in the BMI System could improve the insurance coverage and thus reduce the problem of disparities in the BMI System.²²⁰ On the other hand, Doctor 2 interviewed said that the current BMI System was good because it provided participants with basic medical protection.²²¹ However, he found that the free healthcare system in Hong Kong was more attractive because of the idea of universal access to free healthcare irrespective of differences in age, sex and income.²²² Since he thought that "healthcare was a public welfare",²²³ he hoped that a free healthcare system like that of Hong Kong could be established in Shanghai

medical care at designated hospitals and community healthcare centers (Shanghai Municipal Government, 2008; Shanghai Charity Foundation, 2009). Besides, they gave subsidies to vulnerable people when seeking medical treatment (Shanghai Municipal Government, 2008). For example, in February 2001, the Shanghai Charity Foundation initiated the nation's first medical charity card project which gave free medical charity cards and subsidies to poor elderly residents aged over 60 who fell below poverty threshold (Shanghai Municipal Government, 2008). Up to October 2009, the Shanghai Charity Foundation had distributed 232, 550 medical charity cards and the medical expenses it subsidized had been accumulated to RMB 116 million (Yau and Lai, 2009). In 2006, Shanghai Angel Charity Foundation also distributed free medical cards and gave subsidies to the poor (Shanghai Municipal Government, 2006). For example, SACF Medical Charity Card, which ran until 2011, provided people under poverty-line with free medical treatment, free medical examination, free drugs donated by pharmaceutical companies, and an annual medical subsidies of RMB 500 (US\$62) (Shanghai Municipal Government, 2006; Shanghai Angel Charity Foundation, 2009a). Another example was that SACF Loving Care Medical Card provided basic medical services for the disables, the elderly and low-income population (Shanghai Angel Charity Foundation, 2009b). Nevertheless, the charity organizations in Shanghai only implemented the medical charity card project on selected regions such as Yangpu District and Hongkou District in Shanghai (Shanghai Municipal Government, 2008; Yau, 2007) or a specific period of time. Therefore, the problem of vulnerable people without access to healthcare due to the lack of money still existed.

²¹⁸ Interview with Doctor 1.

²¹⁹ Interview with Doctor 1.

²²⁰ Interview with Doctor 1.

²²¹ Interview with Doctor 2.

²²² Interview with Doctor 2.

²²³ Interview with Doctor 2.

so that the poor and the vulnerable could receive medical care when being sick.²²⁴

Concerning the problems of soaring healthcare expenditures and SID, Doctor 2 interviewed acknowledged that there were doctors in other Shanghai hospitals “frequently padding the medical bills with expensive and unnecessary medication, treatment, examinations, and even unneeded operations”.²²⁵ He and his colleagues did not pad the medical bills because the hospital he worked for emphasized medical ethics.²²⁶ But he admitted that the bonus policy implemented by the hospital substantially increased his monthly income for at least four times.²²⁷ The monthly income which included both salary and bonus was about RMB 5,000 for resident physicians, RMB 7,000 for doctor-in-charge, RMB 10,000 for associate chief, and RMB 12,000 for chief physicians at the third-tiered hospital he worked for.²²⁸

On the other hand, Doctor 1 interviewed argued that it was the disorder of drug

²²⁴ Interview with Doctor 2.

²²⁵ Interview with Doctor 2. Chen Hong (pseudonym), who was a doctor working at a Shanghai hospital, disclosed in a newspaper interview that how a doctor jacked up the medical bills (Luo, 2006). He said that a doctor would change oral antibiotics into injection because he/she could earn more revenues by charging the fees of “using injection syringe and manual injection” (Luo, 2006). And if a doctor changed oral antibiotics into intravenous infusion, he/she could even earn more revenues by charging “the fees of using infusion apparatus, a saline water solution, and a bottle of glucose water” (Luo, 2006).

²²⁶ Interview with Doctor 2.

²²⁷ Interview with Doctor 2.

²²⁸ Interview with Doctor 2. In Shanghai, doctors had low baseline salaries. According to Luo (2006), the monthly salary of doctors varied according to their ranks. The monthly salary of resident physicians (junior) was about RMB 1,000, doctor-in-charge (intermediate) RMB 1,400, associate chief (senior) RMB 2,000, and chief physician (senior) RMB 2,500 (Luo, 2006). It showed that the bonuses received by Doctor 2 interviewed and his colleagues were about five times higher than their monthly salaries.

distribution channel being the main cause of soaring healthcare expenditures.²²⁹ He said that the central government's withdrawal of price control on drugs since Deng's era had left much room for different members in the drug distribution channel to make profits from production to consumption.²³⁰ Drug manufacturers who were drug suppliers, wholesale pharmaceutical companies which were drug distributors, and hospitals and drug stores which were drug retailers made use of the complicated and highly non-transparent drug distribution channel to mark up drug prices in order to earn as much money as possible.²³¹ As Doctor 1 said during the interview, the Price Bureau allowed drug manufacturers to add a 5 to 10 per cent markup on the production costs of the drugs.²³² But drug manufacturers liked to exaggerate the production costs such as the costs of raw materials, labor, machinery and management in order to gain more profits.²³³ On top of the manufacturer prices, the first-tier drug distributor added a 5 to 10 per cent markup to constitute the first-tier drug wholesale prices.²³⁴ On top of the first-tier drug wholesale prices, the second-tier drug distributor added a 5 to 10 per cent markup to constitute the second-tier drug wholesale prices.²³⁵ On top of the second-tier drug wholesale prices, the third-tier drug distributor added a 15 to 20 per cent markup to constitute the third-tier drug

²²⁹ Interview with Doctor 1.

²³⁰ Interview with Doctor 1.

²³¹ Interview with Doctor 1.

²³² Interview with Doctor 1.

²³³ Interview with Doctor 1.

²³⁴ Interview with Doctor 1.

²³⁵ Interview with Doctor 1.

wholesale price.²³⁶ Then, hospitals added a 15 per cent markup on the third-tier drug wholesale price as profit margin (See **Diagram 6**).²³⁷ Imported drugs also went through similar drug distribution process.²³⁸ But some drugs would even go through two or three more layers of sub-distributors before reaching hospitals in Shanghai.²³⁹ Hence, the drug retail prices reflected markups charged by hospitals, wholesale pharmaceutical companies and drug manufacturers, which could be many times higher than the manufacturer prices.²⁴⁰ That was why patients who were consumers ended up paying unreasonably expensive drug fees.²⁴¹

Both Doctor 1 and Doctor 2 interviewed said that they were sympathetic about patients' eagerness to save money through self-medication.²⁴² However, they discouraged the practice of self-medication because patients may not have accurate diagnosis for their illnesses that taking drugs without professional advice would only worsen their health status and lead to paying higher treatment charges at last.²⁴³ In fact, the Shanghai Municipal Medical Insurance Bureau had issued the internal guideline which imposed a number of restrictions on doctors, from the number of

²³⁶ Interview with Doctor 1.

²³⁷ Interview with Doctor 1.

²³⁸ Interview with Doctor 1.

²³⁹ Interviews with Doctor 1 and Doctor 2.

²⁴⁰ Interviews with Doctor 1 and Doctor 2.

²⁴¹ Interviews with Doctor 1 and Doctor 2.

²⁴² Interviews with Doctor 1 and Doctor 2.

²⁴³ Interviews with Doctor 1 and Doctor 2.

prescription drugs for each patient, the length of medication for each patient, to the average monthly cost of prescription drugs for each patient.²⁴⁴ Doctors who failed to follow the internal guideline would face financial penalties.²⁴⁵ As Doctor 2 said during the interview, the internal guideline stated that “each prescription should not exceed five medicines” and the length of medication should not exceed three days for emergency prescription, one week for outpatient prescription, and one month for chronic illness prescription.²⁴⁶ The average monthly cost of prescription drugs for each patient varied among different departments at hospitals but the limit set on the Dermatology Department he worked for was RMB 100.²⁴⁷ However, he and his colleagues found it difficult to follow the internal guideline because they inclined to prescribe more drugs to treat some complicated illness or to elderly patients who were inconvenient to walk for saving their travelling time.²⁴⁸ As medical frontline workers, they thought that the penalty policy reduced the medical freedom they deserved and induced pressure to them.²⁴⁹ Meanwhile, Doctor 2 interviewed also said that because of following the internal guideline, he and his colleagues were sometimes complained or even scolded by patients, in particular those BMI participants, for prescribing too

²⁴⁴ Interview with Doctor 2.

²⁴⁵ Interview with Doctor 2.

²⁴⁶ Interview with Doctor 2.

²⁴⁷ Interview with Doctor 2.

²⁴⁸ Interview with Doctor 2.

²⁴⁹ Interview with Doctor 2.

little medicine.²⁵⁰

(5) Pharmaceutical Company Managers

Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2 interviewed thought that although the new BMI System implemented in 2000 provided a few million urban employees in Shanghai with basic insurance coverage, it was unable to reduce the financial burden of insured participants when seeking medical care.²⁵¹ The problem of soaring healthcare expenditures continued to plague Shanghai citizens and raised a serious question about the sustainability of the BMI fund in the long run.²⁵² The problem of soaring healthcare expenditures remained unsolved because the Shanghai municipal government lacked an effective mechanism to fight against collusion among doctors, hospitals, drug manufacturers and pharmaceutical companies, and the disorder of drug distribution channel.²⁵³ As Pharmaceutical Company Manager 2 said during the interview, it was common for drug manufacturers and wholesale pharmaceutical companies to send pharmaceutical representatives to hospitals to meet Pharmaceutical Affairs Committee, which decided what drugs the hospital should purchase.²⁵⁴ The Committee comprised Vice Dean of

²⁵⁰ Interview with Doctor 2.

²⁵¹ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁵² Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁵³ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁵⁴ Interview with Pharmaceutical Company Manager 2.

hospital, Hospital Pharmacy Director, chief physicians from different Units such as Respiratory Unit, Cardiovascular Unit and Orthopedic Unit.²⁵⁵ The legitimate way for the pharmaceutical representatives to promote their drugs was presenting the scientific data of the drugs in terms of clinical safety and efficacy to Pharmaceutical Affairs Committee.²⁵⁶ Private foreign pharmaceutical companies like the ones Pharmaceutical Company Manager 1 and 2 worked for followed the legitimate practice.²⁵⁷ However, drug manufacturers and distributors who faced tremendous pressures to survive in an increasingly competitive environment preferred using unscrupulous means to respectively lure hospitals to purchase and doctors to prescribe certain kinds of drugs.²⁵⁸

Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2 interviewed acknowledged that it was common for drug manufacturers and pharmaceutical companies, especially the state-owned ones, to give Shanghai hospitals and doctors kickbacks, commissions, cash gift or gifts of significant value such as digital products, entertainment, having banquets in five-star hotels and luxury

²⁵⁵ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁵⁶ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁵⁷ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁵⁸ Interview with Pharmaceutical Company Manager 1. After the implementation of economic reforms in the 1980s, the drug manufacturing and wholesale sectors had become highly competitive because of the growth of different kinds of formal enterprises in the pharmaceutical industry, including sole proprietorships, collective enterprises and joint ventures (Bao, 2008, p.79).

vacations in exchange for purchasing and prescribing the companies' products.²⁵⁹

Commissions or kickbacks could range from hundreds of RMB to more than ten thousands of RMB, depending on the type and volume of drugs prescribed by doctors.²⁶⁰ The companies' products usually were new, expensive imported drugs that could not be reimbursed from the BMI.²⁶¹ Pharmaceutical Company Manager 1 interviewed said that kickbacks or other forms of rewards were "dirty", "unethical", "unhealthy" practices which "buried one's conscience" and could not be discussed further during the interview.²⁶² Pharmaceutical Company Manager 2 interviewed said that commission and kickbacks were an irresistible temptation and "a stimulator which drove doctors to prescribe expensive or over-prescribe unnecessary drugs".²⁶³

Soaring healthcare expenditures was the result of the collusion behaviors of doctors, hospitals, drug manufacturers and pharmaceutical companies.²⁶⁴ It deprived citizens' rights of obtaining medicines at reasonable prices.²⁶⁵ In fact, *the Drug Catalogue* which was originally used to inform the BMI participants about which essential medicines could be reimbursed by the BMI became a useful guide to inform doctors, hospitals, drug manufacturers and pharmaceutical companies about which

²⁵⁹ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁶⁰ Interview with Pharmaceutical Company Manager 1.

²⁶¹ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁶² Interview with Pharmaceutical Company Manager 1.

²⁶³ Interview with Pharmaceutical Company Manager 2.

²⁶⁴ Interview with Pharmaceutical Company Manager 2.

²⁶⁵ Interview with Pharmaceutical Company Manager 2.

drugs could hardly make lucrative profits.²⁶⁶ The pecuniary incentives from drug manufacturers and wholesale pharmaceutical companies distorted or switched doctors' prescribing habits.²⁶⁷ In order to generate more revenues for the hospitals, doctors intentionally prescribed new, imported, or expensive drugs that were excluded from *the Drug Catalogue* for reimbursement.²⁶⁸

Besides, the disorder of drug distribution channels led to drug retail prices "being 30 to 40 times higher than the manufacturer prices".²⁶⁹ It raised the question of whether the BMI fund would be sustainable in the long run.²⁷⁰ The mandatory drug price reductions implemented by the Price Bureau in Shanghai failed to hold down drug prices but produced the new problem of inexpensive and effective generic drugs disappearing from the market.²⁷¹ Pharmaceutical companies' rules of survival were "knowing how to play the game and being quick to respond".²⁷² Once the government placed price caps on certain drugs, drug manufacturers would find these price-cut drugs unprofitable to produce while drug distributors and retailers found

²⁶⁶ Interview with Pharmaceutical Company Manager 1.

²⁶⁷ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁶⁸ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁶⁹ Interview with Pharmaceutical Company Manager 2.

²⁷⁰ Interview with Pharmaceutical Company Manager 2.

²⁷¹ Interview with Pharmaceutical Company Manager 1. The Price Bureau in Shanghai followed the instructions of the National Development and Reform Commission mandated by the State Council to implement mandatory drug price reduction. In order to limit the drug retail prices, the Price Bureau in Shanghai set the retail prices of certain approved medications well below the free market prices. The National Development and Reform Commission was the successor of the State Planning Commission, which managed the centrally planned economy of the PRC.

²⁷² Interview with Pharmaceutical Company Manager 2.

these price-cut drugs unprofitable to sell.²⁷³ In order to avoid revenue loss, drug manufacturers would produce lower volumes of price-cut drugs or replace price-cut drugs with expensive substitute drugs which were not affected by the drug price reduction policy.²⁷⁴ Eventually, price-cut drugs would disappear from the market.²⁷⁵ Drug manufacturers would make price-cut drugs become new drugs again by giving them a new name, new packaging, or new dosage so that they could still be sold expensively in the market.²⁷⁶ As to the hospitals and doctors, they would react by prescribing expensive substitute medicines or asking patients to take more unnecessary medical tests in order to compensate for the loss of drug sales revenues.²⁷⁷ At last, patients were still the ones suffering tremendous loss.²⁷⁸

(6) Private Insurance Managers and Director

Private insurance managers interviewed did not like urban health insurance reform because of two main reasons. This first reason was that the implementation of the new BMI System in 2000 and other health insurance schemes afterwards adversely affected the development and growth of commercial health insurance market.²⁷⁹ As

²⁷³ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁷⁴ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁷⁵ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁷⁶ Interview with Pharmaceutical Company Manager 1.

²⁷⁷ Interviews with Pharmaceutical Company Manager 1 and Pharmaceutical Company Manager 2.

²⁷⁸ Interview with Pharmaceutical Company Manager 1.

²⁷⁹ Interviews with Insurance Company Manager 1 and Insurance Company Manager 2. According to Insurance Company Manager 2, following the BMI Scheme, the Shanghai municipal government implemented five insurance schemes which provided partial health insurance coverage to urban,

Insurance Company Manager 1 and 2 said during their interviews, the Shanghai municipal government had provided different segments of population, including urban employees, retirees, individual businessmen and urban residents, with basic medical protection through multi-type health insurance schemes implemented since 2000 and afterwards.²⁸⁰ Most of the BMI participants did not find it necessary to join the individual commercial health insurance scheme because the individual commercial health insurance scheme had limited insurance categories and would unavoidably increase the financial burden of an individual.²⁸¹ Due to the dominant role played by the BMI System in providing insurance coverage for the Shanghai population, the commercial health insurance could only play a supplementary role in Shanghai and have little room to develop and grow in the market.²⁸²

suburban and rural population. These five insurance schemes were: (1) Basic Medical Insurance for Individual Businessmen and Professionals in Shanghai (August 2002), (2) Basic Medical Insurance for Urban Residents in Shanghai (January 2008), (3) Comprehensive Insurance for Migrant Workers in Shanghai (September 2002), (4) Small Town Social Insurance (October 2003), and (5) New Rural Cooperative Medical System (2005). Insurance scheme (1) mainly covered the medical expenses of serious outpatient illnesses and hospitalization for individual businessmen and professionals who were self-employed persons. Insurance scheme (2) was a voluntary scheme covering partial medical expenses of hospitalization for urban residents who paid a lump-sum to join the scheme. Insurance scheme (3) was a compulsory scheme providing migrant workers from other municipalities, autonomous regions and provinces in China with hospitalization insurance. Insurance scheme (4) is a compulsory scheme providing suburban employees and land-deprived peasants with partial medical coverage for serious outpatient illnesses, hospitalization and emergency room stay. Insurance scheme (5) was a subsidized voluntary medical insurance scheme covering the outpatient and inpatient medical expenses of peasants and rural residents. It required every participant to contribute RMB 10. Correspondingly, the local and central government respectively gave subsidies amount to RMB 10 to each participant. The NRCM fund was used to cover 70 per cent to 80 per cent of outpatient medical expenses and inpatient medical expenses below RMB 5,000. It was also used to cover 20 per cent to 30 per cent of inpatient medical expenses above RMB 5,000.

²⁸⁰ Interviews with Insurance Company Manager 1 and Insurance Company Manager 2.

²⁸¹ Interviews with Insurance Company Manager 1 and Insurance Company Manager 2.

²⁸² Interviews with Insurance Company Manager 1 and Insurance Company Manager 2.

The individual commercial health insurance could hardly become a profitable business in Shanghai.²⁸³ The Shanghai municipal government left the low-income groups, the poor, and the unemployed uninsured.²⁸⁴ But these vulnerable groups of people were financially incapable of joining commercial health insurance scheme.²⁸⁵ On the other hand, those who bought individual commercial health insurance were usually less healthy people who saw doctors more often.²⁸⁶ This led to insurance companies setting the premium higher than that of the BMI in order to prevent financial loss.²⁸⁷ As Insurance Company Manager 2 said during the interview, the monthly premium of an individual commercial health insurance could range from few hundred RMB to few thousands of RMB, depending on one's needs and economic ability.²⁸⁸ For example, one of the individual commercial health insurances provided by the health insurance company he worked for required a participant to pay RMB 15,000 as the annual premium and covered VIP and specialist services at hospitals.²⁸⁹ The expensive premiums could hardly attract participants to join the individual commercial health insurance.²⁹⁰ In fact, individual commercial health insurance was usually treated as a rider added to the base plan.²⁹¹ The base plan was usually life

²⁸³ Interviews with Insurance Company Manager 1 and Insurance Director 1.

²⁸⁴ Interview with Insurance Company Manager 2.

²⁸⁵ Interview with Insurance Company Manager 2.

²⁸⁶ Interview with Insurance Company Manager 2.

²⁸⁷ Interview with Insurance Company Manager 2.

²⁸⁸ Interview with Insurance Company Manager 2.

²⁸⁹ Interview with Insurance Company Manager 2.

²⁹⁰ Interview with Insurance Company Manager 2.

²⁹¹ Interviews with Insurance Company Manager 1 and Insurance Director 1. An insurance rider is an

insurance because life insurance was more profitable.²⁹² During the interview, insurance managers and director were unable to provide the statistics about the number of Shanghai population joining commercial health insurance because their companies did not have the record.²⁹³ Nevertheless, the Operating Statistics of Insurance Industry in 2009 showed that only about 6 per cent of premium income came from health insurance while about 69 per cent came from life insurance (Shanghai Bureau of China Insurance Regulatory Commission, 2010) (See **Table 18**). This implied that there were not many participants joining the commercial medical insurance in Shanghai.

The second reason for private insurance managers interviewed disliking urban health insurance reform was the problem of soaring healthcare expenditures remaining unsolved.²⁹⁴ Insurance Company Manager 1 and 2 interviewed complained that the Shanghai municipal government only focused on establishing the BMI System to reduce the moral hazard on the demand side while neglecting the establishment of an effective prevention mechanism to control moral hazard on the

insurance added to the base plan in order to provide the insured with additional insurance coverage that is not covered by the base plan. The insured who buy the base plan can pay extra premium in order to enjoy the coverage provided by the insurance rider.

²⁹² Interviews with Insurance Company Manager 1 and Insurance Director 1.

²⁹³ Interviews with Insurance Company Manager 1, Insurance Company Manager 2, and Insurance Director 1.

²⁹⁴ Interviews with Insurance Company Manager 1, Insurance Company Manager 2, and Insurance Director 1.

supply side.²⁹⁵ The soaring healthcare expenditures caused by the combined force of SID and the disorder of the drug distribution channel seriously hurt the interests of the insurance business and impeded the growth and development of commercial health insurance market.²⁹⁶ As Insurance Manager 2 said during the interview, the profit-seeking behavior of hospitals and doctors was detrimental to the insurance business.²⁹⁷ Doctors who took advantage of asymmetric information induced patients to buy unnecessary and expensive drugs, do unnecessary medical examinations and surgeries, and prolong the length of hospital stays and treatments, leading to a drastic escalation of medical expenses.²⁹⁸ Since patients and doctors were agents of health insurance companies, health insurance companies due to imperfect information were in an inferior position to collect patients' medical information and to supervise doctors who were profit-minded and failed to act in a fully responsible manner.²⁹⁹ Both Insurance Company Manager 1 and 2 interviewed argued that the Shanghai municipal government could have boosted the confidence of private insurance companies in Shanghai by following the insurance industry's suggestion of establishing a constraint mechanism to restrain the profit-seeking behavior of hospitals and doctors.³⁰⁰ However, the Shanghai municipal government refused to establish the constraint

²⁹⁵ Interviews with Insurance Company Manager 1 and Insurance Company Manager 2.

²⁹⁶ Interviews with Insurance Company Manager 1 and Insurance Company Manager 2.

²⁹⁷ Interview with Insurance Company Manager 2.

²⁹⁸ Interview with Insurance Company Manager 2.

²⁹⁹ Interview with Insurance Company Manager 2.

³⁰⁰ Interviews with Insurance Company Manager 1 and Insurance Company Manager 2.

mechanism because it feared that the constraint mechanism established “would hurt the interests of hospitals and doctors who may ask the government for financial support or monetary compensation”.³⁰¹ The insurance industry felt frustrated and disappointed that the Shanghai municipal government gave empty promises about strengthening the development of commercial health insurance.³⁰²

(7) A Government Official

Government Official 1 interviewed thought that the Shanghai municipal government implemented the new BMI System with good intentions because it wanted to provide basic healthcare protection for as many citizens as possible.³⁰³ She also thought that the Shanghai municipal government moved in the right direction by introducing the ideas of social responsibility and social pooling to the BMI System because the BMI System could insure citizens against catastrophic illness.³⁰⁴ In reality, however, she thought that the BMI System could neither provide enough healthcare protection for incumbent employees nor remain sustainable in the long run due to poor institutional design and the lack of a national health insurance or anti-fraud legislation to support the BMI System.³⁰⁵

³⁰¹ Interview with Insurance Director 1.

³⁰² Interviews with Insurance Company Manager 1 and Insurance Director 1.

³⁰³ Interview with Government Official 1.

³⁰⁴ Interview with Government Official 1.

³⁰⁵ Interview with Government Official 1.

For the poor institutional design, Government Official 1 interviewed said that the low contribution rate from urban employees resulted in slow accumulation of money in the individual MSAs that could be used for seeing doctors.³⁰⁶ Based on the principle of “basic healthcare protection, wide population coverage” (*bao ji ben, guang fu gai*), the Shanghai municipal government carefully considered an affordable premium rate for urban employees to make contribution without making the employees feel that the BMI system was a financial burden.³⁰⁷ However, low contribution rate resulted in depleting the individual MSAs easily and quickly.³⁰⁸ More often than not, urban employees had to pay out-of-pocket, especially when the problem of expensive drug fees still existed.³⁰⁹ Another institutional design problem was that the Shanghai municipal government put ‘the old people’ (*jiu ren*) who were retirees and those who still enjoyed free healthcare nowadays and ‘the new people’ (*xin ren*) who were young or incumbent urban employees in the same health insurance pool.³¹⁰ As Government Official 1 said during the interview, it was not an ideal or appropriate practice for the government to mix ‘the old people’ with ‘the new people’ because ‘the old people’ had higher health risk and healthcare expenditures, which

³⁰⁶ Interview with Government Official 1.

³⁰⁷ Interview with Government Official 1.

³⁰⁸ Interview with Government Official 1.

³⁰⁹ Interview with Government Official 1.

³¹⁰ Interview with Government Official 1.

substantially depleted the BMI fund.³¹¹ The Shanghai municipal government guaranteed the retired cadres, old Red Army and disabled military personnel the right of continuously enjoying free healthcare.³¹² But it no longer paid the medical expenses for these special groups of people for fear of bearing any financial burden and increasing work units' and other BMI participants' expectations for the government's financial injection into the BMI fund.³¹³ Without the financial support from the government, the BMI fund had become financially unsustainable and occurred a deficit over the past few years.³¹⁴ Government Official 1 was asked if she could further explain about the BMI fund deficit problem she mentioned because the deficit problem she raised was in contradiction to the record of China Statistical Yearbook, with figures indicating the revenues of the BMI fund being greater than the expenses of the BMI fund from 2002 to 2009 (See Table 19).³¹⁵ But Government

³¹¹ Interview with Government Official 1.

³¹² Interview with Government Official 1.

³¹³ Interview with Government Official 1.

³¹⁴ Interview with Government Official 1.

³¹⁵ During the interview, Government Official 1 was unable to provide the deficit numbers of the BMI fund and said that no one could get the real deficit number because the BMI fund deficit problem was a very sensitive topic. But this study found that the deficit problem of the BMI fund was disclosed by the Shanghai municipal government at the 40th Standing Committee meeting of the 12th Shanghai Municipal People's Congress on November 28 in 2007 (Chen, 2007). During the 40th Standing Committee meeting, the Shanghai municipal government reported that the BMI fund actually had accumulated a deficit of RMB 2 billion over the past five years (Chen, 2007). The figure given by the Shanghai municipal government was in direct contradiction to the record of China Statistical Yearbook. According to China Statistical Yearbook from 2003 to 2008, the revenues of the BMI fund were greater than the expenses of the BMI fund from 2002 to 2007. In 2002, the revenue of the BMI fund was about RMB 9 billion while the expense of the BMI fund was about RMB 7 billion. In 2007, the revenue of the BMI fund was about RMB 27 billion while the expense of the BMI fund was about RMB 23 billion. It showed that China Statistical Yearbook did not release the accurate records of the BMI fund in Shanghai. One explanation for the figures of the BMI fund in Shanghai being overstated in China Statistical Yearbook was that the Shanghai municipal government who discovered the deficit in the BMI fund at the end of every year borrowed money from the Shanghai Municipal Finance Bureau to make up the differences (Chen,

Official 1 interviewed said that the BMI fund deficit problem was “a very sensitive topic” and “a taboo subject” which could not be openly and further discussed.³¹⁶ She only said that the BMI fund deficit problem really existed and had made the BMI participants, especially the young ones, have a dim hope for the usefulness of the BMI System.³¹⁷ She also “felt a sense of powerlessness” because she had no idea when the BMI fund deficit problem could stop before it became irreversible.³¹⁸ However, she was not enthusiastic about the capability of the government to solve the BMI fund deficit problem because the problems of ageing population in Shanghai and the soaring healthcare expenditures continued to worsen the situation.³¹⁹

As Government Official 1 said during the interview, the mandatory drug price reduction policy was ineffective to reduce drug prices because drug manufacturers would react by playing the trick of “putting old wine in a new bottle” in order to escape price controls.³²⁰ The vicious circle of new expensive drugs replacing price-cut drugs continued.³²¹ At the same time, the relationship between the Shanghai

2007). Then, it returned the owed money to the Shanghai Municipal Finance Bureau at the beginning of the second year (Chen, 2007). Hence, it was possible that the loans borrowed from the Shanghai Municipal Finance Bureau were treated as revenues and thus overstated the revenues of the BMI fund in Shanghai. According to Government Official 1, the BMI fund deficit problem continued nowadays although the figures of China Statistical Yearbook showed that the revenues of the BMI fund were still greater than the expenses of the BMI fund in 2008 and 2009.

³¹⁶ Interview with Government Official 1.

³¹⁷ Interview with Government Official 1.

³¹⁸ Interview with Government Official 1.

³¹⁹ Interview with Government Official 1.

³²⁰ Interview with Government Official 1.

³²¹ Interview with Government Official 1.

Municipal Medical Insurance Bureau and the SMHB became tense, with the former being responsible for supervising and administering the operation of the BMI System and the latter responsible for supervising medical service delivery and implementing the municipal essential medicine system at hospitals.³²² It was because the SMHB regarded the financial penalty imposed by the Shanghai Municipal Medical Insurance Bureau on hospitals and doctors for overcharging and over-prescription as interrupting hospital business.³²³ Government Official 1 interviewed foresaw the deterioration of relationship between the Human Resource and Social Security Bureau and the SMHB because the responsibility of imposing financial penalty on hospitals and doctors fell on the Human Resource and Social Security Bureau after the Shanghai Municipal Medical Insurance Bureau was incorporated into the Human Resource and Social Security Bureau in 2009.³²⁴

Apart from the poor institutional design, Government Official 1 interviewed said that the lack of a national health insurance or anti-fraud legislation was another reason why the BMI System could hardly provide enough healthcare protection for

³²² Interview with Government Official 1.

³²³ Interview with Government Official 1.

³²⁴ Interview with Government Official 1. On January 30, 2011, the Shanghai municipal government promulgated *The Procedures of the Shanghai City on Supervising the Administration of the Basic Medical Insurance* through Decree No. 60, which stated that the Human Resource and Social Security Bureau could impose financial penalty ranging from RMB 3,000 to RMB 100,000 on hospitals which overcharged and over-prescribed drug (Shanghai Government Legislative Information Network, 2011). Please refer to Article 16 of *The Procedures of the Shanghai City on Supervising the Administration of the Basic Medical Insurance*.

incumbent employees.³²⁵ She admitted that the poor institutional design had driven citizens and some employers to involve in fraud conspiracy for saving money.³²⁶ While it was common for younger BMI participants to get higher insurance coverage by using the medical insurance certificates of their parents or the elderly, work units reduced or escaped premium contributions by falsifying salary record of the companies.³²⁷ It was undeniable that the fraudulent behaviors would negatively affect the operation of the BMI System and were unfair to participants who fully complied with the insurance payment requirement.³²⁸ However, the Shanghai municipal government found it difficult to plug these loopholes because of the lack of a national health insurance or anti-fraud legislation.³²⁹ Without any health insurance legislation, the Shanghai municipal government found it difficult to detect, investigate and combat fraud activities.³³⁰ As Government Official 1 said during the interview, the operation of the BMI System would be better if a national health insurance legislation could be enacted to increase the government's capacity to identify, report, sanction, and combat fraud.³³¹

³²⁵ Interview with Government Official 1.

³²⁶ Interview with Government Official 1.

³²⁷ Interview with Government Official 1. For example, in 2003, a newspaper report said that after investigation, the Shanghai Medical Insurance Bureau found that the identity of a 75-year-old BMI participant was used to make an unjustified claim about an abortion surgery expenses which cost more than RMB 10,000 (Chen, 2003).

³²⁸ Interview with Government Official 1.

³²⁹ Interview with Government Official 1.

³³⁰ Interview with Government Official 1.

³³¹ Interview with Government Official 1.

(8) Scholars and Researchers

All the professors interviewed argued that urban health insurance reform in Shanghai was a failure.³³² In China, Shanghai was officially recognized by the central government as a success story of health insurance implementation and a role model for other parts of China to follow.³³³ After implementing the BMI Scheme in 2000, the Shanghai municipal government had made continuous efforts for extending insurance coverage to different segments of population through multi-type insurance schemes.³³⁴ By 2008, the Shanghai municipal government had provided 90 per cent of Shanghai population with health insurance coverage that it was praised for achieving the national goal of wide population coverage at the fastest pace.³³⁵ However, the professors interviewed argued that Shanghai only appeared successful on the surface in terms of the number and pace of health insurance schemes was

³³² Interviews with Professor 1, Professor 2, Professor 3, Professor 4, Professor 5, and Professor 6.

³³³ Interviews with Professor 1, Professor 2, and Professor 5.

³³⁴ Interviews with Professor 2, Professor 5, and Professor 6.

³³⁵ Interviews with Professor 2 and Professor 6. According to Shanghai National Economic and Social Development Statistical Report 2008 and the Shanghai Statistical Yearbook 2009, the BMI scheme was the most dominant medical insurance scheme in 2008, with about 4.5 million working participants and about 3.2 million retired participants (Shanghai Municipal Statistics Bureau and National Bureau of Statistics in Shanghai, 2009; Shanghai Municipal Statistics Bureau, 2009). Basic Medical Insurance for Urban Residents in Shanghai had about 2 million participants, Basic Medical Insurance for Individual Businessmen and Professionals in Shanghai having about 166,700 participants, Comprehensive Insurance for Migrant Workers in Shanghai having about 3.8 million participants, Small Town Social Insurance having about 1.5 million participants, and NRCMS having about 1.8 million participants in 2008 (Shanghai Municipal Statistics Bureau and National Bureau of Statistics in Shanghai, 2009; Shanghai Municipal Statistics Bureau, 2009). If adding the number of participants in all the medical insurance schemes together, it showed that about 90 per cent of Shanghai population was covered by medical insurance in 2008. According to Shanghai Statistical Yearbook 2009, the year-end resident population in Shanghai was about 18.8 million in 2008.

implemented.³³⁶ Following the BMI Scheme, all the health insurance schemes implemented afterwards provided less favorable treatment for participants (See Table 20 to 23).³³⁷ Professor 6 interviewed criticized that the whole health insurance system in Shanghai comprising multi-type schemes was very fragmented and “similar to a traditional feudal system that divided people into different classes and ranks”.³³⁸ In particular, the BMI System, which was the first and the most dominant health insurance system implemented in Shanghai, was a symbol of inequality.³³⁹ In fact, a critical look at urban health insurance reform implemented in 2000 showed that the reform revealed more problems than achievements.³⁴⁰ Summarizing the arguments made by the professors interviewed, urban health insurance reform in Shanghai was a failure due to three main reasons: the BMI System being inherently age discriminatory, the government shirking its responsibility for funding healthcare, and the problem of soaring healthcare expenditures remaining unsolved.

³³⁶ Interviews with Professor 1, Professor 2, Professor 3, Professor 4, Professor 5, and Professor 6.

³³⁷ Interviews with Professor 1, Professor 2, and Professor 6. For example, since Comprehensive Insurance for Migrant Workers in Shanghai (September 2002) and Small Town Social Insurance (October 2003) were comprehensive social insurance schemes, the premiums contributed by participants were not solely focused on providing medical insurance. For Comprehensive Insurance for Migrant Workers in Shanghai (September 2002), the premiums contributed were used for industrial injuries, hospitalization and old-age allowance. As to Small Town Social Insurance (October 2003), every contributor paid 24 per cent of the premium base in which 17 per cent was for old-age insurance, five per cent for health insurance, and two per cent for unemployed insurance. Therefore, both insurance schemes provided less favorable health insurance coverage.

³³⁸ Interview with Professor 6.

³³⁹ Interviews with Professor 1 and Professor 6.

³⁴⁰ Interviews with Professor 2 and Professor 6.

Firstly, the BMI System was inherently age discriminatory.³⁴¹ It was a highly stratified system dividing participants into different age groups.³⁴² It let the retirees enjoy higher and better medical coverage than the incumbent employees.³⁴³ As Professor 2 said during the interview, the central government was inclined to favor the elderly when designing the BMI system because most of the elderly “lived a difficult life during Mao’s era and they deserved to share the fruit brought by economic prosperity nowadays”.³⁴⁴ The impact of the Confucian idea of respecting for elders and the virtue of filial piety in taking care of the elderly led to the institutional design of the BMI System favoring the elderly or retirees.³⁴⁵ With limited financial resources, the trade-off of providing the elders or retirees with better and higher medical coverage was the younger insured participants enjoying less medical coverage.³⁴⁶ Therefore, urban health insurance reform was a failure because the reform institutionalized inequalities through the establishment of the BMI System, with the elders enjoying more favorable insurance coverage.³⁴⁷

Secondly, the government shirked its responsibility for funding healthcare.³⁴⁸

³⁴¹ Interviews with Professor 1, Professor 2, Professor 3, Professor 4, Professor 5, and Professor 6.

³⁴² Interviews with Professor 1, Professor 2, Professor 3, Professor 4, Professor 5, and Professor 6.

³⁴³ Interviews with Professor 1, Professor 2, Professor 3, Professor 4, Professor 5, and Professor 6.

³⁴⁴ Interview with Professor 2.

³⁴⁵ Interviews with Professor 2, Professor 6, and Researcher 1.

³⁴⁶ Interview with Professor 2.

³⁴⁷ Interview with Professor 2 and Professor 6.

³⁴⁸ Interviews with Professor 2 and Professor 5.

The BMI System was financed by mandatory contribution from both the work units and their employees without the financial support from the government.³⁴⁹ But it was used for covering the medical expenses of different groups of people, including employees, retirees, and retired cadres, old Red Army and disabled military personnel.³⁵⁰ The BMI fund was inadequate to cover all the medical expenses, especially the expensive medical expenses of retirees and privileged people who still enjoyed free healthcare.³⁵¹ During Mao's era, it was the government's responsibility to pay the medical expenses of retired cadres, old Red Army and disabled military personnel.³⁵² After the implementation of urban health insurance reform in 2000, however, the government shifted this financial responsibility to the incumbent employees and the work units.³⁵³ As Professor 2 said during the interview, the Shanghai municipal government, in accordance with *the 1998 Decree*, gave retired cadres, old Red Army and disabled military personnel the privilege of continuously enjoying free healthcare because these special groups of people were senior CCP members, high-ranking government officials, or prestigious leaders fighting for the country when they were young and showing deep and continuing loyalty to the CCP.³⁵⁴ The government wanted these political elites to know that they were not left

³⁴⁹ Interview with Professor 2.

³⁵⁰ Interview with Professor 2.

³⁵¹ Interviews with Professor 2 and Professor 6.

³⁵² Interview with Professor 2.

³⁵³ Interview with Professor 2.

³⁵⁴ Interview with Professor 2.

out and forgotten by the government.³⁵⁵ The promise made by the government to take care of these special groups of people was “a historical debt the government should pay”.³⁵⁶ However, the government was afraid of bearing the heavy financial burden brought by this promise that it made the incumbent employees and the work units responsible for paying the medical expenses of these special groups of people.³⁵⁷ As a result, the government had put the incumbent employees, especially the younger incumbents, in a very disadvantageous and unequal position because most of the premiums contributed by the incumbent employees and the work units ended up paying the medical expenses of these special groups of people.³⁵⁸ The substantial medical expenses of these special groups of people exhausted the BMI fund quickly.³⁵⁹ Incumbent employees felt insecure and became anxious about the BMI fund being inadequate and unsustainable to finance their healthcare in future.³⁶⁰

Thirdly, the implementation of the BMI System failed to solve the problem of soaring healthcare expenditures.³⁶¹ Since Deng era, the Shanghai municipal government had implemented financial responsibility system, which increased the financial autonomy of medical institutions to charge the medical services they

³⁵⁵ Interview with Professor 2.

³⁵⁶ Interview with Professor 2.

³⁵⁷ Interviews with Professor 2 and Professor 6.

³⁵⁸ Interviews with Professor 1, Professor 2, Professor 5, and Professor 6.

³⁵⁹ Interviews with Professor 2 and Professor 6.

³⁶⁰ Interviews with Professor 2 and Professor 6.

³⁶¹ Interviews with Professor 1, Professor 2, Professor 3, Professor 5, and Professor 6.

provided and the drugs they prescribed at a profit.³⁶² Nowadays, the proportion of government subsidies to hospitals was only about 5 per cent.³⁶³ In order to gain the remaining 95 per cent of revenues on their own, Shanghai hospitals used drug sale as the major source of revenue because the disorder of drug distribution channel caused by the greed of doctors, hospitals, drug manufacturers and pharmaceutical companies provided plenty of room to make a profit.³⁶⁴ In response to soaring drug prices, the Shanghai Municipal Medical Insurance Bureau imposed financial penalty on hospitals and doctors who failed to follow the internal guideline which prohibited over-prescription and overcharging.³⁶⁵ But this penalty policy caused strong discontent from the SMHB.³⁶⁶ The SMHB argued that the Shanghai Municipal Medical Insurance Bureau had no rights to meddle in hospital affairs by instructing what the hospitals and doctors should or should not do.³⁶⁷ The reaction from the SMHB also caused strong discontent from the Shanghai Municipal Medical Insurance Bureau, which complained that the SMHB did nothing to restrain the profit-seeking

³⁶² Interviews with Professor 2, Professor 3, and Professor 5.

³⁶³ Interviews with Professor 2 and Professor 6.

³⁶⁴ Interviews with Professor 1, Professor 3, and Professor 5. According to Zhao (2009), Shanghai hospitals had strong incentives to maximize their revenues from four sources: consultation and treatment services, examination service, hospital material fees (e.g. surgical tools and injection syringe) and drug sales. Drug sales became the largest revenue source for hospitals. For example, the revenue structure of Shanghai No.6 People's Hospital, which was a municipal hospital, showed that drug sales accounted for about 40 per cent of gross income of the hospital in 2008, which was followed by hospital material fees (19.5 per cent), consultation and treatment services (19 per cent), and examination service (17 per cent) (Zhao, 2009). The revenue structure of Shanghai No.6 People's Hospital was revealed by Mr. He Meng Qiao, Dean of Shanghai No. 6 People's Hospital.

³⁶⁵ Interview with Professor 6.

³⁶⁶ Interviews with Professor 2 and Professor 6.

³⁶⁷ Interview with Professor 2.

behavior of hospitals and doctors.³⁶⁸ As Professor 2 and Professor 6 said during their interview, both the bureaux had the same administrative ranking, implying that both had equal footing.³⁶⁹ The financial penalty policy was not effective enough to restrain the profit-maximizing behavior of doctors and hospitals without the coordination of the SMHB.³⁷⁰ In fact, the government did not make enough effort to restrain the revenue-maximizing behavior of hospitals and doctors because the government did not want to increase subsidies to hospitals or make any financial compensation.³⁷¹ As a result, many BMI participants had to pay out-of-pocket because of expensive drug fees.³⁷² Although commercial health insurance could be joined by Shanghai citizens as an alternative to cover their medical expenses, it only played a supplementary role in the health insurance system in Shanghai.³⁷³ The premium rate of commercial health insurance was too high that Shanghai citizens preferred saving money on their own to pay their medical expenses.³⁷⁴ The establishment of the BMI System did not make the Shanghai citizens feel secure and protected, thereby losing its existence value and the meaning of implementing urban health insurance reform.³⁷⁵

³⁶⁸ Interview with Professor 2.

³⁶⁹ Interviews with Professor 2 and Professor 6.

³⁷⁰ Interviews with Professor 2 and Professor 6.

³⁷¹ Interviews with Professor 2, Professor 3, Professor 5, and Professor 6.

³⁷² Interviews with Professor 1, Professor 2, Professor 3, Professor 5, and Professor 6.

³⁷³ Interviews with Professor 1, Professor 3, Researcher 1, and Researcher 2.

³⁷⁴ Interviews with Professor 1, Professor 3, Researcher 1, and Researcher 2.

³⁷⁵ Interviews with Professor 2 and Professor 6.

From the above, it shows that different actors, including former LIS and GHS beneficiaries, BMI participants, non-BMI participants, doctors, pharmaceutical company managers, private insurance managers and director, a government official, scholars and researchers, responded differently to the new urban health insurance reform in Shanghai because of having different interests and expectations. Historical institutionalism emphasizes the role of policy feedback in shaping interest groups and influencing how the public “navigate the social world’s complexities” (Pierson, 1994, p.41). The views of a variety of actors interviewed reflected policy feedback. The old LIS and GHS provided LIS and GHS beneficiaries with free medical benefits. During the interviews, former LIS and GHS beneficiaries who had become BMI participants were against the new health insurance reform because they became responsible for paying their own medical bills. Their views reflected the exposure model of policy feedback that they felt more comfortable with the old free healthcare system. Their views also reflected the experience model of policy feedback that their previous personal experience of enjoying free healthcare made them dislike the new health insurance reform.

Another policy feedback that retirees could enjoy better medical coverage and retired cadres, old Red Army and disabled military personnel could continue to enjoy

free healthcare made BMI participants interviewed feel that the new health insurance scheme was unfair. Also, policy feedback from economic reform that hospitals and doctors could enjoy the autonomy of earning more revenues led to the problem of moral hazard from the supply side. However, without an effective prevention mechanism to control moral hazard on the supply side, BMI participant and non-BMI participants interviewed found that the new health insurance scheme was useless to provide medical protection while private insurance managers complained that their business interests were hurt. Besides, the policy feedback of bureaux having the same administrative ranking led to the Shanghai Medical Insurance Bureau being unable to exert authority over the SMHB that the problem of hospitals and doctors overcharging patients remained unresolved. Although most of the actors interviewed were against the new health insurance reform, they failed to form an impassable barrier to obstruct the implementation of the new contributory health insurance scheme. It was because policy feedback from the authoritative political institutions did not give any veto opportunities for citizens and different stakeholders such as insurers to overturn political decisions or policy results.

6.5 Historical Institutionalism and the Case Study of Shanghai: Findings and Implications

The refined theory of historical institutionalism comprises seven explanatory elements: contextual conditions, ideas, actors, political institutions, timing and sequences, path dependency, and policy feedback. When it is adopted to examine urban health insurance reform in Shanghai, it focuses on how the complex interplay of forces, namely contextual influences, ideas, actors, political institutions, timing and sequences, path dependency, and policy feedback, shaped urban health insurance reform process.

Having looked at urban health insurance reform through the lens of historical institutionalism, this study argues that the case of Shanghai is an example of institutional change in which the Shanghai municipal government successfully implemented health insurance reform in 1998 that the free healthcare system was replaced by a new contributory health insurance system. It argues that the implementation of health insurance reform and big change in healthcare financing policy path was possible because of (1) changes in political and economic contexts, (2) ideological shift from egalitarianism to pro-market policies, (3) policy feedback which accelerated the pace of collapse of free healthcare system, (4) the authoritative political institutions with the strong influence of the CCP and a highly centralized decision-making structure, (5) the dominance of the political leader and key bureaucratic stakeholders from different ministries in the healthcare insurance reform

process, (6) new ideas being championed by the political leader and key bureaucratic actors, and (7) the decentralization power given to the local governments to implement urban health insurance reform. It is the dynamic interplay of these forces enabling the Shanghai municipal government to leverage big change in healthcare financing without any impediments.

Firstly, historical institutionalism argues that changes in contextual conditions, namely political, economic or social context, can generate the sources of institutional and policy changes. In the PRC, the change in the political context due to the rise of Deng Xiaoping as the new political leader since 1978 triggered the change in the economic context when Deng dismissed the ideology of egalitarianism that was embedded in the socialist economy for more than three decades and endorsed the new ideology of marketization to modernize the PRC through implementing the economic reform. Economic reform caused the free healthcare system to malfunction and collapse afterwards and led to the establishment of a new health insurance system to adapt to the changing environments. As Gu (2001a) argued, the drastic changes in the institutional configuration of the economic system in 1978 broke down “the equilibrium present under the planned economy” (p.199), thereby causing tremendous pressure to induce institutional change in the healthcare financing system (Gu, 2001a,

p.199; Gu, 2001c, p.133). The case study of Shanghai verified the second source of institutional dynamism identified by Thelen and Steinmo (1992) that the change in the political or socioeconomic context led to existing institutions performing new tasks because new political actors emerged to pursue new goals through the existing institutions (p.16). It showed that changes in the political and economic contexts created the window of opportunity for changing the policy path of healthcare finance.

Secondly, historical institutionalism argues that policy feedback provides resources and creates incentives that can facilitate, strengthen or inhibit the formation or expansion of stakeholder interests (Pierson, 1994, pp.40-1). In Shanghai, policy feedback from the LIS and GIS created beneficiaries who could enjoy generous medical benefits. However, these beneficiaries lacked the strength and power to form political coalitions against the CCP's health insurance reform because of the authoritative political institution with the strong influence of the CCP.

Besides, policy feedback from the economic reform implemented since 1978 and the LIS and GHS implemented since the early 1950s induced negative feedback effects, thereby undermining the fiscal and social sustainability of the free healthcare system in Shanghai. Policy feedback from fiscal decentralization, the financial

responsibility system and the relaxation of price controls created strong incentives for hospitals and doctors to charge patients substantially greater than the actual cost in Shanghai. It created the problem of moral hazard from the supply side. On the other hand, policy feedback from the LIS and GHS provided generous medical benefits for beneficiaries, leading to the problem of moral hazard from the demand side. Under the economic reform, policy feedback from the enterprise reform imposed greater financial pressure for enterprise units to pay the medical expenses of LIS beneficiaries. But policy feedback from the GHS remained unchanged that the central government was still responsible for financing GHS through the state budget. Policy feedback from the LIS that only allowed employees of SOEs and collective enterprises to enjoy free medical benefits led to employees who were laid off from SOEs and collective enterprises under the economic reform losing their entitlement to the LIS. Also, policy feedback from the LIS that only required SOEs and collective enterprises to provide LIS for their employees exacerbated the problem of employees being ‘underinsured’ and ‘uninsured’ when private enterprises emerged and prospered under the enterprise reform and foreign enterprises under the Open Door Policy did not need to provide LIS for their employees. In brief, policy feedback from the economic reform and the LIS and GHS created many problems that led to the collapse of the free healthcare system in Shanghai and compelled the government to implement urban health

insurance reform.

Thirdly, historical institutionalism argues that political institutions play a determinant role in constraining or facilitating the structure of political opportunities for political actors in a given polity (Hall and Taylor, 1996, p.941; Immergut, 1998, p.21) and shaping their strategies and goals in the decision-making process that in turn shape the political outcomes (Thelen and Steinmo, 1992, p.6; Koelble, 1995, p.236). In the PRC, the authoritative political institutions with the strong influence of the CCP and a highly centralized decision-making structure enabled the central government to implement a nationwide urban health insurance reform in 1998 without any political impediments. The closed policy-making process was only confined to a small circle of senior officials from different ministries. The policy making process involved bargaining among different senior officials. There were competing policy options, conflicting perspectives and conflicting interests among senior officials. As Koelble (1995) and Immergut (1998) argued, the policy formulating process involved bargaining due to divergent institutional position, institutional responsibilities and relationships with others. However, different senior officials in this closed policy-making process would find ways to reconcile their differences and reach a consensus because they knew that the Central Committee was the final

decision-maker. On the other hand, the closed policy-making process did not provide any veto opportunities for non-bureaucratic stakeholders in health insurance reform or interest groups to affect policy proposals or policy results. Stakeholders or interest groups in health insurance reform such as employers/work units, employees, patients, doctors, pharmaceutical companies and insurance companies barely had a chance to exert any political influence. In brief, the centralized political system placed the central government in an advantageous position to implement urban health insurance reform without any political opposition.

Besides, the central government's delegation of power to the local governments increased the autonomy, discretion, efficiency, enthusiasm, flexibility, incentives, initiatives and support of local governments for implementing health insurance reform. The Shanghai municipal government's successful experience in implementing hospitalization insurance scheme in 1996 gained recognition from the central government that its activism and confidence to implement urban health insurance reform was boosted. In 2000, it implemented the BMI System in Shanghai.

Fourthly, historical institutionalism argues that ideas play a role in policy making. The ideological shift from egalitarianism to marketization in the late 1970s

transformed the PRC's economic system from a socialist planned economy to a market economy. Deng's endorsement of the pro-market economic policies also affected the ideas adopted to implement urban health insurance reform. In the PRC, the new ideas of individual MSA, the SPF, co-payment, individual responsibility and social solidarity were championed by the political leader and key bureaucratic actors from different ministries that a new mandatory health insurance system replaced the free healthcare system in Shanghai. These new ideas could achieve political prominence because they fitted into the market-oriented economic context well and were believed to be a solution to the intractable problems of moral hazard from the demand side and rising healthcare expenditures. At the same time, the path-dependent logic also affected the design of the new health insurance model. The practice of excluding the self-employed and having the work units bearing higher contribution rate reflected the institutional legacies of the past that the health insurance benefit was work-unit based and the work units assumed the financial responsibility to pay for employees' medical expenses. Besides, the design of the BMI System showed that the political leader and key bureaucratic actors from different ministries were affected by the Confucian idea of respecting for elders because the new BMI System let retirees who did not have to pay any premium enjoy better medical coverage than incumbent employees. It shows that political actors followed the logic of appropriateness,

established norms, routines, rules of thumbs or existing values when choosing their course of action (Hall and Taylor, 1996, p.939; Oliver and Mossialos, 2005, p.11; Steinmo, 2008, p.126).

As Figueras et al. (1998) argued, the actual implementation of reform programmes is a major challenge faced by policy makers (p.13). The case study of Shanghai shows a big change in the urban health insurance system could take place because of the complex interplay of forces, namely the strong political institutions, policy feedback, contextual influences, and ideological shift. The successful implementation of urban health insurance reform in Shanghai matches the argument of Freeman (2000), who argued that institutional change was a product of the interaction between different forces. As Freeman (2000) argued,

“Change is a product of the interaction between the institutional and procedural routine characteristic of any given health system, and the pressures on that system from its environment...What mattered for the reform of health care was the combination of relative pressure on government, and its relative capacity to do something about it. Change has to do with the relationship between structure and conjuncture: Structures are the institutions and processes that form the infrastructural framework for policy (decisions) within which dynamic events unfold over time. This

may be thought of as an endogenous universe, which then may be subject to exogenous shocks, that is, conjunctures” (p.77).

6.6 Conclusion

To conclude, the Shanghai municipal government had implemented urban health insurance reform since the mid-1980s. It reformed the urban health insurance system through three phases: (1) the exploration phase (1984-1988); (2) the experimental phase (1994-1996); and (3) the implementation phase (1998-2001). It was capable of departing from the established policy path by replacing the free healthcare system with a new contributory health insurance system because of changes in political and economic contexts, ideological shift from egalitarianism to pro-market policies, policy feedback which accelerated the pace of collapse of the free healthcare system, the authoritative political institutions with the strong influence of the CCP and a highly centralized decision-making structure, the dominance of the political leader and key bureaucratic stakeholders from different ministries in the healthcare insurance reform process, new ideas being championed by the political leader and key bureaucratic actors, and the decentralization power given to the local governments to implement urban health insurance reform. It is the dynamic interplay of these forces enabling the Shanghai municipal government to leverage big change in urban health

care financing without any impediments. The next chapter will examine the healthcare system in Hong Kong before 1990.

CHAPTER SEVEN: HONG KONG CASE STUDY: THE HISTORICAL

BACKGROUND

7.1 Introduction

This chapter examines the historical development of healthcare system and the role of the colonial government in healthcare provision in the pre-reform era from 1841 to 1990. It provides important historical context necessary for understanding healthcare financing reform in Hong Kong by showing that the establishment of public health and healthcare systems in Hong Kong were the products of Western presence in the nineteenth century and by looking at the contextual conditions and political institutions in which the healthcare system was embedded in the pre-reform era (1841-1990). It is divided into four sections. Section 7.2 examines the institutions of government, the public health and healthcare systems in Hong Kong in early years (1841-1941). Section 7.3 examines healthcare development in post war years (1945-1990). Section 7.4 discusses how the contextual conditions and political institutions shaped the development trajectory of healthcare in Hong Kong. Section 7.5 gives a conclusion.

An overview of the development trajectory of the healthcare system in Hong

Kong before 1990 shows that during the early colonial period, the colonial government was indifferent to providing healthcare services to its subjects because the prevailing philosophy was that the government should have limited functions and focus on developing the economy of Hong Kong. The expatriate-business alliance which articulated the interests of business elites also discouraged the colonial government from providing healthcare which would increase taxation. Until the Second World War, the colonial government played only a negligible role in healthcare provision. After the Second World War, however, the critical junctures brought by the economic crisis of the inactivity of entrepôt trade in the late 1940s and early 1950s and the political crisis caused by the 1966 and 1967 riots forced the colonial government to change its apathetic attitude towards healthcare provision and provide more healthcare facilities and services. It was obliged to increase its involvement in healthcare provision out of political, economic, and social considerations. In the 1980s, the colonial government established the Hospital Authority (HA) to deflect the complaints from the community about the poor service quality of public hospitals. This further confirmed the role of the colonial government in providing healthcare services for its people. It created a deep impact on healthcare financing reforms in Hong Kong in the following decades.

7.2 Early Years (1841-1941)

Hong Kong was located at the mouth of Pearl River Delta in southern China (Wong and Gui, 2004, p.1). From the period 1841 to 1997, “Hong Kong was a British colony” (Scott, 2010, p.5). It comprised three parts: Hong Kong Island, the Kowloon Peninsula, and the New Territories. Britain acquired Hong Kong Island “as a part of the settlement imposed on China” (Tang, 1998, p.45) after her victory in the First Opium War (1839-1842), the Kowloon Peninsula after her victory in the Second Opium War (1856-1860), and a lease on the New Territories for 99 years during the Scramble for Concessions in 1898 (**See Diagram 7**). On 5 April, 1843, Britain issued the Chartered Letters Patent and the Royal Instructions, which were the conventional legal device declaring Hong Kong as a Crown Colony and establishing the colonial administration in Hong Kong (Collins, 1975, p.46; King, 2003, pp.73-4).

(a) The Institutions of the Government of Hong Kong

The formal governmental structure of Hong Kong was “constructed on the basis of the classical colonial structure” (Harris, 1988, p.27). It was composed of the Governor, the Executive and Legislative Councils, and the Judiciary (Harris, 1988, p.27). The Chartered Letters Patent and the Royal Instructions set out the powers and responsibilities of the Governor, the Executive and Legislative Councils, and the

Judiciary (Collins, 1975, p.46; Harris, 1988, p.4). The Governor was “the single and supreme authority responsible to and representative of the Queen” (King, 2003, p.73) and was “in a real sense the head of the Government [of Hong Kong]” (King, 2003, p.73). He was assisted and advised by the Councils to make laws, appoint and suspend officials, appoint and dismiss judges, exercise the power of pardon of convicted criminals, and make grants of land (Endacott, 1973, p.37; Harris, 1988, pp.84-6; Tsang, 2004, p.19). The Executive Council (Exco) was endowed with the task of advising the Governor in the exercise of his powers (Harris, 1988, p.88; King, 2003, p.74; Tsang, 2004, p.19). The Legislative Council (Legco) “was given the authority to pass local ordinances enforceable in the colony” (Tsang, 2004, p.19). Both the Exco and Legco Councils were not elected bodies (King, 2003, p.74). Both the official and unofficial members in the Councils were appointed by the Governor (King, 2003, p.74; So, 2003, p.474). The Judiciary was “in charge of the administration of justice and [adjudicated] civil disputes as well as criminal cases” (Ho, 2004, p.50). It operated on the principle of complete independence from the Exco and Legco (Harris, 1988, p.103; Ho, 2004, p.50).

The colonial government was strongly centralized to “maintain political control” (Scott, 2010, p.6) and “perpetuate colonial rule” (Scott, 2010, p.5). Consistent with

the centralized government, the civil service was “organized on strongly hierarchical lines” for policy implementation (Scott, 2010, p.6). Government departments developed autonomously from each other and focused on “top-down implementation rather than lateral co-ordination” (Scott, 2010, p.6). Until the Second World War, all the senior positions in the civil service were occupied by British expatriates (So, 2003, p.474; Scott, 2010, p.7). The executive-led principle was dominant during colonial times, assuming leadership by the Governor and civil servants (Lam, 2007, p.10). Under the leadership of the Governor, many major public policy decisions were formulated in-house in the Government Secretariat (Wong, 2007, p.76; Scott, 2010, p.9), which contained within it the Colonial Secretary who was the person “in charge of the civil service” (Scott, 2010, p.70) and the most senior civil servants who were in charge of “the central functions of finance, policy-making and the regulation of the civil service” (Scott, 2010, p.70). After the consultation with the Government Secretariat, the colonial government would issue a green paper which clearly indicated its preferred position on a policy proposal and was sometimes distributed to the public for discussion (Scott, 2010, p.9). A green paper was followed by the issue of a white paper which detailed the government’s chosen plan of action (Scott, 2010, p.9). Then, the policy action plan would go to the Exco for approval and the Legco for passing legislation (Scott, 2010, p.9). This systematic arrangement for policy

formulation and policy implementation showed that the political system of Hong Kong was actually a system dominated only by bureaucrats but no politicians (Wong, 2007, p.76). The absence of politics in Hong Kong led to Hong Kong being described as “an administrative state” (Harris, 1988) with “only administration but no politics” (Wong, 2007, p.76).

The early colonial regime in Hong Kong was not a democratic system because it was “an elite-consensual polity” (King, 2003, p.75). As a colonial regime, the government “suffered from a legitimacy deficit” (Scott, 2010, p.9) and found it difficult to “generate consent for its rule” (Scott, 2010, p.9). In order to make the governing regime legitimate, the colonial government adopted the practice of “administrative absorption of politics” (King, 2003, p.72) that co-opted business and social elites who existed “as a form of patronage” (Harris, 1988, p.32) into the decision-making system in exchange for their loyalty and support for the colonial government (King, 2003, p.72; Scott, 2010, p.298). These elites who were the appointed unofficial members in the Councils were wealthy men (King, 2003, p.74), representatives from the great British *hongs* (commercial establishments) (Harris, 1988, p.50; So, 2003, p.474), Chinese business leaders (Ma, 2007, p.97), and the Chinese elites who came from established rich families (King, 2003, p.74; Ma, 2007,

p.98) or had high reputation and social status (Harris, 1988, p.57). Starting from 1850, the Governor appointed the representatives of the British *hongs* such as Jardine, Swire and Matheson into the Councils (Harris, 1988, p.50; Ma, 2007, p.97; So, 2003, p.474). At the turn of the twentieth century, the Governor appointed the Chinese business leaders and the Chinese elites into the Councils (Ma, 2007, pp.97-8). Through the appointment system, the senior government officials and business elites formed a close expatriate-business alliance (Ma, 2007, p.98; So, 2003, p.474) which guaranteed the monopolistic representation of big business interests in the colonial government (So, 2003, p.474). “Consensus on new policies was sought behind closed doors” (Ma, 2007, p.98) between the Exco, government officials, and the Legco, and most government proposals were rubber-stamped in the Legco (Ma, 2007, p.98). In brief, the elite-consensual polity was a closed decision-making system which legitimized the government’s decisions only by the consensus of elites and only articulated the interests of business elites (Scott, 1989). The colonial administration was cohesive because of a “high degree of political consensus and trust among the ruling elites” (Cheung, 2010, p.40). It only provided a channel for elite-to-elite communication instead of elite-to-mass communication (King, 2003, p.80). The colonial government had little consultation with the mass who “were expected to be grateful recipients of whatever was provided” (Scott, 2010, p.9).

(b) The Public Health and Healthcare Systems in Hong Kong

Regarding Hong Kong as “the borrowed place, the borrowed time” (Wong, 2009, p.137), the colonial government “governed Hong Kong without long-term perspective and vision” (Wong, 2009, p.137). In line with colonial policy elsewhere, the British government expected the colonial government in Hong Kong “to be small and to provide only minimal services” (Scott, 2010, p.6). Scott (1989) called the colonial government “a minimal state” (p.42), with functions limited to “a level compatible with the maintenance of the society” (Scott, 1989, p.42). For much of the history before the Second World War, the colonial government only provided the barest minimum of public services to meet the needs of the people (Tang, 2000, p.114; Gould, 2006, p.18; Scott, 2010, p.6). Its role was primarily to maintain law and order (Tang, 1998, p.46; Tang, 2000, p.114; Scott, 2010, p.6) and “support the growth of a capitalist economy” (Scott, 2010, p.6) through entrepôt trade. It kept a low level of taxation to attract investment (Wong, 2009, p.138) and “encouraged free trade with minimum intervention” (Gould, 2006, p.18). In order to save public expenditure and avoid tax increases (Scott, 1989; Scott, 2010), its role to provide sanitation and healthcare was negligible (Tang, 2000, p.114).

Due to having large swamps and a tropical climate, Hong Kong was a hot-bed of fatal diseases such as fever, diarrhea and dysentery, leading to illness and premature death amongst local Chinese, European traders, officials, and men of the military corps (Jarman, 1996a, pp.7-8; Gauld, 1997, p.24).³⁷⁶ As the colony grew, poor sanitation and “primitive arrangements for water supply, waste disposal and garbage removal” (Gould, 2006, p.19) further deteriorated the health conditions of the people. The colonial government appointed the Colonial Surgeon in 1843 and established the Committee of Public Health in 1844 to develop and enforce sanitary rules and measures among all classes of residents in order to improve sanitation and building standards (Gauld, 1997, p.24; Gauld and Gould, 2002, p.35). In 1883, the colonial government set up the Sanitary Board to deal with the heavy workload of improving public health (Gauld and Gould, 2002; Ho, 2002). However, the sanitary rules and measures brought little improvement in sanitary conditions because of the opposition and resistance from the Chinese people, property owners, tenants and British merchants (Scott, 1989; Gauld, 1997; Gould, 2006; Ma, 2007). The Chinese people regarded the sanitary rules and measures as an unwarranted intrusion which disrupted

³⁷⁶ Edited by R.L. Jarman (1996), *Hong Kong Annual Administration Reports, 1841-1941*, which contained six volumes, is the “collection of administration and other reports [covering] the first 100 years of British rule in Hong Kong” (Jarman, 1996a, p.v). For the first time, it reproduced some of the reports that were never published (Jarman, 1996a, p.vi). In volume 1, it contained a report on Hong Kong written by Governor J.F. Davis in 1844, which talked about how the geological character and climate of Hong Kong led to the sickness and death of military corps and local Chinese. For details, please refer to “Report on the Island Of Hong Kong (Enclosure 1, in No.1)” (Volume 1, pp.5-16).

the Chinese way of life (Scott, 1989, pp.52-3; Gauld, 1997, p.24). Property owners feared that better sanitary standards meant smaller profits while tenants feared that better sanitary standards meant higher rents (Gould, 2006, p.19). British merchants feared that the cost of sanitary improvement would lead to extra tax payment (Ma, 2007, p.99). It was not until the outbreak of bubonic plague which claimed thousands of lives in the mid-1890s did the maintenance of proper sanitary conditions become “an essential element to protect human lives and the economic development” of Hong Kong (Ho, 2002, p.167). In 1935, the colonial government reformed and renamed the Sanitary Board as the Urban Council to further improve the public health of its inhabitants (Scott, 1989, p.53; Ma, 2007, p.99).

The colonial government had little involvement in healthcare provision. In 1843, it appointed the Colonial Surgeon and established the Medical Board to mainly serve the medical needs of government officials and European citizens (Ho, 2002, p.167). In 1850, it established a government hospital to mainly provide medical treatment for the police, civil servants and prisoners and later fee-paying private patients (Scott, 1989, p.50; Gauld, 1997, p.25; Gauld and Gould, 2002, p.39; Ho, 2002, p.169; Gould, 2006, p.19). In 1872, it established the Medical Department to manage the government hospital and “performed health control on board” (Ho, 2002, p.169). Before the

Second World War, the colonial government left the provision of medical services for the general public to market forces (Gould, 2006, p.19) and not-for-profit organizations including “churches, missionaries and Chinese charitable organizations” (Scott, 2010, p.121). There were private hospitals independently operating and being financed outside the colonial government’s direct control (Chu, 1992, p.860). But they must be registered with the colonial government and received a certificate of registration after their accommodations, equipment, and staffing were judged fit for operation (Chu, 1992, p.860). In 1843, the first private hospital was established by private general practitioners to provide Western treatment (Gauld, 1997, p.25; Gauld and Gould, 2002, p.39). There were also government-assisted hospitals, which were private, not-for-profit hospitals receiving “a major portion of their funding through government subventions” (Chu, 1992, p.860). Since they received government subventions, “their financial autonomy over operations [was] virtually non-existent” (Chu, 1992, p.863). In 1872, the Tung Wah hospital sponsored by the colonial government and the local community was established to provide Chinese treatment and later Western treatment free of charge (Scott, 1989, p.51; Sinn, 1989, p.50; Gauld, 1997, p.25).

In brief, the colonial government was reluctant to become involved in healthcare

provision and it left the tasks of building hospitals and offering free medical services to missions and benefactors (Gauld and Gould, 2002, p.39). By the early twentieth century, a ‘tripartite’ hospital system had been established in Hong Kong, with the government hospitals, government-assisted hospitals (including Tung Wah), and private hospitals all providing medical services (Gauld, 1997, p.25; Gauld and Gould, 2002, p.41). More hospitals were established “in accordance with the escalating population” (Gauld and Gould, 2002, p.41). In the 1930s, the colonial government which still had little commitment to healthcare drew up hospital expansion plans to address the problems of “funding, overcrowding and shortfall in provision” (Gould, 2006, p.20). However, its plan was interrupted by the outbreak of the Second World War and the Japanese invasion of Hong Kong in December 1941 (Gauld and Gould, 2002, p.42).

7.3 Post War Years (1945-1990)

The Second World War largely destroyed the economy and infrastructure of Hong Kong (Gauld, 1997, p.26; Tang, 2000, p.116). During the post-war years, the colonial government had the immediate need to rehabilitate the public administration and reestablish entrepôt trade (Hong Kong Government, 1964, p.2). It still had close ties with business elites. It prioritized economic development and strongly supported the

laissez-faire policy which favored a balanced budget and low taxation (Wong, 1999, p.77). Until 1949, the colonial government focused on controlling communicable diseases to maintain healthy conditions for developing entrepôt trade (Wong, 1999, p.77) and had little involvement in healthcare provision. In order to solve the problem of bed and staff shortages at hospitals (Gauld, 1997, p.26; Gauld and Gould, 2002, p.43), the colonial government expediently recruited unregistered doctors on a temporary basis to provide a restricted range of medical treatments and services to patients (Wong, 1999, p.79; Gould, 2006, p.20). Its involvement in healthcare provision was kept to a minimum (Wong, 1999, p.80). However, changes in the geopolitical environment triggered a change in the colonial healthcare policy (Tang, 2000, p.116). On one hand, the CCP coming into power in the PRC in 1949 and the trade embargo imposed on the PRC by the United Nation in 1950 led to a drastic reduction in the entrepôt trade volume in Hong Kong (Wong, 1999, p.81). On the other hand, the influx of mainland refugees and immigrants provided Hong Kong with a large volume of cheap labor, knowledge, skill, capital and technology to successfully restructure itself to manufacturing industry in the 1950s (Wong, 1999, p.81). Realizing the importance in providing a healthy workforce for the expansion of industrializing economy (Wong, 1999, p.87), the colonial government began to provide more hospital facilities and free medical services to its population in the

1960s.

(a) The First Medical White Paper (1964)

In 1964, the colonial government issued the first Medical White Paper entitled *Development of Medical Services in Hong Kong*, which was the first “consolidated and publicly-available document detailing the government’s development plans” (Gauld and Gould, 2002, p.44). In the 1964 Medical White Paper, the colonial government mentioned that a healthy population was an economic asset to Hong Kong (Hong Kong Government, 1964, p.30). It stated the minimal ratios of provision necessary for augmented clinic and hospital services to meet the medical needs of its population (Hong Kong Government, 1964, p.11). Its targets were to provide by 1972 4.25 hospital beds per 1,000 population, one standard urban clinic to about 100,000 urban population, one standard rural clinic to about 50,000 rural population, and one polyclinic for every 500,000 population (Hong Kong Government, 1964, pp.12-26; Hong Kong Government, 1974, p.3). Besides, the colonial government stated that it would provide low cost or free medical services directly or indirectly to the large section of the population which could not afford healthcare (Hong Kong Government, 1964, p.9).³⁷⁷ It stated in the 1964 Medical White Paper that there were respectively

³⁷⁷ The government’s statement of providing low cost or free medical services to the large section of the population which could not afford healthcare also appeared in the *Hong Kong Annual Report 1959* (p.129), *Hong Kong Annual Report 1960* (p.123), *Hong Kong Annual Report 1961* (p.131), and

50 per cent of the community being unable to pay for outpatient charges and 80 per cent of the community being unable to pay for inpatient charges (Hong Kong Government, 1964, p.30). In fact, the colonial government did not intend to provide highly subsidized medical services to the whole community but to those who failed to afford healthcare with their own means (Wong, 1999, p.101). In reality, however, patients “who could afford to go private could go public if they wish” (Wong, 1999, p.102) because means testing all patients involved high administrative costs. In brief, the publication of the 1964 Medical White Paper showed that the colonial government had become more directly involved in healthcare provision.

(b) The Second Medical White Paper (1974)

The colonial government further increased healthcare provision after the outbreak of the 1966 and 1967 riots which shattered its legitimacy. The 1966 riot caused by poor social and working conditions and people’s grievances against the unresponsive colonial government, and the territory-wide and anti-colonial 1967 riot inspired by the Cultural Revolution in the PRC “enabled the government to understand the danger of remoteness with the general public” (Wong, 1999, p.115). In order to strengthen its political legitimacy and enhance social stability (Wong, 1999, p.116), the colonial

Hong Kong Annual Report 1962 (p.138).

government implemented a 'big bang' social policy which led to a "sudden growth of social policy in Hong Kong in the 1970s" (Tang, 1998, p.61). Governor MacLehose drastically expanded the provision of medical and health services, housing, education and social welfare and these four areas became the pillars to support the future well-being of Hong Kong (Tang, 1998, p.63).

In 1974, the colonial government issued the second Medical White Paper entitled *The Further Development of Medical and Health Services in Hong Kong*. The 1974 Medical White Paper was a 10-year medical expansion plan concerning the expansion of the general public health services and the development of additional hospital and clinical facilities for inpatient and outpatient services in order to meet the demands of growing population (Hong Kong Government, 1974, pp.1-2). Its goals were to improve hospital bed ratio to 5.5 beds per 1,000 population, add new specialized units such as a clinical pathology unit and a burns unit at some public hospitals, build up medical and health services in new towns, establish new hospitals and clinics, and establish training schools to produce more doctors, nurses and dentists (Hong Kong Government, 1974). The colonial government stated in the 1974 Medical White Paper that it must take the economic conditions and the availability of fiscal resources into account when achieving its goals (Hong Kong Government, 1974, p.34). It showed

that the colonial government did not unconditionally provide healthcare services (Wong, 1999). Healthcare development was still subordinate to economic development (Wong, 1999, p.125) and relied on the economy for funding.

A booming economy from the mid-1960s to the mid-1980s enabled the colonial government to “pursue a vigorous public hospital and clinic construction programme” (Gould, 2006, p.21). However, the Medical Department, which changed its name to the Medical and Health Department (M&HD) in 1958 (Ho, 2002, p.172), became “increasingly monolithic and unwieldy in terms of management and operations” within an outdated pre-war structure (Gould, 2006, p.21). Despite an increase in the number of hospitals, hospital bed ratio, and medical staff, there was growing dissatisfaction with the public hospital system, “with criticism both from within and from the community (Grant and Yuen, 1998, p.171). Medical staff experienced low morale in and frustration with their working environment due to excessive patient overcrowding, the lack of communication with their supervisors, shortfall of doctors, and the lack of promotion prospects (Scott and Co, 1985, p.8). There were inequalities between government and government-assisted hospitals (Scott and Co, 1985, p.1). Government-assisted hospitals received a lower level of resources, government funding and staff fringe benefits compared with government hospitals (Scott and Co,

1985, pp.3 – 11). The community was discontented with declining service standards due to overcrowding, long waiting times, the lack of consultation times, the shortage of hospital facilities and the use of camp beds (Scott and Co, 1985, p.7; Grant and Yuen, 1998, pp.171-2; Gauld and Gould, 2002, p.57).

(c) *The Scott Report (1985)*

In 1984, the Exco approved a review of hospital management. Believing that an internal inquiry would only lead to the support for the status quo, the Governor appointed “W.D. Scott and Co., an Australian affiliate of accountants Coopers and Lybrand” (Gauld, 1998, p.930) to conduct an independent review of hospital management. In December 1985, W.D. Scott and Co. published the report entitled *The Delivery of Medical Services in Hospitals* (commonly known as *The Scott Report*). It recommended the creation of a statutory HA to supersede M&HD for managing all government and government-assisted hospitals (Scott and Co., 1985, pp.2-3). The HA was independent from the government but largely funded by it and accountable to it (Scott and Co., 1985, pp.2-4). It thought that the HA, being outside the civil service, could lead to more flexible employment arrangements, more effective management, policy implementation and service delivery, and better responsiveness to citizen demands (Scott and Co., 1985, pp.5-9). Late in 1988, a Provisional Hospital Authority

was established to construct a detailed plan for the implementation of *The Scott Report* (Gauld, 1998, p.931). As advocated by *The Scott Report*, in early 1989, M&HD was split into a new Department of Health to take charge of public health functions and a Hospital Services Department being an interim arrangement for managing government and government-assisted hospitals (Gauld, 1998, p.931; Gauld and Gould, 2002, p.65). On December 1, 1990, the HA, a corporate body with complete administrative and financial autonomy, was inaugurated to replace the Hospital Services Department. According to Hospital Authority Ordinance enacted in 1990, the HA should uphold the principle that “no person should be prevented, through lack of means, from obtaining adequate medical treatment” (Hospital Authority Ordinance, section 4(d)). Although legally applied only to the HA, the colonial government “subsequently adopted this as a statement of its overall health care policy” (Gould, 2005, p.180).

Following the establishment of the HA, the operating costs of public hospitals kept increasing because the no-turn away policy and the commitment of the HA to the ongoing expansion and upgrading of facilities and services attracted more patients to the public hospitals (Gauld, 1998, p.932; Gould, 2005, p.190; Gould, 2006, p.22). According to Gauld (1998) and Gould (2006), the HA captured over 90 per cent of

inpatient admissions, with the market share of private hospitals proportionally diminishing. Since the colonial government failed to redefine the extent of its financial responsibility within the healthcare system, it continued to heavily subsidize the HA, which was 98 per cent taxpayer funded (Gauld, 1997, p.33). On the other hand, private hospitals found it increasingly difficult to compete with the HA (Gauld, 1997, p.33). The gap between public and private hospitals was “so large in terms of both the level of supply and prices” (Cheung, 1994, p.354) that there was “virtually little complementarity between the two” (Cheung, 1994, p.354). The two sectors remained rigidly separated from each other (Gould, 2006, p.21).

In fact, the establishment of the HA had created a deep impact on healthcare financing reforms in Hong Kong in the following decades. The more successful the HA was in its service improvement, the more patients were drawn away from the private hospitals (Cheung, 1994, p.361). This left little room for private hospitals for level-field competition (Cheung, 1994, p.361). On the other hand, the colonial government “faced a serious dilemma over health financing (Gauld, 1997, p.34): how to contain health spending and maintain the universally-accessible service without compromising service quality (Gauld, 1997, p.34). With the rapid growth of ageing population, higher user expectations, and rising medical costs, the colonial

government was under growing pressure to implement healthcare financing reform.

7.4 Discussion

Using the theory of historical institutionalism to review the development trajectory of the healthcare system in Hong Kong before 1990 shows that how the interplay of political institutions and critical junctures caused by changes in the contextual conditions shaped the development of healthcare policy in Hong Kong over time. It shows that the political and economic crises became turning points for the colonial government to change its apathetic attitude towards healthcare provision and become more involved in financing and providing healthcare.

As outlined in Chapter Three, historical institutionalism emphasizes that history matters. It takes history or time seriously, specifying sequences, tracing and analyzing processes over substantial stretch of years to explain important political outcomes or real-world puzzles (Pierson and Skocpol, 2002, pp.695-8). History is the contingent product of the interactions of multiple political actors and institutions operating in and influenced by broader political, economic and social contexts over time (Lecours, 2000, p.514; Pierson and Skocpol, 2002, p.706). An overview of the development trajectory of healthcare system in Hong Kong shows that the establishment and

institutionalization of public health and healthcare systems in Hong Kong were the product of Western presence in Hong Kong in the nineteenth century when Hong Kong became the British colony because of British military aggression against China (Tang, 1998, p.45).

As outlined in Chapter Three, historical institutionalism emphasizes that institutions matter. Institutions play a determinant role in distributing power among political actors in a given polity and shaping their strategies and goals in the decision-making process that in turn shape the political outcomes (Thelen and Steinmo, 1992, p.6; Koelble, 1995, p.236). The historical overview of the healthcare system in Hong Kong showed that the political institutions significantly affected the establishment of healthcare system in Hong Kong. The political system of Hong Kong was strongly centralized to maintain political stability, with the civil service being hierarchically organized to implement policies. It was not a democratic system because it only appointed business elites to the Councils and made policy decisions behind closed doors. The colonial government which lacked a popular mandate formed an alliance with the business elites. It endorsed pro-market principles that it favored developing a capitalist economy through free trade and adopting a laissez-faire policy with minimal government intervention and a low level of taxation

(Gauld, 1998; Tang, 1998; Scott, 2010). It had little involvement in healthcare provision in order to save public expenditure and avoid tax increases. It mainly dealt with public health and provided medical services for government officials, European citizens, and prisoners only. Churches, missionaries, charitable organizations, and private practitioners were main healthcare providers and hospital founders that provided free medical treatment for the mass. Before the Second World War, the institutional triad of healthcare providers which included the government, government-assisted, and private hospitals was entrenched (Gauld, 1998, p.929).

Historical institutionalism argues that changes in contextual conditions, namely political, economic or social context, can generate the sources of institutional and policy changes. During the immediate post-war years, the colonial government which prioritized economic development still had minimum involvement in healthcare provision. However, changes in the geopolitical environment triggered the colonial government to reconsider its role in healthcare provision. While the CCP coming into power in the PRC in 1949 led to the inactivity of entrepôt trade, the influx of mainland refugees and immigrants who had knowledge, skill, capital and technology helped transform Hong Kong into a labor-intensive manufacturing economy. In order to reproduce a healthy workforce to facilitate economic growth, the colonial

government was committed to building more hospitals, increasing hospital bed ratios, and providing low cost or free medical services for the population through the issue of the 1964 Medical Paper. As Wong (1999) argued, the colonial government used healthcare service as a form of the social wage to supplement the low private wage earned by the local population (p.133).

The riots of 1966 and 1967 which led to the legitimacy crises triggered the colonial government to further increase more healthcare facilities and services through the issue of the 1974 Medical White Paper. The colonial government used healthcare service as political and social stabilizers. It shows that the critical junctures brought by the economic crisis of the inactivity of entrepôt trade in the late 1940s and early 1950s and the political crisis caused by the 1966 and 1967 riots forced the colonial government to change its apathetic attitude towards healthcare provision and provide more healthcare facilities and services. As Scott (2010) argued, the colonial government became a larger healthcare provider “grudgingly under the pressure of social and political forces that it could not entirely control” (p.121). The colonial government’s greater involvement in healthcare provision due to economic restructure in the 1950s and the political crisis in the late 1960s verified the third source of institutional dynamism identified by Thelen and Steinmo (1992) that changes in

political or economic context led to old actors adopting new goals or strategies within the old institutions (pp.16-7). In brief, the colonial government had involuntarily increased its involvement in healthcare provision out of political, economic, and social considerations.

In the 1980s, the increasing demands for qualitative rather than quantitative improvements in the public hospital system drove the colonial government to establish the HA both as a means of cutting costs and “deflecting complaints about healthcare” (Scott, 2010, p.212). The no-turn away policy and the commitment of the HA to the ongoing upgrading of facilities and services attracted a majority of the population to the public hospitals. It further confirmed the role of the colonial government in providing healthcare services its people. With the rapid growth of ageing population, higher user expectations, and rising medical costs, the colonial government faced a serious dilemma over healthcare financing and was under tremendous pressure to implement healthcare financing reform.

7.5 Conclusion

To conclude, a historical overview of the development trajectory of healthcare in Hong Kong shows that the establishment and institutionalization of public health and

healthcare systems were the products of Western presence in Hong Kong in the nineteenth century when Hong Kong became the British colony in 1841. The colonial regime was indifferent to providing healthcare services to its subjects because the colonial government's endorsement of pro-market principles and the expatriate-business alliance favored economic development and low taxation. Until the Second World War, the colonial government played only a negligible role in healthcare provision. After the Second World War, however, the critical junctures brought by the economic crisis of the inactivity of entrepôt trade in the late 1940s and early 1950s and the political crises caused by the 1966 and 1967 riots forced the colonial government to change its apathetic attitude towards healthcare provision and provide more healthcare facilities and services. It was obliged to increase its involvement in healthcare provision out of political, economic, and social considerations. In the 1980s, the colonial government established the HA to deflect the complaints from the community about the poor service quality of public hospitals. This further confirmed the role of the colonial government in providing healthcare services for its people. It created a deep impact on healthcare financing reforms in Hong Kong in the following decades. The details of healthcare financing reforms will be pursued in the following chapter.

CHAPTER EIGHT: HONG KONG CASE STUDY: HEALTH INSURANCE

REFORMS

8.1 Introduction

This chapter examines healthcare financing reforms in Hong Kong since the early 1990s and explains why the government failed to bring a drastic change in the funding structure of healthcare notwithstanding repeated attempts. It is divided into four sections. Section 8.2 examines the proposed financing options during the transition period (1991-1997) and the reasons for the failure in implementing health insurance reform in 1993. Section 8.3 examines the proposed financing options during the Tung Administration (1997-2005) in the post colonial era and explains why healthcare financing reforms in 1999 and 2000 ended in failure. Section 8.4 examines the proposed financing options during the Tsang Administration (2005 --- present) and the views of different stakeholders, citizens, scholars and the government official on the new regulated voluntary private health insurance scheme proposed in October 2010. Section 8.5 discusses the findings and implications. Section 8.6 gives a conclusion.

The refined theory of historical institutionalism comprises seven explanatory elements: contextual conditions, ideas, actors, political institutions, timing and

sequences, path dependency, and policy feedback. When it is adopted to examine healthcare financing reforms in Hong Kong, it focuses on how the complex interplay of forces, namely contextual influences, ideas, actors, political institutions, timing and sequences, path dependency, and policy feedback, shaped the process of healthcare insurance reform.

Having looked at healthcare financing reforms through the lens of historical institutionalism, this study argues that the case of Hong Kong is an example of path dependency. Hong Kong remains status quo in healthcare financing because the government's repeated attempts to implement healthcare financing reforms faced severe opposition and ended in failure. This study argues that the government failed to implement healthcare financing reform in 1993 because of (1) the political system becoming more democratic and representative, (2) policy feedback from government's previous commitment to healthcare, (3) the old ideas of free healthcare and equality being championed by citizens and legislators, and (4) a robust economy. Besides, it argues that the government failed to implement healthcare financing reforms in 1999 and 2000 because of (1) a disjointed political system, (2) difficult economic circumstances, (3) the new idea of mandatory contributions lacking public and political acceptance, (4) policy feedback from previous healthcare policies and

the mandatory pension scheme, and (5) the institutionalization of old ideas. This study argues that it is the complex interplay of forces at different stages that constrained the government from implementing healthcare financing reforms.

8.2 Transition Period (1991-1997)

As mentioned in the last chapter, after the Second World War, the critical junctures brought by the economic crisis of the inactivity of entrepôt trade in the late 1940s and early 1950s and the political crisis caused by the 1966 and 1967 riots forced the colonial government to change its apathetic attitude towards the provision and finance of healthcare and provide more healthcare facilities and services out of political, economic, and social considerations. The government's decisions to increase its involvement in healthcare during these critical junctures triggered feedback mechanism that reinforced the government's involvement in providing and financing healthcare in future. In the 1980s, the colonial government established the HA to deflect the complaints from the community about the poor service quality of public hospitals. This further confirmed the role of the colonial government in providing and subsidizing healthcare services for its people. However, a rapidly ageing population, higher public expectations for improved medical services, and rising medical costs caused by highly expensive drugs and advanced medical technology began to put

great pressure on the colonial government to reform the financing structure of healthcare (Hong Kong Government, 1993, pp.14-17).

(a) The Proposal for Healthcare Financing Reform

In July 1993, the colonial government published the first consultation document on healthcare financing entitled *Towards Better Health* (commonly known as *The Rainbow Report* because of the design of the cover), which proposed five reform options:

- (1) the percentage subsidy approach which raised charges based on a percentage of the actual operating cost;
- (2) the target group approach which introduced more expensive semi-private beds and itemized charging at public hospitals based on the principle of cost recovery while groups with less ability to pay were granted waiver;
- (3) the coordinated voluntary insurance approach which encouraged the take-up of private health insurance schemes approved by a designated statutory body;
- (4) the compulsory comprehensive insurance approach which required all households in Hong Kong to join a health insurance scheme centrally administered by the government that covered primary and hospital care in

both public and private sectors; and

- (5) the prioritization of treatment approach which focused on treating patients with higher priority conditions (Hong Kong Government, 1993, pp.27-38).

The Rainbow Report stated that the colonial government preferred “a combination of the target group approach and the percentage subsidy approach” (Hong Kong Government, 1993, p.41) and also the introduction of the coordinated voluntary insurance as a framework which facilitated an effective operation of the target group approach and percentage subsidy approach (Hong Kong Government, 1993, p.41). However, the issue of *The Rainbow Report* invoked severe criticisms and dissatisfaction from legislators and the community, leading to the government’s decision to withdraw the proposal and continue to heavily subsidize healthcare services.

(b) Reasons for Failing to Reform the Funding Structure of Healthcare

Having looked at healthcare financing reform in 1993 through the lens of historical institutionalism, this study argues that the government failed to implement healthcare financing reform because of four main reasons: (1) the political system becoming more democratic and representative, (2) policy feedback from government’s previous

commitment to healthcare, (3) the old ideas of free healthcare and equality being championed by citizens and legislators, and (4) a robust economy.

(i) The Political System Becoming More Democratic and Representative

Historical institutionalism argues that political institutions play a determinant role in constraining or facilitating the structure of political opportunities for political actors in a given polity (Hall and Taylor, 1996, p.941; Immergut, 1998, p.21) and shaping their strategies and goals in the decision-making process that in turn shape the political outcomes (Thelen and Steinmo, 1992, p.6; Koelble, 1995, p.236). Before 1985, Hong Kong was an elite-consensual polity in which the colonial government appointed business and social elites in the Exco and Legco and made policy decisions behind closed doors. The political system was not democratic and there was the lack of communication between the colonial government and the general public. However, this closed political system had begun to change since 1985 when political reforms were implemented in Hong Kong. As Professor 1, Professor 2 and the former member of the Public Complaints Committee of the HA said during their interviews, before 1985, the colonial government could easily secure the support from the Exco and the Legco because the appointed business elites in the Councils were proponents of the government's recommended policies rather than opponents of the government's

recommended policies.³⁷⁸ However, the democratization reform implemented since 1985 led to the colonial government losing majority support for its recommended policies, including the proposal for healthcare financing reform in 1993.³⁷⁹

The democratization reform implemented since 1985 warrants a discussion here with the help of literature. The Sino-British Joint Declaration of 1984 which stated that the PRC would resume the exercise of sovereignty over Hong Kong on July 1, 1997³⁸⁰ triggered the implementation of democratization reform in Hong Kong as part of the British decolonization process and changed the political design of the Legco and the Exco (Lam, 2003; Ma, 2007). The introduction of the indirect election of legislators based on functional constituencies which represented business and professional interests in 1985 and the introduction of the direct election of legislators for the first time in 1991 substantially reduced the number of appointed official in the Legco and turned the Legco into a more representative political institution. It also accelerated the formation and growth of political parties (Choy, 1999).

Besides, the arrival of Chris Pattern in 1992 as the new and last Governor further

³⁷⁸ Interviews with Professor 1, Professor 2, and the former member of the Public Complaints Committee of the HA.

³⁷⁹ Interviews with Professor 1, Professor 2, and the former member of the Public Complaints Committee of the HA.

³⁸⁰ For details, the Sino-British Joint Declaration could be found on the website of Constitutional and Mainland Affairs Bureau at <http://www.cmab.gov.hk/en/issues/jd2.htm>.

democratized the political system of Hong Kong by prohibiting members from simultaneously serving on the Exco and Legco in order to avoid conflict of roles and in 1995 abolishing the appointment system in the Legco (Ma and Choy, 2003; Ma, 2007). Appointed members who resigned from the Exco to keep their seats in the Legco were not obligated to support the colonial government thereafter while the appointed Legco members who wanted to gain a seat in future election through direct election would not blindly support the government position in debates (Ma and Choy, 2003, p.290; Ma, 2007, p.105). These measures weakened the capacity of the colonial government in securing majority support in the Legco. As Professor 1, Professor 2 and the former member of the Public Complaints Committee of the HA said during their interviews, on the surface, the colonial government wanted to leave Hong Kong with glory through the implementation of the democratization reform³⁸¹. In reality, however, the democratization reform changed the institutional configuration of the elite-consensual polity into a consultative democracy, leading to the colonial government having a difficult time to secure a guaranteed majority support from the members in the Councils, in particular the Legco.³⁸² Pro-democratic parties which had a landslide victory in the 1991 Legco election put tremendous pressure on the colonial government because democrats who had a strong sense of social

³⁸¹ Interviews with Professor 1, Professor 2, and the former member of the Public Complaints Committee of the HA.

³⁸² Interviews with Professor 1, Professor 2, and the former member of the Public Complaints Committee of the HA.

responsibility did not easily agree with the government.³⁸³ As a result, the Governor spent much time to discuss policy issues with the legislators who gathered and reflected public opinions in the Legco.³⁸⁴

(ii) Policy Feedback, the Endorsement of Old Ideas, and a Robust Economy

Historical institutionalism argues that policy feedback provides resources and creates incentives that can facilitate, strengthen or inhibit the formation or expansion of stakeholder interests (Pierson, 1994, pp.40-1). Besides, it shapes public attitudes towards contemporary public policies (Pierson, 1994, p.45; Gusmano et al., 2002, p.734). Policy feedback from the government's previous commitment to provide free medical services and increase the number of hospitals, clinics and hospital beds since the early 1960s had continuously increased the public acceptance of and demand for the government's involvement in providing and financing healthcare services. Policy feedback from the establishment of a public healthcare system heavily subsidized by taxation generated a strong and wide base of public support because every citizen in Hong Kong could have universal access to free healthcare irrespective of age, sex, income or health status. The ideas of government provision, free healthcare, universal access and equality became deeply entrenched in the public healthcare system that

³⁸³ Interviews with Professor 1, Professor 2, and the former member of the Public Complaints Committee of the HA.

³⁸⁴ Interviews with Professor 1, Professor 2, and the former member of the Public Complaints Committee of the HA.

created framing effects. As Professor 1, Professor 2 and the former member of the Public Complaints Committee of the HA said during their interviews, since the community had the prevailing philosophy that healthcare service was a social welfare and citizen right, they raised strong objections to the five reform options proposed by the government in *The Rainbow Report*.³⁸⁵ The former member of the Public Complaints Committee of the HA interviewed said that although the heavily subsidized medical service was originally a product made by the colonial government out of political and economic calculation, it gradually became deep-rooted in the citizens' mind that free or low cost healthcare service was their rights and the colonial government had the responsibility to provide healthcare service for them.³⁸⁶ Professor 1 interviewed also argued that the establishment of the HA in 1990 further strengthened the view that providing healthcare services for the public was 'a responsibility the colonial government could not shirk'.³⁸⁷

Since the old ideas entrenched in public healthcare system were endorsed by the general public, it led to new ideas lacking public and political acceptance. Besides, a robust economy at that time when new programmatic ideas were proposed to reform the funding structure of healthcare failed to provide a window of opportunity for the

³⁸⁵ Interviews with Professor 1, Professor 2, and the former member of the Public Complaints Committee of the HA.

³⁸⁶ Interview with the former member of the Public Complaints Committee of the HA.

³⁸⁷ Interview with Professor 1.

colonial government to persuade citizens to accept new ideas. Programmatic ideas proposed in the 1993 *Rainbow Report*, such as the target group approach, the percentage subsidy approach and the coordinated voluntary insurance, did not generate wide support but severe criticisms. As Professor 1, Professor 2 and the former member of the Public Complaints Committee of the HA said during their interviews, a robust economy at that time did not justify the request made by the colonial government to implement healthcare financing reform or ask the citizens to share a proportion of their medical expenses through alternative financing options.³⁸⁸

The economic statistics provided by the literature could give a clearer picture about how robust the Hong Kong economy was. Before the hand-over in 1997, Hong Kong had routinely experienced an annual growth respectively in its GDP and the per capita GDP (Lee, 2009, p.9). From 1986 to 1993, the annual growth rate of GDP was about 7 per cent while that of per capita GDP was about 6 per cent (Lee, 2009, pp.34-5). It showed that Hong Kong had a strong economic growth before hand-over and the colonial government was not under any financial pressure necessitating reforming the structure of healthcare finance.

In fact, the arguments of policy feedback, old ideas gaining wide public and

³⁸⁸ Interviews with Professor 1, Professor 2, and the former member of the Public Complaints Committee of the HA.

political acceptance, and the robust economy could be substantiated by the archive of the Legco. The Official Record of Proceedings of the Legco (1993-94) showed that during a motion debate held on October 13, 1993 in the Legco, the majority of the appointed, indirectly elected and directly elected legislators opposed the proposed financing options raised by the colonial government based on seven main arguments which could be summarized as follows:³⁸⁹

(1) Healthcare service was an important social welfare benefit (Hong Kong

Legislative Council, 1994a, pp.170-232);

(2) Healthcare service was a citizen right (Hong Kong Legislative Council,

1994a, pp.170-232);

³⁸⁹ The author got a photocopy of the Official Record of Proceedings of the Legco (1993-94) which contained the motion debate on the proposed financing options of *The Rainbow Report* among legislators during a meeting on October 13, 1993. It recorded the stances and views of legislators on the proposed financing options in detail. In order to summarize the arguments made by legislators about the proposed financing options, the author conducted a content analysis of the Official Record of Proceedings of the Legco (1993-94). She read the Official Record line by line and focused on locating the stances and views of legislators on the proposed financing options. She used a pen to underline the key words, phrases or sentences which represented the views of legislators on the proposed financing options. Besides, she counted how frequently the same argument appeared in the Official Record. In order to categorize the arguments, she gave an alphabet to each of the argument located in the Official Record. For example, she would use “W” to represent the argument of “healthcare service as a social welfare benefit” and “R” to represent the argument of “healthcare service as a citizen right”. If a legislator made the same argument repeatedly in the Official Record, the author would only count the repeated argument as one time only. For example, if a legislator repeated the argument of “healthcare service as a citizen right” twice in the Official Record, the author would only count it as one time only. After the content analysis, the author found that the frequencies of each of the argument made by legislators were as follows: (1) “healthcare service being an important social welfare benefit” appeared 14 times; (2) “healthcare service being a citizen right” appeared two times; (3) “the government using the healthcare financing reform to shirk its (basic) responsibility for healthcare provision” appeared five times; (4) “the government using the healthcare financing reform to back out its commitment to healthcare” appeared seven times; (5) the argument that “the government should uphold its time-honored policy of no one being denied adequate medical treatment through lack of means” appeared four times; (6) “the government grossly overlooking the development of primary healthcare” appeared 10 times; and (7) “the government having a huge surplus under a prosperous economy” appeared four times in the Official Record.

- (3) The government used the healthcare financing reform to shirk its (basic) responsibility for healthcare provision (Hong Kong Legislative Council, 1994a, pp.170-232);
- (4) The government used the healthcare financing reform to back out of its commitment to healthcare (Hong Kong Legislative Council, 1994a, pp.170-232);
- (5) The government should uphold its time-honored policy that “no one should be denied adequate medical treatment through lack of means” (Hong Kong Legislative Council, 1994a, pp.170-232);
- (6) The government incompetently managing the development of primary healthcare was the reason for spiraling healthcare expenditures (Hong Kong Legislative Council, 1994a, pp.170-232).
- (7) The government did not have any financial burden of funding healthcare because it made a huge surplus under a prosperous economy and it had already committed to raise the recurrent spending on healthcare by 22 per cent in real terms from 1992 to 1997 (Hong Kong Legislative Council, 1994a, pp.170-232).

During the motion debate, the legislators gathered and reflected public opinions

about the proposed financing options in the Legco by conducting opinion polls. The results of the public opinions conducted by different legislators showed a consistent result that the majority of citizens surveyed were against the proposed financing options and thought that healthcare service was a welfare service. According to the Official Record of Proceedings of the Legco (1993-94), an opinion poll conducted by the United Democrats of Hong Kong (UDHK)³⁹⁰ showed that among the 1,337 questionnaires returned, 90 per cent of the respondents were against the cost-pegged charging system proposed in *The Rainbow Report* and over 90 per cent of the respondents were against the proposal of itemized charging (Hong Kong Legislative Council, 1994a, p.194). Besides, it showed that an overwhelming 97 per cent regarded public medical service as a welfare service which should be provided by the government (Hong Kong Legislative Council, 1994a, p.194). Another opinion poll conducted by the directly elected legislator Mr. James To in September 1993 showed that among the 500 questionnaires returned, 95 per cent of the respondents disagreed with the government's proposal of itemized charging while 89 per cent disagreed with the cost-pegged charging system (Hong Kong Legislative Council, 1994a, p.212). Besides, it showed that 98 per cent of respondents regarded public medical service as a welfare service which should be provided by the government (Hong Kong

³⁹⁰ The United Democrats of Hong Kong (UDHK) was merged with another pro-democracy party called the Meeting Point to form the Democratic Party in 1995.

Legislative Council, 1994a, p.212). The Official Record of Proceedings of the Legco (1993-94) showed that both the legislators and the community strongly opposed the healthcare financing reform.

In fact, motion debates in the Legco did not have any binding power on the colonial government but provided legislators with a chance to express their views and create public pressure (Ma, 2002, p.360). Nevertheless, motion debates received widespread media coverage shortly after the direct election in the Legco in 1991 and created considerable political impact for the government (Ma, 2002, p.360). As the Secretary for Health and Welfare said during the Legco meeting, change to the healthcare financing system, “in order to take root, must have the support of the community” (Hong Kong Legislative Council, 1994a, p.227). But the colonial government failed to receive positive feedback during the consultation period. At last, the Secretary for Health and Welfare announced at the end of the consultation period that the colonial government would not implement the healthcare financing reform due to “public opposition and fear of public misunderstanding” (Hong Kong Legislative Council, 1994b, p.3235) and that “the status quo should be remained” (Legislative Council Secretariat, 2005a, p.1). Policy feedback from the democratization reform reduced the colonial government’s capacity of securing

majority support for its recommended policies while providing a chance for the views of the public being channeled into the Legco through the elected legislators. The government's previous commitment to healthcare produced a lock-in effect that reduced the government's capacity of implementing healthcare financing reform. As Professor 1, Professor 2, and the former member of the Public Complaints Committee of the HA said during their interviews, the Governor did not dare to implement any healthcare financing reform in 1993 when facing opposition from legislators and the community because he was the one who wanted to promote a more open and representative government in Hong Kong.³⁹¹ It was important for him to avoid confrontation with the legislators and the public during the political transition period.³⁹² Since the Governor Chris Pattern always talked about adherence to the principles of "openness, fairness and acceptability to the public" (Hong Kong Legislative Council, 1994a, p.175), he could not disregard the criticisms and oppositions of legislators and the community by changing the financing structure of healthcare. Hence, the implementation of healthcare financing reform became an issue leaving for the post-colonial government to deal with.

In sum, the colonial government failed to bring any structural change in

³⁹¹ Interviews with Professor 1, Professor 2, and the former member of the Public Complaints Committee of the HA.

³⁹² Interviews with Professor 1, Professor 2, and the former member of the Public Complaints Committee of the HA.

healthcare financing through the public consultation of *The Rainbow Report* in 1993 because of the complex interplay of forces, namely the political system becoming more democratic and representative, policy feedback from government's previous commitment to healthcare, the old ideas of free healthcare and equality being championed by citizens and legislators, and a robust economy.

Since 1985, the political system of Hong Kong became more democratic and representative because of the introduction of the democratization reform triggered by the Sino-British Joint Declaration of 1984. The introduction of the indirect and direct election into the Legco substantially reduced the number of appointed officials in the Legco and made the Legco become a more representative political institution. The change of political leadership to the new Governor Chris Patten further democratized the political system of Hong Kong by prohibiting members from simultaneously serving on the Exco and Legco and abolishing the appointment system in the Legco. Members in the Councils who had electoral consideration and wanted to win votes in future elections would not easily support the colonial government. The change in the institutional configuration from the elite-consensual polity to a consultative democracy unavoidably weakened the capacity of the colonial government in securing majority support in the Legco. It increased the difficulties of the colonial government

in implementing healthcare financing reform because it had to be responsive to the Legco.

Besides, policy feedback from government's previous commitment to healthcare strengthened the role of the colonial government in providing and financing healthcare. New financing options proposed in *The Rainbow Report* generated public discontent because the principle of cost recovery that asked citizens to pay more went against the thought of citizens that healthcare service was a welfare benefit and right. These financing options also went against public expectation that the colonial government should be committed to the finance and provision of healthcare services. Also, a buoyant economy at that time showed that the financial sustainability of healthcare system was not a question at all because the colonial government enjoyed large surplus. With strong economic growth, the colonial government found it difficult to convince the citizens to pay more for their medical expenses. Citizens regarded the proposed financing options as an excuse for the government to shirk its responsibility of paying the healthcare expenditures. Therefore, they did not support the government's proposal and favored the maintenance of the status quo. At last, the colonial government's effort to implement healthcare financing reform in 1993 ended in failure.

8.3 The Tung Chee-hwa Administration (1997 - 2005)

After returning to the Chinese rule on July 1, 1997, Hong Kong became the HKSAR under the concept of “one country, two systems” (Lee, 2009, p.162). The Basic Law, which was the constitutional instrument for the HKSAR, laid down the general framework of governance that was similar to that of the colonial governance: a high degree of autonomy, executive-led government, a capitalist way of life, a balanced budget, a low tax policy, and the protection of individual rights and freedoms.³⁹³

The formal governmental structure and functions of the HKSAR was similar to that of colonial administration, with the Chief Executive replacing the Governor at the apex of the structure (Scott, 2010, p.71). The Exco, the Legco, and the civil service were still the key actors or institutions in the political system. Since 1997, the executive-led principle had remained dominant in the HKSAR (Lam, 2007, p.10). The Exco was composed of the Chief Executive, the Principal Officials and non-official members (Burns, 2004). The work of the Chief Executive was supported by the Principal Officials who were responsible for policy formulation and supervision of

³⁹³ The Basic Law was promulgated by the PRC in 1990 and came into effect on July 1, 1997 when Hong Kong was returned to the PRC. It stipulated that under the principle of “one country, two systems”, the socialist system and policies would not be practiced in the HKSAR. The full text of the Basic Law could be found at <http://www.basiclaw.gov.hk/en/index/>.

subordinate departments within their portfolios (Li, 2007, p.25). Principal Officials that included three senior secretaries (The Chief Secretary for Administration, the Financial Secretary, and the Secretary for Justice) and 11 bureau secretaries were held by senior civil servants until 2002 when the Principle Officials Accountability System (POAS) was introduced to “enhance the accountability of the Principal Officials for policy failures” (Scott, 2010, p.52) and enable the Chief Executive to form his/her own governing team “without the restriction of having to choose from inside the civil service” (Li, 2007, p.24). Since 2002, Principal Officials had been held by non-civil service political appointees on contract and “could be dismissed by the Chief Executive” (Scott, 2010, p.13). Since 1997, the government had remained highly centralized with a hierarchically-organized civil service (Scott, 2010). The Chief Secretary for Administration was the successor of the Colonial Secretary and became the head of the civil service (Scott, 2010, p.71). The civil service was divided into 16 policy bureaux headed by a senior civil servant, which formulated policy that the departments below them were responsible for implementation (Scott, 2010).

(a) The Proposals for Healthcare Financing Reform

Tung Chee-hwa was the first Chief Executive of the HKSAR government. During Tung’s first term of office, the HKSAR government released two consultation

documents on healthcare financing in 1999 and 2000. However, both consultation documents were shelved due to widespread criticisms from the legislators and stiff resistance from the public. In November 1997, the HKSAR government commissioned a team of economists, public health specialists, physicians and epidemiologists from Harvard University, which was led by Professor William Hsiao and Professor Winnie Yip, to conduct a study on the current healthcare system and recommend reform options to improve healthcare financing in Hong Kong. The decision of using overseas experts, as illustrated later in this section, was due to Tung lacking his own team of policy advisors and his distrust of the civil service.

In April 1999, the Harvard Team completed the study with the release of a public consultation report entitled *Improving Hong Kong's Health Care System: Why and For Whom?* (hereafter *The Harvard Report*) (Health and Welfare Bureau, 2000, p.2). The HK\$7 million *Harvard Report* found that the current healthcare system in Hong Kong suffered from three inter-related weaknesses, which included the compartmentalized healthcare system, the variable quality of healthcare, and the questionable long-term financial sustainability (The Harvard Team, 1999, pp.52-82). In order to improve healthcare financing in Hong Kong, the Harvard Team presented five reform options in *The Harvard Report*:

- (1) maintaining the status quo;
- (2) capping the government budget for healthcare;
- (3) raising user fees at public hospitals and clinics;
- (4) implementing Health Security Plan (HSP) and Saving Accounts for Long Term Care (MEDISAGE), a two-tier mandatory health insurance scheme which required both employers and employees to jointly contribute about 1.5 to 2 per cent of employees' wages to HSP for paying inpatient and outpatient medical expenses, and 1 per cent of employees' wages to MEDISAGE for purchasing long-term care insurance at age of 65. The concept of "money follows the patient" was introduced by establishing the Health Security Fund, Inc. to pay a standard payment rate to public or private healthcare provider chosen by a patient (The Harvard Team, 1999, p.13); and
- (5) competitive integrated system which adopted the HSP and MEDISAGE option and reorganized the HA into 12 to 18 regional Health Integrated Systems for providing preventive, primary, outpatient and hospital care (The Harvard Team, 1999, pp.92-112).

After evaluating five reform options (**See Table 24**), the Harvard Team recommended

that the HKSAR government adopt the HSP and MEDISAGE first, which could pave the way for implementing competitive integrated system in the long run (The Harvard Team, 1999, p116). However, *The Harvard Report* was shelved due to public resentment.

In December 2000, the HKSAR government produced its own version of healthcare financing reform in a public consultation document entitled *Life Long Investment in Health* (hereafter *The Life Long Investment document*), which proposed a mandatory medical savings scheme by establishing Health Protection Accounts (HPA). The mandatory medical savings scheme required every individual aged 40 to 64 to contribute 1 to 2 per cent of his/her earnings to a personal account that cover the future medical and dental expenses of both the individual and his/her spouse when the individual reached the age of 65 (Health and Welfare Bureau, 2000, p.57). An individual would only be reimbursed at the public sector rates if he/she sought medical treatment at the private sector and needed to meet the price difference either from his/her own means or “from the entitlement of private insurance” (Health and Welfare Bureau, 2000, p.57). However, *The Life Long Investment document* was shelved due to public resentment. As a result, the Tung administration failed to reform the funding structure of healthcare and the status quo was maintained.

(b) Reasons for Failing to Reform the Funding Structure of Healthcare

Having looked at healthcare financing reform in 1999 and 2000 through the lens of historical institutionalism, this study argues that the HKSAR government failed to implement healthcare financing reforms because of five reasons: (1) a disjointed political system, (2) difficult economic circumstances,³⁹⁴ (3) the new idea of mandatory contributions lacking public and political acceptance, (4) policy feedback from previous healthcare policies and the mandatory pension scheme, and (5) the institutionalization of old ideas. It shows that the complex interplay of these forces constraining the government from implementing healthcare financing reforms.

(i) A Disjointed Political System

Historical institutionalism argues that political institutions play a determinant role in constraining or facilitating the structure of political opportunities for political actors in a given polity (Hall and Taylor, 1996, p.941; Immergut, 1998, p.21) and shaping their strategies and goals in the decision-making process that in turn shape the political outcomes (Thelen and Steinmo, 1992, p.6; Koelble, 1995, p.236). While a cohesive

³⁹⁴ Whilst Hong Kong economy has been generally successful, there have been episodes of economic problems --- in this case, the local impact of 1997 Asian Financial Crisis. To know more about 1997 Asian Financial Crisis, please see Pak Wai Lui (1998), *The Asian Financial Crisis and After Problems and Challenges for the Hong Kong Economy*. Hong Kong: Hong Kong Institute of Asian Pacific Studies; Y.C. Jao (2001), *The Asian Financial Crisis and Ordeal of Hong Kong*. Westport, Conn: Quorum Books.

political system facilitates policy implementation, a disjointed political system acts as an impediment to gather political support, reach a consensus on policy decisions and implement policies. In Hong Kong, the continuation of the mode of executive-led and bureaucracy-based governance became unsustainable after the 1997 handover (Eliza, 1999, p.943-4; Cheung, 2007a, p.52-3; Cheung, 2007b, p.22; Cheung, 2010, p.40). It was because the political institutions, actors occupying that inherited political institutions, their thinking and interests, and the policy environment had undergone significant changes (Cheung, 2007a, p.52-3; Cheung, 2010, p.40). A disjointed political system after the 1997 handover became an impassable barrier to implement healthcare financing reforms. The disjointed political system was attributed to policy feedback from the democratization reform implemented in the final years of the colonial rule on one hand, and the fracture and disharmony within the Exco since the post-handover era on the other hand. Two consequent implications of the democratization reform were that the Tung administration suffered the legitimacy crisis when facing a more representative Legco and the Exco-Legco relationship became very tense when the Exco was delinked from the Legco. Besides, the Chief Executive's distrust of the civil service and his paternalistic attitude towards the civil service led to his poor working relationship with the civil service and disunity within the Exco. The political system became disjointed in the post-handover era, causing a

series of policy blunders and failures, including the implementation of healthcare financing reforms.

The legitimacy deficit and the tense Exco-Legco relationship caused by policy feedback from the implementation of democratization reform warrants a detailed discussion here with the help of interviewing data and literature. During their interviews, Professor 1, the former Legco member 1, Civil Servant 2, and the former member of the Public Complaints Committee of the HA shared the view that there had been the lack of institutional collaboration in the executive-led political system since the post-colonial era.³⁹⁵ It was obvious to see that the HKSAR government suffered legitimacy crisis and the Exco had a tense relationship with the Legco.³⁹⁶ Like the colonial administration, the Tung administration suffered from a legitimacy deficit because both the Chief Executive and the Exco lacked an electoral mandate.³⁹⁷ While the Chief Executive was elected by a Selection Committee dominated by 400 business and pro-China elites, members in the Exco were appointed by the Chief Executive. “The small circle election of the Chief Executive”³⁹⁸ and the pro-business and pro-Beijing image of Tung administration limited the capacity of the HKSAR

³⁹⁵ Interviews with Professor 1, the former Legco member 1, Civil Servant 2, and the former member of the Public Complaints Committee of the HA.

³⁹⁶ Interviews with Professor 1, the former Legco member 1, Civil Servant 2, and the former member of the Public Complaints Committee of the HA.

³⁹⁷ Interviews with Professor 1, the former Legco member 1, Civil Servant 2, and the former member of the Public Complaints Committee of the HA.

³⁹⁸ Interviews with the former Legco member 1 and Civil Servant 2.

government to secure majority support from citizens who had a deep distrust of Beijing and anti-communist sentiments (Lau, 2002b).

On the other hand, the Legco obtained legitimacy and electoral mandate because legislators were elected by voters. As the former Legco member 1 said during the interview, as a representative political institution, the Legco had popular mandate to oppose the government's healthcare financing proposals, which made the HKSAR government unable to take any action except abandoning its proposals.³⁹⁹ In the Legco, there were 18 panels that roughly corresponded to the policy bureaux of the HKSAR government (Ma, 2002, p.359). The panels did not have the veto power to block the government's proposals, but the power of appropriation and legislation obtained by the Legco gave the panels' opinions more weight (Ma, 2002, p.359). The Panel on Health Services monitored and examined government's healthcare policies, and provided a forum for legislators to exchange and express their views on healthcare policies (The Legislative Council, 2011). It also gave legislators a venue to question government officials in charge of healthcare policies face-to-face and "push for policy change" (Ma, 2002, p.359). The Panel on Health Services was where the meeting and debate on healthcare financing reform took place.

³⁹⁹ Interview with the former Legco member 1.

The legitimacy crisis suffered by the Tung administration had already made it hard to secure support for its policy implementation. What made the problem worse was the tense relationship between the Exco and the Legco. The colonial legacy of separating the Exco membership from the Legco membership in 1993 led to the disjunction between the work of the two Councils (Scott, 2000, p.40). Before 1993, the colonial government could largely rely on the support of the members who simultaneously served the two Councils to help government's policies cruise through the Legco (Ma and Choy, 2003, p.289). With the de-linking of the Exco and Legco, the Legco had the right to challenge the Exco and to "bring requests for policy changes to its notice" (Scott, 2000, p.44). When it came to the post-handover era, the situation was that government officials and the heads of policy bureaux were left to present a lengthy defence of their reform proposals and became targets of anger and criticism in the Legco. As the former Legco member 1, Civil Servant 2 and Civil Servant 3 said during their interviews, the Exco-Legco relationship had become tense since the post-handover period because members of the Exco thought that members of the Legco always played the opposition role and were being too critical of government's policies in order to gain more votes in future elections.⁴⁰⁰ On the other

⁴⁰⁰ Interviews with the former Legco member 1, Civil Servant 2, and Civil Servant 3.

hand, the Legco members thought that they had the responsibility to channel citizens' voice into the Legco, especially when the HKSAR government chose to do things in its own way that its proposed reform options and policies did not truly reflect the expressed wishes and needs of citizens.⁴⁰¹ In fact, even the pro-government and pro-Beijing political party, the Democratic Alliance for the Betterment of Hong Kong (DAB), and the government-friendly and pro-business political party, the Liberal Party, failed to give reliable support to the HKSAR government in the Legco when it came to the issue of healthcare financing. Since the post-handover period, the Democratic Party, the DAB, and the Liberal Party became three dominant political parties that exhibited "divergent views on the politics of Hong Kong" (Lam, 2003, p.225). However, on issues of healthcare, the DAB actually shared the pro-grassroots position with the Democratic Party (Ma, 2007, p.106) while the Liberal Party adopted a pro-business position that represented the voices of employers. These political parties, as illustrated below, did not support the healthcare financing options proposed by the government but put pressure on the government. As a result, the tense Exco-Legco relationship was detrimental to implement healthcare financing reform.

The legitimacy deficit suffered by the Tung Administration and the tense

⁴⁰¹ Interviews with the former Legco member 1, Civil Servant 2, and Civil Servant 3.

Exco-Legco relationship had already disarticulated the political system of Hong Kong. What further worsened the disjointed political system was the disunity within the Exco. The disunity within the Exco was attributed to the Chief Executive's distrust of the civil service on one hand, and his paternalistic attitude towards the civil service on the other hand. As illustrated below, the fracture and disharmony within the Exco became an impediment to hold the members together for countering oppositional forces from the Legco and the community when implementing healthcare financing reforms. The Chief Executive's distrust of the civil service led to his poor working relationship with the civil service. As Civil Servant 2 said during the interview, Tung thought that the civil service which served the colonial administration was not a loyal partner to him.⁴⁰² His reluctance to listen to the advice of senior civil servants when formulating policies and his paternalistic attitude that required the civil service to follow what he said showed a lack of respect for the civil service.⁴⁰³ In fact, most of the Principal Officials in the Tung administration were principal officials of Governor Patten (Lau, 2002b, p.12). The retention of these former colonial officials was a move to maintain public confidence in the future of Hong Kong because their track record of administrative performance could gain public trust (Lau, 2002b, p.12). However, these senior civil servants' perception that they played a leadership role in

⁴⁰² Interview with Civil Servant 2.

⁴⁰³ Interview with Civil Servant 2.

policy-making went against the Chief Executive's perception that civil servants should be subordinate to a political master (Lee, 1999, pp.947-8). The Chief Executive's attitude to compete with the civil service for taking policy initiatives led to both parties having difficulties in working with one another (Lee, 1999, p.948).

Being a shipping tycoon, Tung was a political newcomer and an outsider of the civil service. He had "limited political experience before his political ascendancy" (Lau, 2002b, p.10). He failed to have "a preexisting network of political allies to assist him" (Lau, 2002b, p.10) and support him in policy making. Therefore, what he could do was becoming a political loner who created a grand policy agenda that ended up achieving little (Lau, 2002a, p.ix) or finding policy advisors outside the civil service for analyses. In fact, Tung's decision to commission the Harvard Team to recommend reform options for improving healthcare finance was due to his distrust of the civil service and lacking his own team of policy advisors on healthcare. As Professor 1 said during the interview, Tung's decision to hire the Harvard Team was due to his belief that the Team headed by a senior health economist who had experience in reforming healthcare systems of other countries represented authority.⁴⁰⁴ Besides, Tung believed that "the fame and reputation of the Harvard University could easily win public

⁴⁰⁴ Interview with Professor 1.

acceptance”.⁴⁰⁵ Nevertheless, Tung failed to understand the political reality that healthcare financing reform was not as simple as what he thought because it involved lots of vested interests.⁴⁰⁶

In fact, implementing healthcare financing reform was part of Tung’s project to depoliticize Hong Kong. “Tung’s political conservatism and the objection of Beijing” (Lau, 2002b, p.4) made further democratization in Hong Kong impossible. By deliberately focusing on economic and social issues such as healthcare financing reform, the Tung administration attempted to “draw people’s attention away from political issues” (Lau, 2002b, p.8) and establish its political legitimacy by producing satisfactory policy outputs (Lee, 1999; Lau, 2002b). However, it ignored the political reality that social issues such as healthcare financing reform only escalated politicization. As Professor 1, the former Legco member 1, Social Worker 1, and Doctor 2 said during their interviews, the rise of political parties, pressure groups and civil societies stimulated by the democratization process since the early 1990s and extensive media coverage heightened the political awareness of the community.⁴⁰⁷

Political parties, pressure groups and civil societies had been active and vibrant to

⁴⁰⁵ Interview with Professor 1.

⁴⁰⁶ Interviews with Professor 1 and Civil Servant 4.

⁴⁰⁷ Interviews with Professor 1, the former Legco member 1, Social Worker 1, and Doctor 2.

influence the government policies related to their interests.⁴⁰⁸ Apart from channeling citizens' voices through the Legco, political parties mobilized the mass to take collective action such as demonstrations to express public grievances.⁴⁰⁹ On the other hand, pressure groups and civil societies actively worked outside the formal political institutions to press for policy changes while extensive media coverage of healthcare financing reform formulated public opinions.⁴¹⁰ Since healthcare financing reforms touched upon vested interests embedded in the healthcare system, it unavoidably provoked a public outcry and created discontent against the HKSAR government. It meant that healthcare financing reform as a de-politicization project of the Tung administration actually became a political issue because of the rise of political parties, pressure groups and civil societies and extensive media coverage.

(ii) The Difficult Economic Circumstances and Policy Feedback

Historical institutionalism argues that changes in contextual conditions, namely political, economic or social context, can generate the sources of institutional and policy changes. Contextual changes created a window of opportunity for political actors to adopt new goals or strategies. In Hong Kong, the government respectively proposed the mandatory health insurance scheme in 1999 and the mandatory medical

⁴⁰⁸ Interviews with Professor 1, the former Legco member 1, Social Worker 1, and Doctor 2.

⁴⁰⁹ Interviews with Professor 1, the former Legco member 1, Social Worker 1, and Doctor 2.

⁴¹⁰ Interviews with Professor 1, the former Legco member 1, Social Worker 1, and Doctor 2.

savings scheme in 2000 amid economic downturn. However, it failed to obtain wide public and political support. Both the mandatory schemes were strongly resisted by both the Legco and the community who thought that the schemes were introduced at the wrong time when Hong Kong had suffered a severe economic downturn after the Asian financial crisis of 1997. The economy of Hong Kong was hard hit by the Asian financial crisis (Wong and Luk, 2007, p.192). The GDP of Hong Kong “shifted from high growth, to slow and even negative growth” (Wong, 2009, p.145). In 1998, GDP growth of Hong Kong was down to -5.3 per cent for the first time in its history (Ho, 2002, p.179; Lee, 2005, p.7).⁴¹¹ Besides, the average annual rate of growth per capita GDP fell from 4.5 per cent in the pre-handover era (1983-1997) to 1.9 per cent in the post-colonial era (1997-2001) (Sung, 2002, p.123). Also, the unemployment rate went up rapidly from 2.2 per cent in 1997 to 6.2 per cent in 1999 (Wong, 2009, p.145). Although the unemployment rate fell back to 4.9 per cent in 2000, it rose to 5.1 per cent in 2001 and even reached a record high of 7.9 per cent in 2003 (Wong, 2009, p.145). “The huge surpluses of colonial days were gone” (Scott, 2010, p.11) and the budget deficit had snowballed to a record high of HK\$ 65 billion by 2002, which amounted to 5.2 per cent of GDP (Lee, 2009, p.167). Both the middle and lower classes suffered “unemployment, wage decline and asset deflation” (Lee, 2005, p.7).

⁴¹¹ According to Ho (2002), Hong Kong did not experience any negative GDP growth from 1963 to 1997 (p.179).

Both the Legco and the community complained that it was inappropriate and untimely for the government to propose these mandatory health insurance or medical savings schemes at a time of economic hardship.

Legislators and political parties were against the mandatory health insurance or medical savings schemes because of the perceived financial burden imposed by these mandatory schemes and policy feedback from the government's decision of implementing the Mandatory Provident Fund (MPF). Historical institutionalism argues that policy feedback provides resources and creates incentives that can facilitate, strengthen or inhibit the formation or expansion of stakeholder interests (Pierson, 1994, pp.40-1). Besides, it shapes public attitudes towards contemporary public policies (Pierson, 1994, p.45; Gusmano et al., 2002, p.734). Policy feedback from the government's decision of implementing the Mandatory Provident Fund (MPF) warrants a discussion here because it helps understand about how legislators, political parties and the public viewed about the proposed mandatory schemes for healthcare. In August 1995, the colonial government enacted the Mandatory Provident Fund Schemes Ordinance in order to provide a framework for establishing a compulsory personal savings scheme known as MPF for retirement protection (Mandatory Provident Fund Schemes Authority, 2010, p.18). In September 1998, the

Mandatory Provident Fund Schemes Authority was established to “regulate, supervise and monitor the operation of the MPF System” (Information Services Department, 2011, p.1). In 1999, the Authority drew up the timetable that the MPF System would come into operation in December 2000 (Legislative Council Panel on Financial Affairs, 1999). The MPF scheme was an “employment-based, contribution-defined, [and] privately managed” scheme (Chow and Chou, 2005, p.139). It required employees to contribute 5 per cent of their salaries and employers had to match this amount (Chow and Chou, 2005, p.139). According to Chow and Chou (2005), the MPF scheme could not provide adequate financial protection for employees when they were old until they had contributed for at least 30 years (p.139). However, since the scheme was mandatory, employees had to join it without any choice. The MPF scheme was regarded as an unpopular scheme because of its mandatory nature, the perceived financial burden it brought and its insufficient retirement protection.⁴¹²

Since legislators, political parties and the public got a bad impression of the MPF scheme even before its actual implementation, they felt annoyed when the HKSAR government consecutively proposed the mandatory health insurance in 1999 and medical savings schemes in 2000.⁴¹³

⁴¹² Interview with Professor 2.

⁴¹³ Interview with Professor 2.

Different political parties opposed these mandatory schemes proposed by the HKSAR government. The Democratic Party argued that both the mandatory schemes would increase citizens' financial burden under poor economic environment because citizens were already required to join the MPF (Law and Ho, 1999; Legislative Council Secretariat, 2001b, p.6).⁴¹⁴ The Democratic Party argued that the government should not use the mandatory medical savings scheme to “dig into the pockets of the public” (The Legislative Council, 2001, p.4042), especially to the lowest income group who had “problems with their essential daily expenses” (The Legislative Council, 2001, p.4043). The DAB argued that the mandatory health insurance scheme was “hardly different from a new tax” (Li, 1999, April 26) while the mandatory medical savings scheme would aggravate the financial burden of citizens who had already contributed 5 per cent of their salaries to the MPF scheme and who suffered salary cut or salary freeze (Legislative Council Secretariat, 2001a, p.5). The Liberal Party thought that a mandatory health insurance scheme on top of the MPF scheme would increase the operation costs and undermine the competitive edge of the companies under poor business environment (Wan, 1999b, May 6) while it thought that the controversial mandatory medical savings scheme was “not the right time of implementation” (The Legislative Council, 2001, p.4053). The Democratic Party, the

⁴¹⁴ For more information, please visit the website of Mandatory Provident Fund Schemes Authority (<http://www.mpfa.org.hk/eindex.asp>) or the website of the HKSAR government about MPF (<http://www.gov.hk/en/about/abouthk/factsheets/docs/mpf.pdf>).

DAB, and the Liberal Party recommended the government adopt other measures to control healthcare costs such as revamping the fees structure of public healthcare services, restructuring the HA, and enhancing the primary healthcare services (Legislative Council Secretariat, 2001a, p.5; Legislative Council Secretariat, 2001b, p.6; The Legislative Council, 2001, pp. 4051-2). In brief, legislators and political parties showed a consistent position on opposing the introduction of the mandatory health insurance or medical savings schemes because of the perceived financial burden imposed by these mandatory schemes and policy feedback from the government's decision of implementing the Mandatory Provident Fund (MPF).

Similar to legislators and political parties, Hong Kong citizens also opposed both the mandatory health insurance and medical savings schemes because of the perceived financial burden imposed by these mandatory schemes. As Citizen 2, Citizen 3, Citizen 4, Citizen 6 and Citizen 7 said during their interviews, it was very unkind and inconsiderate for the government to ask the citizens to join the mandatory schemes during the economic recession period when many of them were in an economic plight due to bankruptcies, unemployment, and declining standard of living.⁴¹⁵ They said that the government did nothing to help them go through the

⁴¹⁵ Interviews with Citizen 2, Citizen 3, Citizen 4, Citizen 6, and Citizen 7.

difficult time but used the mandatory schemes as an excuse to ask the citizens to pay for their own medical expenses.⁴¹⁶ Both Citizen 6 and Citizen 7 interviewed said that they were threatened by job insecurity and salary cut at that time that both the mandatory schemes were a nightmare and a burden to them.⁴¹⁷ Citizen 4 interviewed said that the mandatory health insurance scheme was “a tax in disguise” and “a trick played by the government to ask for more money” that was especially unfair to the middle-class people like him.⁴¹⁸ Citizen 6 and Citizen 8 interviewed said that both the mandatory schemes were too much to bear because they had already joined the MPF scheme for retirement protection.⁴¹⁹ Citizen 5 interviewed were against both the mandatory schemes at that time because he thought that the government may increase the rate of contribution if the medical expenditures increased drastically in future.⁴²⁰ As Professor 1, Professor 3, Social Worker 1 and Civil Servant 4 said during their interviews, timing was very important and the economic recession period was never an opportune time to implement any healthcare financing reform.⁴²¹

Also, policy feedback from the establishment of the HA led to the HA and medical professionals who worked in public hospitals opposing both the mandatory

⁴¹⁶ Interviews with Citizen 2, Citizen 3, Citizen 4, Citizen 6, and Citizen 7.

⁴¹⁷ Interviews with Citizen 6 and Citizen 7.

⁴¹⁸ Interview with Citizen 4.

⁴¹⁹ Interviews with Citizen 6 and Citizen 8.

⁴²⁰ Interview with Citizen 5.

⁴²¹ Interviews with Professor 1, Professor 3, Social Worker 1, and Civil Servant 4.

schemes. It was because they worried that the implementation of these mandatory schemes would create the new problem of moral hazard on both the supply side and demand side. The HA and doctors were against the mandatory health insurance scheme proposed by the Harvard Team because the HA would no longer receive funding automatically from the government under the principle of “money follows the patient” and had to compete with private hospitals in the market.⁴²² The “money follows patients” concept would create strong incentives for medical institutions to increase their revenues through over-prescription or doing unnecessary medical examinations or surgeries.⁴²³ The HA and doctors worried that the competition with private hospitals for more financial resources would drive the HA to focus on money rather than patient care when delivering medical service, resulting in the failure in upholding the time-honored policy that “no one would be denied adequate medical care because of lack of means”.⁴²⁴ Since healthcare was not an economic issue, both the mandatory schemes would definitely deter ordinary citizens, especially the poor and the elderly, from seeking medical treatment for the fear of high medical fees.⁴²⁵

On the other hand, both the Hong Kong Medical Association and the HA argued that the mandatory health insurance scheme created moral hazard on the demand side

⁴²² Interviews with Professor 1 and Doctor 2.

⁴²³ Interviews with Professor 1 and Doctor 2.

⁴²⁴ Interviews with Professor 1 and Doctor 2.

⁴²⁵ Interviews with Nurse 1, Doctor 1, Social Worker 1, and Social Worker 2.

because those who were conscious of their own financial contribution would abuse the healthcare system and induce unnecessary demand that ended up increasing both the workload of medical staff and the financial burden of the HA (The Hong Kong Medical Association, 1999; Yeung, 1999, December 27). Another problem was that the negligible savings accumulated in the HPA of the mandatory medical savings scheme only made ordinary citizens stick to the public hospital system, resulting in the failure in reducing the workload of medical staff and the financial burden of the HA. The contribution rate of 1 to 2 per cent of the mandatory medical savings scheme was inadequate to help citizens accumulate enough money in the HPA for paying their future medical expenses, in particular those with chronic or catastrophic diseases.⁴²⁶ Besides, the mandatory medical savings scheme would not drive patients to seek medical treatment at private hospitals because medical charges at private hospitals could be a bottomless pit.⁴²⁷ It meant that the mandatory medical savings scheme ended up defeating the government's purpose of reducing the workload of doctors and alleviating the financial burden of the HA.⁴²⁸

⁴²⁶ Interviews with the former Legco member 1 and Doctor 2. The DAB calculated on the basis of the current median wage of HK\$10,000 and found that the HPA would "have a balance of HK\$56,012 after 25 years of contribution" (The Legislative Council, 2001, p.4078). For low-wage earners, they would only have HK\$20,000 to HK\$30,000 in their HPA (The Legislative Council, 2001, p.4078). The calculation done by Alliance of Patient Mutual Help Organization showed that an individual would only have a mere saving of HK\$40,000 in his/her HPAs when he/she reached 65 and could only have had HK\$222 for monthly healthcare expenditure if he/she had life expectancy of 80 years (*Sing Pao*, 18 December 2000, p.6).

⁴²⁷ Interviews with the former Legco member 1 and Doctor 2.

⁴²⁸ Interviews with the former Legco member 1 and Doctor 2.

(iii) The New Idea Lacking Support and the Institutionalization of Old Ideas

Historical institutionalism argues that ideas matter in policy making (Campbell, 1998) because they either “favor significant policy change or reinforce existing institutional paths” (Hwang, 2006, p.16). In Hong Kong, the new idea of mandatory contribution towards healthcare failed to get public and political support and acceptance because of three main reasons: objection to compulsion, the lack of detailed information about the mandatory schemes, and concern for health as a right. Firstly, both the mandatory health insurance and medical savings schemes restricted the choices of individuals to choose because employees, whether they were willing to join the schemes or not, were required to make financial contributions. Besides, the mandatory medical savings scheme only allowed citizens to use the money deposited into the HPA when they reached 65 years old. As Professor 1 and Professor 2 said during their interviews, citizens strongly resisted both the mandatory schemes because the schemes deprived citizens of their freedom to choose and violated the spirit of freedom embraced by a capitalist city like Hong Kong for a long time.⁴²⁹ It meant that the idea of mandatory contribution was incompatible with the economic and social contexts which promoted freedom. Citizen 1 and Citizen 5 interviewed said that the mandatory medical savings

⁴²⁹ Interviews with Professor 1 and Professor 2.

scheme could no doubt help one save for a rainy day.⁴³⁰ However, they questioned why they had to wait until the age of 65 when the retirement age in Hong Kong was 60 and suggested the government should give flexibility to citizens to use their money stored in the HPA.⁴³¹ The Liberal Party supported a voluntary medical contribution scheme and suggested that the government should let citizens choose the kinds of medical services “according to their ability and wishes” (The Legislative Council, 2001, p, 4054).

Secondly, the reason why different segments of people negatively reacted to the proposed mandatory savings scheme was due to the lack of detailed information about the scheme. Historical institutionalism argues that policy feedback shapes public attitudes toward contemporary public policies (Pierson, 1994, p.45; Gusmano et al., 2002, p.734). Policies provide information for the public that help them interpret the social world (Gusmano et al., 2002, p.734). The exposure model of policy feedback suggests that “the longer [the] citizens interact with a particular policy or institutions, the more ‘comfortable’ they become with that policy” (Gusmano et al., 2002, p.734). Emotional reactions play a particularly important role in shaping public attitudes toward public policies when “the public lacks detailed information about policy

⁴³⁰ Interviews with Citizen 1 and Citizen 5.

⁴³¹ Interviews with Citizen 1 and Citizen 5.

matters” (Gusmano et al., 2002, p.734). Legislators, the Patients’ Rights Group, medical associations, and citizens found the mandatory medical savings scheme especially disappointing and irritating because the HKSAR government refused to give figures and evidence to support its proposed mandatory medical savings scheme despite repeated requests by contending that the figures and evidence confused the picture (Benitez, 2001a, January 26; Benitez, 2001b, January 27; Benitez, 2001c, March 13).⁴³² They criticized that *The Life Long Investment document* was “a blank cheque” (Benitez, 2001a, January 26), “a skeleton proposal” (Benitez, 2000, December 13), “an empty proposal” (Benitez, 2001c, March 13) used by the government to force them to support the mandatory medical savings scheme which was not a real choice at all.

Thirdly, both the mandatory schemes went against legislators’ and citizens’ perception that healthcare was a welfare benefit and the government should be committed to healthcare provision. The DAB argued that the co-responsibility principle emphasized by the mandatory health insurance scheme and the user pay principle emphasized by the mandatory medical savings scheme were actually in conflict with the equity principle emphasized in the current healthcare system and the

⁴³² Secretary for Health and Welfare said in a newspaper interview that the figures would confuse the pictures while the details of the mandatory savings scheme would give citizens an impression that the government had already “made up its mind” (Benitez, 2001b, January 27).

idea that medical service was a social welfare (The DAB, 1999; The Legislative Council, 2001, p, 4078). Both the mandatory schemes went against the principle of social justice by personalizing the issue of healthcare in the name of individual responsibility and aggravated social disparity which increased the financial burden of the low income groups and the poor.⁴³³ The introduction of these two mandatory schemes only gave citizens the impression that the government had an urgent desire to shirk its responsibility in financing healthcare at a time of economic difficulty.⁴³⁴ As Doctor 2, Nurse 1, and Social Worker 2 said during their interviews, the HA had contributed a lot by making continuous improvement of medical services at public hospitals since its establishment in 1990.⁴³⁵ However, it was exactly because of this that the HA had strengthened the image of the public hospital systems as a strong welfare safety net and had acted as a serious obstacle to implementing healthcare financing reforms.⁴³⁶ Since 1990, the establishment of the HA and the enactment of Hospital Authority Ordinance, which stated that the HA should uphold the time-honored policy that “no one should be denied adequate medical treatment through lack of means”, had institutionalized the ideas of free healthcare, universal access to healthcare and equality. The institutionalization of these old ideas reduced

⁴³³ Interviews with the former Legco member 1, the former member of the Public Complaints Committee of the HA, and Civil Servant 1.

⁴³⁴ Interviews with the former Legco member 1, the former member of the Public Complaints Committee of the HA, and Civil Servant 1.

⁴³⁵ Interviews with Doctor 2, Nurse 1, and Social Worker 2.

⁴³⁶ Interviews with Doctor 2, Nurse 1, and Social Worker 2.

the government's capacity of persuading the legislators and the community to accept and support new ideas.

In brief, both the mandatory health insurance and medical savings scheme were perceived by legislators and the community as unpopular reform options and were met with strong resistance. As Dr. Wing-lok Lo, the former legislator of medical functional constituency, said in a newspaper interview, the Harvard Report "achieved nothing but confrontation" (Lee, 2000, October 3) because it did not assess the adverse effect of the proposed mandatory health insurance scheme on local citizens. Professor William Hsiao, who led the Harvard Team, admitted in a newspaper interview that the Team "did not examine how the middle class and the poor would be affected in the scheme" (Wan, 1999a, April 18). Since the release of *The Harvard Report*, the HKSAR government had not shown its stance on the mandatory health insurance scheme proposed by the Harvard Team. Legislator and chairman of the DAB Jasper Tsang said that this was because the HKSAR government tried to distance itself from the unpopularity of *The Harvard Report* (Hong Kong Standard, 26 April 1999, p.3). However, the HKSAR government's quick release of *The Life Long Investment document* which proposed the mandatory medical savings scheme did not secure majority public support but resentment. The Tung administration later admitted

that it should not introduce the mandatory medical savings scheme “in times when Hong Kong was facing economic difficulties” (Legislative Council Secretariat, 2004, p.5). Besides, it would not introduce any long-term healthcare financing scheme unless it was supported by the Legco and the community (Legislative Council Secretariat, 2004, p.6). In brief, the disjointed political system, difficult economic circumstances, the new idea of mandatory contributions lacking public and political acceptance, policy feedback from previous healthcare policies and the mandatory pension scheme, and the institutionalization of old ideas were strong forces to impede any changes in the current healthcare financing system and thus, the status quo of the healthcare financing system was maintained.

8.4 The Donald Tsang Administration (2005 – Present)

Tung Chee-hwa resigned in March 2005 on health grounds (Cheung, 2007a, p.51). His successor Donald Tsang, who was former Chief Secretary for Administration and a longtime civil servant (Cheung, 2007a, p.51; Cheung, 2010, pp.38-9), “was only given a two year term, the balance of Tung’s period in office” (Scott, 2007, p.30). Tsang, due to his bureaucratic background, “returned to the age-old colonial wisdom of government by administrators” (Cheung, 2010, p.39) by mainly depending on “the civil service as the backbone of his administration” (Cheung, 2010, p.48). The senior

civil servants once again provided the government with the unifying and sustaining force that brought “policy and administrative organizations together within more coherent structures and processes” (Cheung, 2010, p.48). On the other hand, in 2008, Tsang extended the political appointment system by adding two layers of politically-appointed officials known as under-secretaries and political assistants. These new political appointees closely worked with bureau secretaries to provide the government with “a broader political support base” (Cheung, 2010, p.48).

(a) The Proposals for Healthcare Financing Reform

The truncated term of office from May 2005 to June 2007 left little room for Tsang to introduce any new policies. Although Tsang mentioned in the 2005-06 Policy Address that the government had embarked on a study and analysis of different healthcare financing options and would release an initial proposal for public discussion in early 2006 (Tsang, 2005),⁴³⁷ the proposal was not released in early 2006 and there was no follow-up on healthcare financing issue in the 2006-07 Policy Address.⁴³⁸ A possible explanation was that Tsang was prudent enough not to take any hasty steps to introduce healthcare reforms which had the potential to encounter great resistance.

⁴³⁷ Please refer to paragraph No. 67 of the 2005-06 Policy Address.

⁴³⁸ The 2006-07 Policy Address focused on economic development, strengthening government support for families, and enhancing the quality of life. For details, please visit the website of the 2006-07 Policy Address (<http://www.policyaddress.gov.hk/06-07/>).

Facing re-election for Chief Executive in 2007, Tsang at first did not reply to a written request made by Election Committee members of the Hong Kong Medical Association concerning a meeting to discuss his ideas about healthcare policies in January 2007 (Lee, 2007a, January 5). He also failed to attend a debate forum organized by the Hong Kong Medical Association in January 2007 for debating and discussing medical issues with chief executive challenger Alan Leong, who was a pan-democratic candidate from Civic Party (Goh, 2007, January 28).⁴³⁹ However, in early February 2007, Tsang pledged in his election platform that a detailed report on healthcare financing would be released during his next term in office (Yung, 2007, February 2) and “the proposed medical financing system would have more flexibility, engaging the government, the Hospital Authority, the private sector and individuals”

⁴³⁹ In 2007, Chief Executive was elected by a 800-person Election Committee (Case, 2007, p.376). The Election Committee was widely understood as “a political caucus representing the privileged few, tilting heavily toward the central government and its local elite allies” (Case, 2007, p.377). Originally, Tsang, who had Beijing’s blessing, would be re-elected as Chief Executive without contest (Case, 2007, p.377). However, Alan Leong, who secured 132 nominations mostly from his pan-democratic strongholds (Leung and Lee, 2007, February 1; Lee et al., 2007, February 15), emerged as a challenger and became the first pan-democrat Chief Executive candidate in the history of Hong Kong (Leung, 2007, January 31). Leong was the former president of the Hong Kong Bar Association and member of the Civic Party, which was a political party founded in 2006 promoting democracy and social justice (Civic Party, 2012). Leong released his election platform entitled “The Hong Kong We Want”, which set out his policy agenda in six areas, namely environmental protection, a justice society, education system, economic policy, urban planning and constitutional reform (Leong, 2007, p.63). He was criticized by Election Committee members of the Hong Kong Medical Association for failing to have any election platform on medical issues (Lee, 2007a, January 5). In late January 2007, Leong attended the debate forum organized by the Hong Kong Medical Association without the presence of Tsang (Goh, 2007, January 28). He was criticized by doctors and the Election Committee members of the Hong Kong Medical Association for his poor understanding about medical issues and the harsh working environment in public hospitals in Hong Kong (Goh, 2007, January 28). At last, his hope of securing the Election Committee members from the Hong Kong Medical Association was dashed when the questionnaire survey conducted by the Hong Kong Medical Association in February 2007 showed that the majority of medical professionals favored nominating Tsang (Lee, 2007b, February 16). 50.5 per cent of the 2,111 medical professionals surveyed favored nominating Tsang while only 43.8 per cent of the medical professionals surveyed favored nominating Leong (Lee, 2007b, February 16).

(Yung, 2007, February 2). He also pledged to increase government spending on public healthcare from the current 15 per cent to 17 percent of total public expenditure in five years, which was approximately HK\$ 40 billion (Yung, 2007, February 2). In the same month, he had closed-door meeting with Election Committee members from the medical sector and told them that “his top priority would be constitutional reform, followed by medical reform and the environmental protection” (Lee and Wong, 2007, February 11). At last, Tsang secured the support of the Election Committee members from the Hong Kong Medical Association in the Chief Executive Election (Lee, 2007b, February 16).⁴⁴⁰

After winning the election in 2007,⁴⁴¹ Tsang “made a new start with his second term” (Cheung, 2010, p.49). The Tsang administration decided to have a two-stage public consultation on healthcare financing. In March 2008, Food and Health Bureau released the first stage consultation document entitled *Your Health, Your Life*. Instead of recommending a particular option, Food and Health Bureau used three months to

⁴⁴⁰ In February 2007, the Hong Kong Medical Association conducted a questionnaire survey of medical professionals’ opinion on the nomination of the Chief Executive candidates (Lee, 2007b, February 16). It released the survey result that “Donald Tsang won the support of 50.5 per cent of the 2,111 respondents, compared with 43.8 per cent who were in favour of nominating Mr. Leong” (Lee, 2007b, February 16). The Election Committee members from the Hong Kong Medical Association abided by their earlier promises made in December 2006 (Yung, 2006, December 12) that they would nominate the Chief Executive candidate based on the winner-takes-all principle of the internal poll result (Lee, 2007b, February 16) and form a block vote (Yung, 2006, December 12).

⁴⁴¹ Tsang, who won 649 votes, defeated Leong, who only got 123 votes in the Chief Executive Election in 2007 (Keatley, 2007).

consult the views of the community on the six supplementary healthcare financing options, “with a view to putting forward concrete recommendations in the second stage consultation” (Food and Health Bureau, 2008a, p.47). The six supplementary healthcare financing options included:

- (1) social health insurance which compulsorily required each employee who earned monthly income of HK\$5,000 or more and capped at HK\$20,000 to contribute 3 per cent to 5 per cent of monthly income to a social health insurance fund designated for healthcare use for every member of the public (Food and Health Bureau, 2008a, p.61);
- (2) out-of-pocket payments which increased the user fees from 5 per cent cost-recovery to 10 per cent cost-recovery (Food and Health Bureau, 2008a, pp.67-8);⁴⁴²
- (3) mandatory savings accounts which compulsorily required each individual in employment to save up 3 per cent to 5 per cent of his/her regular income in

⁴⁴² “The subsidy level of public healthcare in Hong Kong is amongst the highest in developed economies, at over 95 [per cent] of the cost across-the-board for public hospital services” (Food and Health Bureau, 2008a, p.125). Due to high subsidy, citizens only need to pay nominal fees when seeking medical care at public hospitals. For out-patient care, at present, the subsidized fees are HK\$45 for each general out-patient consultation, HK\$60 for each specialist out-patient consultation, and HK\$100 for each Accident & Emergency attendance (Food and Health Bureau, 2008a, p.126). “The fees are inclusive of all diagnostic tests and treatment procedures” (Food and Health Bureau, 2008a, p.126). As to in-patient care, patients only need to pay HK\$100 per day although the average cost is HK\$3,290 per day (Food and Health Bureau, 2008a, p.126). “The fee is a flat-rate inclusive of doctor consultations, drugs, diagnostic tests, treatment procedures, accommodation and food” (Food and Health Bureau, 2008a, p.126).

his/her individual medical savings account for his/her own future medical needs when reaching age 65 (Food and Health Bureau, 2008a, pp.71-2);

(4) voluntary private health insurance which was individually-purchased medical insurance providing risk-pooling for an individual's health risks and more choice of healthcare services from both the public and private sectors (Food and Health Bureau, 2008a, pp.77-81);

(5) mandatory private health insurance which compulsorily required employees aged from 18 to 64 with monthly income HK\$10,000 or above to pay HK\$160 for the monthly insurance premium provided the insured participants with benefit coverage at around 40 per cent of the cost of public healthcare services (Food and Health Bureau, 2008a, p.86); and

(6) personal healthcare reserve which compulsorily required employees earning monthly income HK\$10,000 or above to deposit a fixed percentage of their monthly income (3 per cent to 5 per cent) to their own Personal Healthcare Reserve (PHR) account for financing their own healthcare (Food and Health Bureau, 2008a, p.94). Part of the deposit in the PHR account would be used to subscribe a compulsory regulated health insurance scheme to provide basic healthcare protection before and after retirement while the remaining deposit in the PHR account would be accrued through investment to pay for

future medical expenses after retirement (Food and Health Bureau, 2008a, p.94).⁴⁴³

Your Health, Your Life stated that the six supplementary healthcare financing options proposed would not affect current “tax-based public funding as the major financing source for healthcare services” (Food and Health Bureau, 2008a, p.2). The HKSAR government would “continue to be the major financing source for healthcare” (Food and Health Bureau, 2008a, p.41) while the public healthcare system would “continue to provide an available and accessible safety net for the community” (Food and Health Bureau, 2008a, p.xv). *Your Health, Your Life* stated that the supplementary healthcare financing would only be used to “supplement government funding to cope with increasing healthcare needs” (Food and Health Bureau, 2008a, p.42) and sustain healthcare reform in the long run (Food and Health Bureau, 2008a, p.42). When proposing the six supplementary healthcare financing options, the HKSAR government was aware of the impact of history, contextual conditions and societal values on the choice of healthcare financing options. As stated in *Your Health, Your Life*,

“...the healthcare system of each economy has its own specific history and circumstances...No

⁴⁴³ The advantages and disadvantages of the six supplementary healthcare financing options and existing healthcare financing model were summarized in *Your Health, Your Life*.

one single model can be readily transplanted...ultimately it is each society's own choice, based on its own political, social and economic conditions, as well as the values and expectations of its members, as to what to gain and what to give up by adopting its own specific mix of financing arrangements" (Food and Health Bureau, 2008a, p.44)".

In December 2008, the government released a public consultation report after the first stage public consultation on healthcare financing came to an end. The public consultation report showed that "no single proposal commanded majority support" (Food and Health Bureau, 2008b, p.vii).⁴⁴⁴ Nevertheless, the report showed that the

⁴⁴⁴ In December 2008, Food and Health Bureau released *Your Health, Your Life* Report on First Stage Public Consultation on Healthcare Reform, which contained a detailed consultation result and public responses collected by government-commissioned questionnaire surveys and focus groups. In Appendix V of the Report, it contained detailed findings of three government-commissioned questionnaire surveys. Survey 1 was Telephone Opinion Poll on Healthcare Reform and Financing jointly conducted the Hong Kong Polytechnic University and the Chinese University of Hong Kong. It was conducted from March to August 2008 for a total of 15 weekly rounds, with about 800 and 1,000 respondents being successfully enumerated in each round of the poll. The result of Survey 1 showed that about two-thirds of the respondents agreed that healthcare system must reform now. Besides, most of the respondents supported the supplementary financing option "voluntary private health insurance" (71%), which was followed by "medical savings accounts" (58%), "out-of-pocket payments" (47%), "mandatory private health insurance" (44%), "personal healthcare reserve" (42%), and "social health insurance" (40%). Survey 2 was Telephone Survey on Healthcare Service Reform 2008 conducted by Social Sciences Reserach Centre of the University of Hong Kong in July 2008. A total of 1,118 respondents were successfully interviewed for their level of support about financing reform. The result of Survey 2 showed that about 65% of respondents agreed or strongly agreed that government funding alone was insufficient for implementing healthcare reform and meeting increasing healthcare demand casued by ageing population. Survey 3 was Telephone Survey on Supplementary Financing for Healthcare 2008 conducted by Social Sciences Reserach Centre of the University of Hong Kong from November to December 2008. A total of 1,035 respondents were successfully interviewed for their values in relation to supplementary healthcare financing. The result of Survey 3 showed that about 78.5% of respondents agreed that tax funding alone was insufficient for maintaining and improving the current level and quality of public healthcare services and perceived a need for additional financing. Among these respondents, a rapid increase in ageing population and incresing healthcare demand (23.7%) was the most common reason for the need for additional financing. Besides, among 1,035 respondents interviewed, most of them thought that freedom to choose (84.9%), saving for the future (82.0%) and equity of access (78.6%) were core values behind healthcare financing. For more details of these survey findings, please visit http://www.fhb.gov.hk/beStrong/eng/consultation/consultation_report1.html to read the report.

community embraced five societal values, which included individual need, voluntary participation, equity, freedom to choose, and employer's responsibility.⁴⁴⁵ It provided a useful reference for the government to develop a detailed proposal for the supplementary healthcare financing option in the second stage consultation.

In October 2010, Food and Health Bureau released the second stage consultation document entitled *My Health, My Choice*, which proposed a Health Protection Scheme (HPS) that standardized and regulated voluntary private health insurance (Food and Health Bureau, 2010, p.ii). The consultation document stated that the HPS offered three advantages over existing private health insurance schemes in the market: first, it must accept high-risk individuals and those with pre-existing medical conditions; second, it had transparent age-banded premium schedule, guaranteed renewal for life and was fully portable; and third, it promoted transparent medical fees with packaged charging based on diagnosis-related groups (DRG) and established High-Risk Pool to buffer the risks of high-risk subscribers, with financial injection

⁴⁴⁵ *The 2008 First Stage Report* said that different societal values were observed from the respondents' views towards the supplementary financing proposals and they could be categorized into eight themes: (1) individual vs communal; (2) voluntary vs mandatory; (3) risk-pooling vs savings; (4) equity vs two-tier service; (5) role of employers and employees; (6) user fee increase; (7) income level for contribution; and (8) financial sustainability (Food and Health Bureau, 2008c, p. vii-ix). However, the author thinks that the government's categorization is strange because categories such as (6), (7), and (8) do not seem to reflect societal values. On the other hand, category (1) and (3) seems to present similar societal value while some of the contents in category (1) and (4) can be combined to form the societal value of equity. Therefore, the author tries to argue that *The 2008 First Stage Report* reflected five societal values instead of eight themes. For more details about the eight themes, please refer to the executive summary of *The 2008 First Stage Report*.

from the government when necessary (Food and Health Bureau, 2010, pp.29-30). The government would use HK\$50 billion fiscal reserve earmarked to provide incentives and subsidies to HPS subscribers (Food and Health Bureau, 2010, p.v). It was hoped that the HPS could divert more people to the private healthcare sector and thus “relieve the pressure on the public healthcare system” (Food and Health Bureau, 2010, p.ii).

At the time of this study, the HKSAR government was still collating and analyzing the views gathered from the second stage consultation. Whether or not the voluntary HPS would be implemented, the HKSAR government would continue to heavily subsidize healthcare and the public healthcare system would continue to predominate. It means that Hong Kong would still stick to its original path of funding the universal healthcare system through taxation even if the proposed voluntary private health insurance scheme can be implemented successfully.

(b) Different Views on the Changes Proposed by Health Insurance Reform

The proposed health insurance reform, if implemented successfully, could affect stakeholders in many aspects: citizens’ access to, affordability of and demand for healthcare, healthcare providers’ capacity of and efficiency in healthcare delivery,

insurers' profits and their freedom of action. As illustrated below, different stakeholders who had different interests and expectations toward health insurance reform responded differently to the proposed regulated voluntary private health insurance. This section will examine the views of citizens, civil servants, social workers, insurance consultants, medical professionals, former Legco member, former member of the Public Complaints Committee of the HA, scholars, and a government official on health insurance reform in Hong Kong.

(1) Citizens

Eight citizens interviewed shared the view that the free public healthcare system should be maintained because it was a safety net providing the general public with healthcare protection irrespective of one's income level and promoting the ideas of equality and universal access.⁴⁴⁶ They thought that the government should continue to fund the public healthcare system through taxation because healthcare was a time-honored welfare benefit and the government had the responsibility to provide this welfare for citizens.⁴⁴⁷ They doubted if it was necessary to implement the proposed HPS as an additional source to fund healthcare because of the confused

⁴⁴⁶ Interviews with Citizen 1, Citizen 2, Citizen 3, Citizen 4, Citizen 5, Citizen 6, Citizen 7, and Citizen 8.

⁴⁴⁷ Interviews with Citizen 1, Citizen 2, Citizen 3, Citizen 4, Citizen 5, Citizen 6, Citizen 7, and Citizen 8.

message sent by the HKSAR government.⁴⁴⁸ On one hand, the government said that it was under pressure to implement health insurance reform when facing the problem of rising medical costs.⁴⁴⁹ On the other hand, the government promised to increase the recurrent funding for healthcare, implying that the government was still capable of financing the public healthcare system and meeting the challenge of rising medical costs in the foreseeable future.⁴⁵⁰ Therefore, they doubted if there was an urgent need to implement health insurance reform.⁴⁵¹

Eight citizens interviewed had mixed feelings about joining the proposed HPS and controversial views on the effectiveness of the proposed HPS. Citizen 1 and Citizen 2 interviewed who had no private health insurance were interested in joining the HPS. Citizen 1 who suffered from a devastating disease known as Multiple Sclerosis⁴⁵² said that her applications for hospital insurance and critical illness insurance being repeatedly declined by insurance companies had been a very

⁴⁴⁸ Interviews with Citizen 1, Citizen 2, Citizen 3, Citizen 4, Citizen 5, Citizen 6, Citizen 7, and Citizen 8.

⁴⁴⁹ Interviews with Citizen 1, Citizen 2, Citizen 3, Citizen 4, Citizen 5, Citizen 6, Citizen 7, and Citizen 8.

⁴⁵⁰ Interviews with Citizen 1, Citizen 2, Citizen 3, Citizen 4, Citizen 5, Citizen 6, Citizen 7, and Citizen 8.

⁴⁵¹ Interviews with Citizen 1, Citizen 2, Citizen 3, Citizen 4, Citizen 5, Citizen 6, Citizen 7, and Citizen 8.

⁴⁵² Multiple Sclerosis (MS) is a devastating disease of the central nervous system that “strikes predominantly young adults during their most productive years” (Lau et al., 2002, p.77). To know more about MS in Hong Kong, please refer to Lau et al. (2002). Epidemiological Study of Multiple Sclerosis in Hong Kong Chinese: Questionnaire Survey. *Hong Kong Medical Journal*, vol.8 (2), pp. 77-80. The article can be found at http://www.hkmj.org/article_pdfs/hkm0204p77.pdf.

frustrating experience.⁴⁵³ She was interested in joining the proposed HPS because the HPS accepted pre-existing condition, guaranteed renewal for life, and absorbed risk of high-risk subscribers like her.⁴⁵⁴ Citizen 2 who was a cleaning lady in her mid 50s said that she had financial difficulties in subscribing to private health insurance which required her to contribute an expensive old-age annual premium costing more than HK\$10,000.⁴⁵⁵ She said that the proposed HPS with the transparent premium, transparent medical fees and government regulation sounded attractive and reliable.⁴⁵⁶ She was interested in joining the proposed HPS if the premium was less expensive.⁴⁵⁷ On the other hand, Citizen 7 who was a part-time worker had no private health insurance and did not consider joining the HPS. As a hepatitis B carrier, Citizen 7 interviewed said that the HPS was good news to people with pre-existing conditions like her because the HPS could provide medical coverage for them.⁴⁵⁸ However, she could not afford to join the HPS because she had already been contributing to life insurance with savings plan.⁴⁵⁹ Joining the HPS would impose extra financial burden on her.⁴⁶⁰

⁴⁵³ Interview with Citizen 1.

⁴⁵⁴ Interview with Citizen 1.

⁴⁵⁵ Interview with Citizen 2.

⁴⁵⁶ Interview with Citizen 2.

⁴⁵⁷ Interview with Citizen 2.

⁴⁵⁸ Interview with Citizen 7.

⁴⁵⁹ Interview with Citizen 7.

⁴⁶⁰ Interview with Citizen 7.

Citizen 5, Citizen 6 and Citizen 8 interviewed who had no private health insurance were not interested in joining the HPS. Citizen 5 who was a firm owner was against the proposed HPS because he thought that insurance companies were not trustworthy and insurance subscribers usually could not get what he/she paid for.⁴⁶¹ He thought that the government should not implement health insurance reform but put more financial resources to promote preventive healthcare and educate citizens on how to live a healthy life.⁴⁶² Citizen 6 who was a bank manager found it unnecessary to subscribe to the proposed HPS because he seldom got sick.⁴⁶³ He thought that the government only promoted the positive side of the proposed HPS so as to attract more people to join the Scheme.⁴⁶⁴ He questioned whether the government would drastically raise the premium when there were insufficient participants or when the HK\$50 billion was used up.⁴⁶⁵ In fact, he thought that the voluntary nature of the proposed HPS could hardly attract people to join the Scheme because no one wanted to spend his/her hard earned money on healthcare when he/she had full access to free public healthcare anytime he/she wanted.⁴⁶⁶ Citizen 8 who was a secondary teacher did not subscribe to any private voluntary health insurance because she “had the habit

⁴⁶¹ Interview with Citizen 5.

⁴⁶² Interview with Citizen 5.

⁴⁶³ Interview with Citizen 6.

⁴⁶⁴ Interview with Citizen 6.

⁴⁶⁵ Interview with Citizen 6.

⁴⁶⁶ Interview with Citizen 6.

of saving money and bought stock” to increase her wealth.⁴⁶⁷ She was not interested in joining the proposed HPS, saying that “the HPS was a government trick to shirk its responsibility and ask the citizens to pay for their own medical fees”.⁴⁶⁸ She was discontent with the government targeting the middle class to join the Scheme.⁴⁶⁹ As Citizen 8 said in the interview,

“I think that the proposed HPS is suitable for those who do not have money saving habit. But the government targets middle class people like me to join the Scheme. The Scheme has nothing to do with the poor or the rich because the former do not have extra money to buy any health insurance while the rich has much money to pay for their medical bills without any need to buy health insurance. I have already used one-seventh of my annual salary to pay taxes. As a taxpayer, however, I don’t think I have

⁴⁶⁷ Interview with Citizen 8.

⁴⁶⁸ Interview with Citizen 8.

⁴⁶⁹ According to Lui (2003), the middle class “refers primarily to those professional, administrative, and managerial salaried employees working in various sectors of the Hong Kong economy” (p.161). The middle class is different from the self-employed petty bourgeoisie because its status is not based on the means of production. Instead, it is based on education, professional qualification, or working experience in order to find a better job and have better working conditions (Lui and Wong, 2003, p.5). The middle class emerged in the 1970s, which was a new class representing “an outcome of the structural transformation of the Hong Kong economy” after the Second World War (Lui, 2003, p.162). The emergence of the middle class and the affluent life it represents have the symbolic significance of the so-called “Hong Kong dream”, a dream that can be realized through individual efforts and luck (Lui and Wong, 2003, pp.52-3). The middle class has a belief that an individual can fight for opportunities and change his/her own destiny (Lui and Wong, 2003, p.54). However, the outbreak of Asian financial crisis in 1998 was a shock to the middle class and shattered the belief the middle class upholds. Asian financial crisis led to a dramatic plunge in both the stock and property markets (Lui, 2003, p.177). Business environment deteriorated. The middle class were affected by salary cuts, downsizing, lay-off and unemployment (Lui, 2003, pp.177-8). Educational attainments, working experience, and seniority no longer guarantee promotion prospects as they did in the past. After the outbreak of Asian financial crisis, “security and stability in employment that the middle class has long enjoyed are giving ways to competitiveness and flexibility” (Lui, 2003, p.178). The career path of the middle class is not as smooth as it was in the past. The middle class has become more confused, insecure, and anxious about the uncertain environment (Lui, 2003; Lui and Wong, 2003).

benefited from any government's policies".⁴⁷⁰

Citizen 3 and Citizen 4 interviewed were covered by the group medical insurance of their companies and had no interests in joining the proposed HPS.⁴⁷¹ Citizen 3 who was a bank employee said that she would rather save money on her own for paying medical bills than subscribe to the proposed HPS because insurance companies were not trustworthy.⁴⁷² She thought that similar to the group medical insurance she had, the proposed HPS may reduce patients' freedom to choose by restricting the number of doctor or clinics she could visit when seeking medical care.⁴⁷³ Besides, she doubted whether the premium would be increased if the HK\$50 billion was used up.⁴⁷⁴ Citizen 4 who was a manager said that the group medical insurance provided him with better and more comprehensive coverage.⁴⁷⁵ The benefits provided by the group medical insurance included hospitalization and surgical benefits with full reimbursement, emergency assistance services, supplementary major medical benefits, clinical benefits, dental benefits, and dependent cover.⁴⁷⁶ He usually received medical treatment at private hospitals.⁴⁷⁷ Although he could not enjoy the group medical

⁴⁷⁰ Interview with Citizen 8.

⁴⁷¹ Interviews with Citizen 3 and Citizen 4.

⁴⁷² Interview with Citizen 3.

⁴⁷³ Interview with Citizen 3.

⁴⁷⁴ Interview with Citizen 3.

⁴⁷⁵ Interview with Citizen 4.

⁴⁷⁶ Interview with Citizen 4.

⁴⁷⁷ Interview with Citizen 4.

insurance after retirement, he could rely on the free public healthcare system to get medical treatment.⁴⁷⁸ He said that as a taxpayer, he should utilize the tax-funded public healthcare system when he was old.⁴⁷⁹

In fact, eight citizens interviewed shared the view that the current public healthcare system had been plagued with the problems of lacking medical personnel, long queues and waiting time for public medical services, and the deterioration of service quality.⁴⁸⁰ These problems were attributed to the government's over-reliance on hospital services and the underdevelopment of primary care over the past few decades.⁴⁸¹ Therefore, eight citizens interviewed thought that implementing healthcare financing reform should not be the main concern of the government and healthcare financing reform alone was not effective enough to address the aforementioned problems.⁴⁸² They thought that a comprehensive healthcare reform to develop and strengthen the role of primary care, train more medical professionals, and restructure the HA was needed to resolve and lessen the aforementioned problems, especially when the problem of ageing population would affect the financial

⁴⁷⁸ Interview with Citizen 4.

⁴⁷⁹ Interview with Citizen 4.

⁴⁸⁰ Interviews with Citizen 1, Citizen 2, Citizen 3, Citizen 4, Citizen 5, Citizen 6, Citizen 7, and Citizen 8.

⁴⁸¹ Interviews with Citizen 1, Citizen 2, Citizen 3, Citizen 4, Citizen 5, Citizen 6, Citizen 7, and Citizen 8.

⁴⁸² Interviews with Citizen 1, Citizen 2, Citizen 3, Citizen 4, Citizen 5, Citizen 6, Citizen 7, and Citizen 8.

sustainability, capacity and quality of public healthcare services in the long run.⁴⁸³

(2) Civil Servants

Four civil servants interviewed were not interested in joining the proposed HPS. Civil Servant 1 who was a contract-based civil servant said that the voluntary nature of the proposed HPS was much better than the mandatory health insurance scheme proposed by *the 1999 Harvard Report* and the mandatory medical savings scheme proposed in 2000 because citizens had the freedom to choose whether or not to join the Scheme.⁴⁸⁴ However, she did not have spare money to subscribe to the proposed HPS because her money had been spent on paying the tuition fees of a legal education programme that cost HK\$110,000.⁴⁸⁵ She thought that healthcare was a social welfare benefit and the government was responsible for taking care of citizens' healthcare, especially those who were poor and less fortunate.⁴⁸⁶ The free public healthcare system should be maintained with the government continuously being the main financier of healthcare.⁴⁸⁷

Civil Servant 2 who was a tenured civil servant criticized the health insurance

⁴⁸³ Interviews with Citizen 1, Citizen 2, Citizen 3, Citizen 4, Citizen 5, Citizen 6, Citizen 7, and Citizen 8.

⁴⁸⁴ Interview with Civil Servant 1.

⁴⁸⁵ Interview with Civil Servant 1.

⁴⁸⁶ Interview with Civil Servant 1.

⁴⁸⁷ Interview with Civil Servant 1.

reform proposed by the government as unnecessary because she believed that the government was still capable of funding the public healthcare system.⁴⁸⁸ She was not interested in joining the proposed HPS because she was eligible for civil service medical benefits which include free medical treatment, X-ray examination and drugs in public hospitals, and free dental check according to Civil Service Regulations.⁴⁸⁹ Besides, she could enjoy the dependant cover of her husband's group medical insurance provided by his company that seeking medical treatment in private hospitals could obtain full reimbursement.⁴⁹⁰

Civil Servant 3 who was a senior police officer thought that the HPS was not a useful reform proposal because the problems plaguing the free public healthcare system were multifold, including public hospitals being overcrowded, uneven resource allocation among public hospitals, insufficient support for frontline healthcare personnel, the significant public-private imbalance, and the HA using too much public money to pay staff costs.⁴⁹¹ He thought that apart from implementing healthcare financing reform, the government should implement a structural reform of the HA so that the HK\$30 billion government subvention given to the HA could be used in a better way to improve medical supplies and treatment and prescribe better

⁴⁸⁸ Interview with Civil Servant 2.

⁴⁸⁹ Interview with Civil Servant 2.

⁴⁹⁰ Interview with Civil Servant 2.

⁴⁹¹ Interview with Civil Servant 3.

drugs.⁴⁹²

Civil Servant 4 who was an inspector of police said that she was not interested in joining the proposed HPS because she had already bought a comprehensive private insurance plans which included life insurance, accident insurance, hospital insurance and critical illness insurance.⁴⁹³ Since police officer was a high-risk career, life insurance and accident insurance which could bring security to her and her family were more important than health insurance.⁴⁹⁴ She said that the idea of subscribing to voluntary health insurance was good because the insured could offload their financial risks when getting sick and have more choices of medical services.⁴⁹⁵ However, since Hong Kong already had a free public healthcare system, it was difficult for the government to convince citizens to join the proposed HPS.⁴⁹⁶ After all, the immediate feeling people had after joining the Scheme was having less money in their pockets.⁴⁹⁷

Civil Servant 4 was suspicious of the government's intention of using the proposed

⁴⁹² Interview with Civil Servant 3. The HA used 85 per cent of government subvention to pay staff costs. According to the Hospital Authority Yearbook 2008-9, about HK\$26 billion of HK\$30 billion was used on staff costs (Hospital Authority, 2009, p.67). But the staff costs included the annual salaries of Chief Executive, and the 33 Directors, Cluster Chief Executives and Hospital Chief Executives (Legislative Council Secretariat, 2011a). Each of them had the annual salary that was as high as HK\$2 million to over HK\$4 million (Legislative Council Secretariat, 2011a). Legislator Emily Lau criticized the HA for rewarding the upper-ranked staff generously while giving frontline medical staff niggardly pay (Hong Kong's Information Services Department, 2009).

⁴⁹³ Interview with Civil Servant 4.

⁴⁹⁴ Interview with Civil Servant 4.

⁴⁹⁵ Interview with Civil Servant 4.

⁴⁹⁶ Interview with Civil Servant 4.

⁴⁹⁷ Interview with Civil Servant 4.

HPS as an excuse to dip into middle-class people's pockets and ask middle-class people to take care of their own health.⁴⁹⁸ But the voluntary nature of the health insurance scheme helped the government face less resistance from the public and Legco members because citizens were given space to decide whether to join the Scheme or not.⁴⁹⁹

(3) Social Workers

Both Social Worker 1 and Social Worker 2 interviewed thought that the health insurance reform was meaningless because the low income group and chronically ill patients could not benefit from the proposed HPS.⁵⁰⁰ They said that the government should not use the HK\$50 billion fiscal reserve earmarked to subsidize HPS subscribers because HPS subscribers had economic ability to buy health insurance.⁵⁰¹ Instead, the government should use this amount of fiscal reserve in a more meaningful way by helping the vulnerable groups who were in need of healthcare and improve quality of medical services in public hospitals.⁵⁰² As Social Worker 1 and Social Worker 2 said during their interviews, it was undeniable that the free public healthcare system was a strong safety net providing low income patients, the elderly patients and

⁴⁹⁸ Interview with Civil Servant 4.

⁴⁹⁹ Interview with Civil Servant 4.

⁵⁰⁰ Interviews with Social Worker 1 and Social Worker 2.

⁵⁰¹ Interviews with Social Worker 1 and Social Worker 2.

⁵⁰² Interviews with Social Worker 1 and Social Worker 2.

chronically ill patients with essential medical services.⁵⁰³ Low-income patients, the elderly patients, chronically ill patients, and recipients of Comprehensive Social Security Assistance having financial difficulties could apply to Medical Social Workers stationed in public hospitals or Social Workers of the Social Welfare Department for a medical fee waiver.⁵⁰⁴ A certificate for medical fee waiver which was one-off or valid for three months to one year would be granted by social workers to applicants who passed the income and asset limit tests or to those based on non-financial reasons such as an applicant's clinical condition.⁵⁰⁵ The medical fee waiver system and the free public healthcare system showed that the government had upheld its fundamental philosophy of "no one being denied adequate medical care due to lack of means".⁵⁰⁶ Nevertheless, the free public healthcare system contained the problems of overcrowding, long queues, poorer medical quality and growing shortage of medical professionals that the vulnerable groups who see doctors more often felt tired and psychologically felt bad when seeking medical treatment in public

⁵⁰³ Interviews with Social Worker 1 and Social Worker 2.

⁵⁰⁴ Interviews with Social Worker 1 and Social Worker 2. The Comprehensive Social Security Assistance Scheme is a non-contributory but means-tested scheme administered by the Social Welfare Department to provide a safety net for Hong Kong residents who suffer financial hardship due to various reasons such as low earnings, unemployment, disability, illness and old age (Social Welfare Department, 2011, p.1). The Scheme is designed to bring the income of such residents "up to a prescribed level to meet their basic needs" (Social Welfare Department, 2011, p.1).

⁵⁰⁵ Interviews with Social Worker 1 and Social Worker 2. According to Social Worker 2, Medical Social Workers or Social Workers of the Social Welfare Department have discretion to decide whether an applicant will be granted a one-off medical waiver or a medical waiver that is valid for a period of time based on an applicant's needs and clinical condition. In 2004/05, about 1.1 million persons were granted medical waiver at a cost of over HK\$500 million (Office of The Ombudsman, 2006, p.2). For more detailed information about the medical fee waiver system and the income and asset limit tests, please refer to the information leaflet entitled "Waiving Mechanism of Public Hospitals", which can be accessed online (<http://www.ha.org.hk/haho/ho/hacp/122630e.htm>).

⁵⁰⁶ Interviews with Social Worker 1 and Social Worker 2.

hospitals.⁵⁰⁷ Both Social Worker 1 and Social Worker 2 interviewed said that there was much room for the government to improve the existing public healthcare system by implementing hospital reform although it was possible that the government would face strong opposition from doctors or upper-ranked staff who had embedded interests in the hospital system.⁵⁰⁸

(4) Insurance Consultants

Insurance Consultant 1 and Insurance Consultant 2 interviewed had diverse views on whether the voluntary HPS would be implemented but shared the view that the introduction of the proposed HPS would only bring incremental change to the existing healthcare financing structure.⁵⁰⁹ Insurance Consultant 1 interviewed said that he and his colleagues were against the implementation of the HPS because the regulatory requirements specified in the proposed HPS were too harsh, thereby making the proposed HPS look very unattractive.⁵¹⁰ Two of the regulatory requirements specified in the proposed HPS, namely “no-turn away of subscribers and guaranteed renewal for life” and “high-risk individuals insurable with a cap on premium loading”, would definitely attract the seriously ill and people with pre-existing medical conditions to

⁵⁰⁷ Interviews with Social Worker 1 and Social Worker 2.

⁵⁰⁸ Interviews with Social Worker 1 and Social Worker 2.

⁵⁰⁹ Interviews with Insurance consultant 1 and Insurance consultant 2.

⁵¹⁰ Interview with Insurance consultant 1.

join the Scheme.⁵¹¹ Since insurance companies were for-profit organizations, they were reluctant to bear high risk and suffer heavy financial losses.⁵¹² Insurance Consultant 1 interviewed said that the HPS would be a stillborn scheme without the support of the insurance industry.⁵¹³ Even if the HPS was implemented finally, the voluntary nature of the scheme would only have little take-up rate.⁵¹⁴ The proposed HPS would not attract the rich, the healthy or those who had already bought health insurance but people with pre-existing conditions or people whose insurance applications were rejected by insurance companies before.⁵¹⁵ The HPS would end up playing a negligible role in supplementing public funding.⁵¹⁶

Besides, Insurance Consultant 1 interviewed said that it was too ideal for the government to think that people who subscribed to the HPS would go to private hospitals to receive medical treatment and thus alleviate the burden of the public hospitals.⁵¹⁷ In fact, his clients who bought private health insurance fell back to public hospitals for medical treatment, in particular inpatient treatment, because the charging system in private hospitals was not transparent enough.⁵¹⁸ Although the

⁵¹¹ Interview with Insurance consultant 1.

⁵¹² Interview with Insurance consultant 1.

⁵¹³ Interview with Insurance consultant 1.

⁵¹⁴ Interview with Insurance consultant 1.

⁵¹⁵ Interview with Insurance consultant 1.

⁵¹⁶ Interview with Insurance consultant 1.

⁵¹⁷ Interview with Insurance consultant 1.

⁵¹⁸ Interview with Insurance consultant 1.

proposed HPS offered coverage based on packaged charging to reduce charge uncertainty, it may not gain the support from private hospitals which had different costing and pricing systems.⁵¹⁹ Private hospitals may only provide packaged charging with limited scope or provide no packaged charging at all in order to protect their business.⁵²⁰ Therefore, there was great possibility that people subscribed to the proposed HPS were deterred from using private healthcare services but fell back to public hospitals again when they were sick.⁵²¹ But Insurance Consultant 1 interviewed said that he and his colleagues were against the introduction of packaged charging because it would only distort the operation of the market.⁵²² Hong Kong, as a capitalist city, should not implement any measures which distort the operation of the market.⁵²³

Insurance Consultant 2 interviewed said that there was high possibility that the HPS would be implemented because the scheme was better than current private health insurance products in terms of the type of subscriber, renewal, and portability.⁵²⁴ However, she thought that the implementation details of packaged charging were unclear in the public consultation document that the pricing system at private

⁵¹⁹ Interview with Insurance consultant 1.

⁵²⁰ Interview with Insurance consultant 1.

⁵²¹ Interview with Insurance consultant 1.

⁵²² Interview with Insurance consultant 1.

⁵²³ Interview with Insurance consultant 1.

⁵²⁴ Interview with Insurance consultant 2.

hospitals still lacked transparency.⁵²⁵ It made citizens hesitant about joining the proposed HPS and those who subscribed to the HPS feel more secure to seek medical care in public hospitals where the medical fees were low, the pricing system was transparent, and the risk of bearing uncertain costs were the lowest.⁵²⁶ Besides, Insurance Consultant 2 interviewed thought that introducing packaged charging would not be feasible in private hospitals because private hospitals treated the provision of private medical services as a profit making business.⁵²⁷ Private hospitals would only introduce packaged charging with limited scope or refuse to introduce any packaged charging.⁵²⁸ Without the cooperation of private hospitals, those subscribed to the HPS would not be able to benefit much from the Scheme as the government originally expected.⁵²⁹ And the supplementary role played by the HPS would not be able to alleviate the financial burden of the government in the long run, especially when the problem of ageing population became more serious.⁵³⁰

(5) Medical Professionals

Doctor 1 interviewed thought that citizens would not be enthusiastic about joining the proposed HPS because they did not want to spend extra money on healthcare when

⁵²⁵ Interview with Insurance consultant 2.

⁵²⁶ Interview with Insurance consultant 2.

⁵²⁷ Interview with Insurance consultant 2.

⁵²⁸ Interview with Insurance consultant 2.

⁵²⁹ Interview with Insurance consultant 2.

⁵³⁰ Interview with Insurance consultant 2.

the existing public healthcare system provided them with free medical services.⁵³¹

The immediate effect one felt after subscribing to health insurance was having less money in his/her pocket.⁵³² Besides, it was possible that citizens subscribing to the HPS would still obtain medical treatment in public hospitals for fear of bearing uncertain and expensive medical expenses charged by private hospitals.⁵³³ Doctor 1 interviewed thought that the proposed health insurance reform had little impact on alleviating the burden of public hospitals.⁵³⁴ In fact, he argued that the government should not focus on implementing health insurance reform because a physician shortage was the most urgent problem to deal with.⁵³⁵ As a doctor, money was not his main concern although he recognized that the financial sustainability of the public healthcare system in the long run would be a problem because of the rapid growth of ageing population.⁵³⁶ But he concerned more about delivering quality care to patients.⁵³⁷ The undersupply of doctors in public hospitals lowered the morale of doctors and increased the workload of doctors, which in turn affected the service quality of public healthcare services.⁵³⁸ Patients complained about long waiting times but short consultation times.⁵³⁹ As Doctor 1 said during the interview, the specialist

⁵³¹ Interview with Doctor 2.

⁵³² Interview with Doctor 2.

⁵³³ Interview with Doctor 1.

⁵³⁴ Interview with Doctor 1.

⁵³⁵ Interview with Doctor 2.

⁵³⁶ Interview with Doctor 1.

⁵³⁷ Interview with Doctor 1.

⁵³⁸ Interview with Doctor 1.

⁵³⁹ Interview with Doctor 1. The Accident and Emergency Departments in public hospitals triage

outpatient clinic he worked for only had 180 quotas every day.⁵⁴⁰ In reality, however, it accepted 260 patients in an afternoon when there were only 10 doctors.⁵⁴¹ In general, he and his colleagues worked overtime and could only spend five to eight minutes on each patient.⁵⁴² He thought that the problem of physician shortage should be solved without delay.⁵⁴³ Besides, he thought that a reform on developing primary healthcare should be implemented so that the number of patients flocking to public hospitals could be reduced.⁵⁴⁴

Doctor 2 interviewed criticized the health insurance reform proposed by the government for being piecemeal, lacking details, and ineffective to solve the crux of the problem in the existing public healthcare system.⁵⁴⁵ He thought that it would be difficult for the government to implement the proposed HPS because the packaged charging proposed in the Scheme angered private hospitals and doctors and met

patients into five categories based on their clinical conditions, “namely critical, emergency, urgent, semi-urgent and non-urgent” (Hong Kong’s Information Services Department, 2012). In 2010-11, the Accident and Emergency Departments in public hospitals provided critical patients with immediate treatment, emergency patients with treatment within 15 minutes and urgent patients with treatment within 30 minutes (Hong Kong’s Information Services Department, 2012). But the overall waiting time for non-urgent patients was 101 minutes in 2010-11 (Hong Kong’s Information Services Department, 2012). As to specialist out-patient clinics in public hospitals, it triage patients into three categories, namely urgent, semi-urgent and routine categories (Hong Kong’s Information Services Department, 2012). The current median waiting time for urgent patients and semi-urgent patients are respectively one week and five weeks while that of non-urgent case vary from two weeks to 101 weeks (Hong Kong’s Information Services Department, 2012).

⁵⁴⁰ Interview with Doctor 1.

⁵⁴¹ Interview with Doctor 1.

⁵⁴² Interview with Doctor 1.

⁵⁴³ Interview with Doctor 1.

⁵⁴⁴ Interview with Doctor 1.

⁵⁴⁵ Interview with Doctor 2.

strong resistance from these two parties.⁵⁴⁶ While the government introduced the packaged charging to increase medical cost transparency in private hospitals and enhance consumer protection, private hospitals and doctors regarded the introduction of packaged charging as an unpopular measure adopted by the government to intervene in their business and restrict how much money they could earn.⁵⁴⁷ As Doctor 2 said during the interview, doctors and private hospitals were reluctant to cut the prices in order to fit packaged charging, especially doctors and private hospitals that wanted to earn more profits.⁵⁴⁸ Besides, senior and prestigious specialists would not have any intention to provide packaged charging because they were approached by patients who did not mind paying more for the doctor's expertise and fame.⁵⁴⁹ These doctors had been fully occupied with patients that they had no interest in using packaged charging to attract more patients.⁵⁵⁰

On the other hand, packaged charging did not mean lowering medical fees or providing patients with healthcare services at a more reasonable price.⁵⁵¹ It was because the packaged fees were set higher by hospitals so that the medical costs of

⁵⁴⁶ Interview with Doctor 2.

⁵⁴⁷ Interview with Doctor 2.

⁵⁴⁸ Interview with Doctor 2.

⁵⁴⁹ Interview with Doctor 2.

⁵⁵⁰ Interview with Doctor 2.

⁵⁵¹ Interview with Doctor 2.

high-risk patients would be subsidized by low-risk patients.⁵⁵² Packaged charging would increase the fees of low-risk surgery such as appendectomy but decrease the fees of high-risk surgery such as brain surgery.⁵⁵³ Low-risk patients were treated unfairly for paying higher medical fees.⁵⁵⁴ Besides, hospitals would limit patients' freedom to choose their doctors when implementing packaged charging in order to control medical costs and maintain profit levels.⁵⁵⁵ Patients failing to choose their own doctors under packaged charging meant that patients' rights were not protected".⁵⁵⁶

In fact, Doctor 2 interviewed thought that rather than implementing health insurance reform, the government should focus on implementing doctor work reform because the crux of the problem in the existing public healthcare system was serious wastage problem of doctors in public hospitals.⁵⁵⁷ Heavy workload, long work hours, and excessive call frequency led to high turnover rates of doctors at public hospitals,

⁵⁵² Interview with Doctor 2.

⁵⁵³ Interview with Doctor 2.

⁵⁵⁴ Interview with Doctor 2.

⁵⁵⁵ Interview with Doctor 2.

⁵⁵⁶ Interview with Doctor 2.

⁵⁵⁷ Interview with Doctor 2. According to the information provided by Legislative Council Secretariat (2011b), as at 28 February 2011, "there were 5,063 doctors working in HA and the ratio of doctors per 1,000 population was 0.7" (p.1). The turnover rates of doctors in HA rose from 4.4 per cent in 2009-2010 to 5.3 per cent in 2010-2011 (Legislative Council Secretariat, 2011b, p.1). In 2010-2011, Obstetrics and Gynaecology had the highest turnover rate of 10.2 per cent, which was followed by Ophthalmology (7.3 per cent), and Intensive Care Unit (7.1 per cent) (Legislative Council Secretariat, 2011b, p.1).

especially senior doctors.⁵⁵⁸ The shortage of doctors in public hospitals was one of the reasons why the problems of long queues and service quality deterioration had become more serious in recent years.⁵⁵⁹ Doctor 2 interviewed said that the government should implement doctor work reform to reduce doctors' work hours, reshuffle doctors' work activities, enhance manpower training, attract and retain doctors, which in turn improved the delivery and quality of healthcare service in public hospitals.⁵⁶⁰

Nurse 1 interviewed said that the proposed HPS was not a good option because health insurance was a commodity or product for insurance companies to earn many profits.⁵⁶¹ She thought that buying the HPS did not mean the insured would seek medical care in private hospitals because private hospitals were places for doing minor surgeries and having body check only and their charges were not transparent.⁵⁶² When people were seriously ill, they would still prefer seeking medical treatment in public hospitals.⁵⁶³ Besides, the implementation of the proposed HPS would worsen

⁵⁵⁸ Interview with Doctor 2. According to the information provided by Legislative Council Secretariat (2011b), in September 2006, about 900 HA doctors in 12 clinical specialties worked for more than 65 hours per week on average, representing 18 per cent of HA doctors (p.7). By the end of December 2009, there were still 252 doctors in 10 clinical specialties working for more than 65 hours per week on average, representing 4.8 per cent of HA doctors (Legislative Council Secretariat, 2011b, p.7). In 2009, there were 221 doctors undertaking on-site on-call duties for more than 24 hours in one-go (Legislative Council Secretariat, 2011b, p.7).

⁵⁵⁹ Interview with Doctor 2.

⁵⁶⁰ Interview with Doctor 2.

⁵⁶¹ Interview with Nurse 1.

⁵⁶² Interview with Nurse 1.

⁵⁶³ Interview with Nurse 1.

the problem of manpower shortage in public hospitals because there would be an exodus doctors and nurses from public hospitals to private hospitals in order to earn more money.⁵⁶⁴ Public hospitals would become even more short-handed, leading to doctors and nurses in public hospitals bearing heavier workload, having lower morale and having more medical blunders.⁵⁶⁵ It would also worsen the delivery of healthcare and the quality of medical services.⁵⁶⁶ Nurse 1 interviewed said that the government should not rush into implementing health insurance reform because the idea of individual responsibility promoted by health insurance went against the idea of government responsibility deeply embedded in the free healthcare system.⁵⁶⁷ She emphasized that healthcare was a social welfare and the government should continue to bear the responsibility of funding the public healthcare system.⁵⁶⁸ Besides, she thought that the implementation of health insurance reform was unable to solve a critical shortage of nurses in public hospitals.⁵⁶⁹ She said that the government should implement nurse work reform to increase the supply of nurses, reduce nurses' work

⁵⁶⁴ Interview with Nurse 1.

⁵⁶⁵ Interview with Nurse 1.

⁵⁶⁶ Interview with Nurse 1.

⁵⁶⁷ Interview with Nurse 1.

⁵⁶⁸ Interview with Nurse 1.

⁵⁶⁹ Interview with Nurse 1. According to the information provided by Legislative Council Secretariat (2011c), as at 31 December 2010, "there were 19,951 nurses working in HA"(p.2). The turnover rates of HA nurses rose from 4.1 per cent in 2009 to 5.1 per cent in 2010 (Legislative Council Secretariat, 2011c, p.2). In 2010, Paediatrics (8.8 per cent) had the highest turnover of nurses, which was followed by Obstetrics and Gynaecology (6.2 per cent), and Surgery (5.6 per cent) (Legislative Council Secretariat, 2011c, p.2). In 2009, "the shortage of nurses reached a crisis point" (Cheng, 2010, January 21) that there was a forced closure of a 36-bed ward in Pamela Youde Nethersole Eastern Hospital (Cheng, 2010, January 21). Besides, there was the cancellation of 30 surgeries in Queen Mary Hospital "after more than half the nurses scheduled for duty that day called in sick" (Cheng, 2010, January 21).

hours, improve nurses' working environment and promotion prospects, and enhance the training of nurses.⁵⁷⁰

(6) Former Legco Member

Former Legco Member 1 interviewed argued that the government's real intention of introducing the proposed HPS was shirking its responsibility for funding healthcare because the government anticipated the financial burden caused by the problem of ageing population would be serious in future.⁵⁷¹ The government used the health insurance scheme to spread a message that healthcare was a personal responsibility and asked the citizens, in particular the middle class, to take care of their own health.⁵⁷² As Former Legco Member 1 said during the interview, it was obvious that the government's real target was the middle class when proposing the voluntary health insurance scheme due to the middle class having the financial ability to join the Scheme.⁵⁷³ The poor who barely made ends meet would not join the Scheme while the rich did not need to buy health insurance.⁵⁷⁴ And the elderly could hardly join the Scheme because the indicative annual premium of the proposed HPS was very expensive, which was at least HK\$5,570.⁵⁷⁵ Since the proposed HPS was a voluntary

⁵⁷⁰ Interview with Nurse 1.

⁵⁷¹ Interview with the former Legco Member 1.

⁵⁷² Interview with the former Legco Member 1.

⁵⁷³ Interview with the former Legco Member 1.

⁵⁷⁴ Interview with the former Legco Member 1.

⁵⁷⁵ Interview with the former Legco Member 1. According to Food and Health Bureau (2010), the

scheme, middle-class people could decide whether to join the proposed HPS or not.⁵⁷⁶

But the proposed HPS was very unfair to the middle class because the middle class had already contributed through taxation which paid for the public healthcare system.⁵⁷⁷ Joining the proposed HPS would increase the financial burden of the middle class.⁵⁷⁸

Besides, Former Legco Member 1 interviewed argued that packaged charging was just a promotion gimmick used by the government that could hardly gain support from private hospitals.⁵⁷⁹ Private hospitals were not interested in providing packaged charging because packaged charging reduced their profits.⁵⁸⁰ If the private hospitals refused to provide packaged charging or only provided limited packaged charging, the government would become the provider of packaged charging, private hospital services or other value-added services within public hospitals.⁵⁸¹ It would create a two-tier service structure within the public hospitals while at the same time creating social inequality within public hospitals.⁵⁸² It was because the HPS participants could

indicative annual premiums with zero deductible based on actuarial evaluation varied among different age bands (p.70). The indicative annual premium was HK\$1,570-\$2,360 for people aged 20 to 39, HK\$5,570-\$12,570 for people aged 60 to 84, and HK\$15,000 for people aged over 85 (Food and Health Bureau, 2010, p.70).

⁵⁷⁶ Interview with the former Legco Member 1.

⁵⁷⁷ Interview with the former Legco Member 1.

⁵⁷⁸ Interview with the former Legco Member 1.

⁵⁷⁹ Interview with the former Legco Member 1.

⁵⁸⁰ Interview with the former Legco Member 1.

⁵⁸¹ Interview with the former Legco Member 1.

⁵⁸² Interview with the former Legco Member 1.

enjoy the privileges of seeing a doctor with shorter queuing time and having better service quality while the uninsured had to bear the long queue.⁵⁸³

(7) Former Member of the Public Complaints Committee of the Hospital Authority

Former member of the Public Complaints Committee of the HA interviewed argued that it was wrong for the government to have the thought of implementing health insurance reform because the advantages of the proposed HPS claimed by the government, namely the provision of more choices of value-for-money healthcare services for citizens and lifelong protection, did not exist in reality.⁵⁸⁴ He said that packaged charging which was a major selling point made by the government was not applicable to all patients, especially high-risk patients and those who had complications making the medical costs difficult to calculate.⁵⁸⁵ Complications could never be predicted by patients, family members or doctors.⁵⁸⁶ It was very difficult and impossible to calculate the accurate costs caused by complications and there was no way private hospitals would provide an all-inclusive packaged charging.⁵⁸⁷ If a HPS participant suffered from post surgery complications and needed extra inpatient

⁵⁸³ Interview with the former Legco Member 1.

⁵⁸⁴ Interview with the former member of the Public Complaints Committee of the HA.

⁵⁸⁵ Interview with the former member of the Public Complaints Committee of the HA.

⁵⁸⁶ Interview with the former member of the Public Complaints Committee of the HA.

⁵⁸⁷ Interview with the former member of the Public Complaints Committee of the HA.

stays, he/she would end up paying expensive medical fees.⁵⁸⁸ He said that the government should not overemphasize the positive aspects of packaged charging while hindering its negative aspects just because it wanted more citizens to join the health insurance scheme.⁵⁸⁹ Besides, packaged charging affected doctors' professional judgment by encouraging them to deliver medical services based on prices instead of being based on patients' conditions and needs.⁵⁹⁰ It would violate medical ethics and create an unhealthy doctor-patient relationship.⁵⁹¹

In fact, former member of the Public Complaints Committee of the HA interviewed argued that the proposed HPS was not a feasible scheme to direct patients away from the public hospitals.⁵⁹² Citizens joining the HPS may not obtain healthcare services in private hospitals for fear of private hospital expenses being an endless pit.⁵⁹³ He argued that if the government really concerned about rising medical costs and the financial sustainability of the public healthcare system in the long run as mentioned in the public consultation document, it should not use the implementation of voluntary health insurance reform as a solution.⁵⁹⁴ He believed that implementing structural reform of the HA was a more practical way to help government save money

⁵⁸⁸ Interview with the former member of the Public Complaints Committee of the HA.

⁵⁸⁹ Interview with the former member of the Public Complaints Committee of the HA.

⁵⁹⁰ Interview with the former member of the Public Complaints Committee of the HA.

⁵⁹¹ Interview with the former member of the Public Complaints Committee of the HA.

⁵⁹² Interview with the former member of the Public Complaints Committee of the HA.

⁵⁹³ Interview with the former member of the Public Complaints Committee of the HA.

⁵⁹⁴ Interview with the former member of the Public Complaints Committee of the HA.

while a reform on developing and strengthening primary care was more conducive to having better access to preventive care and reducing citizen's demand for hospital-led healthcare, thereby reducing medical costs and increasing both efficiency and the financial sustainability of the public healthcare system in the long run.⁵⁹⁵

(8) Scholars

Professor 1 interviewed said that the proposed HPS, if being implemented finally, would only play a negligible role in healthcare financing.⁵⁹⁶ At present, there were about 2.4 million people in Hong Kong subscribing to private health insurance, which exceeded one-third of the Hong Kong population.⁵⁹⁷ However, only about 10 per cent of the insured used medical services in private hospitals".⁵⁹⁸ It was because the insured were afraid of insufficient insurance coverage for all the private hospital expenses, having insufficient cash on hand to pay the private hospital expenses in advance, and losing no-claim discount.⁵⁹⁹ There was great possibility that citizens subscribing to the HPS ended up seeking medical care in public hospitals due to the lack of price transparency in private hospitals and the burden of unforeseen medical

⁵⁹⁵ Interview with the former member of the Public Complaints Committee of the HA.

⁵⁹⁶ Interview with Professor 1.

⁵⁹⁷ Interview with Professor 1.

⁵⁹⁸ Interview with Professor 1. According to "*My Health, My Choice*" document, there were about 2.42 million people covered by private health insurance in 2008, which was equivalent to 34 per cent of Hong Kong's resident population (Food and Health Bureau, 2010, p.72). However, the share of private health insurance in financing total health expenditure was only 13 per cent (Food and Health Bureau, 2010, p.78).

⁵⁹⁹ Interview with Professor 1.

costs.⁶⁰⁰ As a result, public hospitals would become further strained.⁶⁰¹ Professor 1 interviewed said that the government was over-optimistic about the effectiveness of the HPS to increase citizens' use of private healthcare services.⁶⁰² Since the HA was the victim of its own success, the implementation of the HPS would not resolve the problem of imbalance between the public and private sectors.⁶⁰³ He criticized the government for proposing health insurance reform while ignoring the importance of developing preventive and primary care in increasing efficiency and cost-effectiveness of the public healthcare system.⁶⁰⁴

Professor 2 interviewed said that the packaged services provided by private hospitals would be piecemeal because most of the businesses of private hospitals came from the rich and there was tight supply of medical services in private hospitals.⁶⁰⁵ Besides, he worried that the proposed HPS would “stimulate moral hazard from both the supply and demand sides”⁶⁰⁶ when doctors tried to earn more money by having unnecessary tests, operations and treatments while patients tried to get more reimbursement by having longer inpatient stays.⁶⁰⁷ Also, he thought that the

⁶⁰⁰ Interview with Professor 1.

⁶⁰¹ Interview with Professor 1.

⁶⁰² Interview with Professor 1.

⁶⁰³ Interview with Professor 1.

⁶⁰⁴ Interview with Professor 1.

⁶⁰⁵ Interview with Professor 2.

⁶⁰⁶ Interview with Professor 2.

⁶⁰⁷ Interview with Professor 2.

government should utilize the HK\$50 billion drawn from the fiscal reserve in a better way by helping the poor and the seriously ill instead of using the money as an incentive to encourage people to join the HPS.⁶⁰⁸ It gave a very bad impression to citizens that the government used tax dollars to subsidize private insurance companies.⁶⁰⁹ Professor 2 interviewed said that “tax deduction or tax rebate were more effective to attract people to join the HPS”.⁶¹⁰ But he said that “the government should consider developing primary healthcare which played a gate-keeping role to relieve the burden on public hospitals”.⁶¹¹

Professor 3 interviewed criticized the government for targeting the working population, especially the middle class, when proposing the HPS.⁶¹² He said that the proposed HPS was an unfair scheme and would definitely increase the financial burden of citizens who had already paid tax and contributed to MPF.⁶¹³ He argued that the implementation of health insurance reform was not a right solution to solve the problems of rising medical costs and ageing population. He suggested the government strengthen and promote the development of Chinese medicine because Chinese medicine was conducive to maintaining good health, preventing diseases, and

⁶⁰⁸ Interview with Professor 2.

⁶⁰⁹ Interview with Professor 2.

⁶¹⁰ Interview with Professor 2.

⁶¹¹ Interview with Professor 2.

⁶¹² Interview with Professor 3.

⁶¹³ Interview with Professor 3.

treating both common and chronic diseases, which in turn reduced citizens' demand for hospital-led and curative medical services.⁶¹⁴

(9) Government Official

Government Official 1 interviewed said that the government intended to maintain the tax-funded public healthcare system which was efficient, equitable, and accessible

⁶¹⁴ Interview with Professor 3. Since 1998, “formal education at tertiary level on Chinese medicine has been introduced in Hong Kong” (Health and Welfare Bureau, 2000, p.32). At present, three local universities, namely the Baptist University, the Chinese University of Hong Kong, and the University of Hong Kong, operate a full-time degree course on Chinese medicine (Health and Welfare Bureau, 2000, p.32; Hong Kong’s Information Services Department, 2011). In 1999, the HKSAR government enacted the Chinese Medicine Ordinance to “provide the statutory framework for the regulatory control and development of Chinese medicine in Hong Kong” (Legislative Council Secretariat, 2005b, p.1). In his 2001-2002 Policy Address, the Chief Executive announced the introduction of Chinese medicine in the public sector in the form of outpatient service (Legislative Council Secretariat, 2007, p.1), with a view to “integrating Chinese medicine and western medicine in the public healthcare system in the long run” (Legislative Council Secretariat, 2005b, p.1) and providing “Chinese medicine in the hospital services” (Legislative Council Secretariat, 2005b, p.1). His target was establishing 18 Chinese medicine clinics by 2005 (Legislative Council Secretariat, 2007, p.2). However, the actual progress of establishing Chinese medicine clinics was slower than the target that only three public Chinese medicine outpatient clinics were established by 2005 on a trial basis (Legislative Council Secretariat, 2005b, p.1; Legislative Council Secretariat, 2007, p.2). A tripartite model was adopted in the clinics that the HA collaborated with a non-governmental organization and a local university (Legislative Council Secretariat, 2007, p.2). Under the collaboration model, the HA was responsible for “ensuring standardization and safety in the use of Chinese medicine products” (Legislative Council Secretariat, 2007, p.2) while the non-governmental organization was responsible for “the day to day operations of the clinics” (Legislative Council Secretariat, 2007, p.2) and the university was responsible for managing the research and training programmes of the clinics (Legislative Council Secretariat, 2007, p.2). According to Health, Welfare and Food Bureau and Hospital Authority (2005), the number of consultation per month in the three public Chinese medicine clinics increased from 3,873 in January 2004 to 6,803 in March 2005 (p.2). In his Policy Address in 2005, the Chief Executive was committed to establish six new Chinese medicine clinics in 2005-2006 (Legislative Council Secretariat, 2007, p.2). At present, there are a total of 16 public Chinese medicine outpatient clinics (The Hospital Authority, 2011). When all the 18 public Chinese medicine clinics were established, it would only take up 5 to 6 per cent of the Chinese medicine service market in Hong Kong (Legislative Council Secretariat, 2007, p.4). The Chinese medicine clinics serve patients through a daily quota system and charge a fee of HK\$120 “for each consultation, including two doses of Chinese medicine” (Legislative Council Secretariat, 2007, p.3). The level of subsidy for the public Chinese medicine outpatient clinics is about 50 per cent (Legislative Council Secretariat, 2007, p.4). In his 2010-2011 Policy Address, the Chief Executive mentioned that the legislation on proprietary Chinese medicines would come into effect in phases from late 2010 (Tsang, 2010). But the government has not announced any concrete policies or new arrangement to develop and promote Chinese medicine over the past seven years.

and used the proposed HPS to supplement instead of replacing public funding.⁶¹⁵ He said that in light of much opposition to previous healthcare financing reforms, the government had to carefully consider the level of public acceptance and the reaction of Legco members who represented the interests of grassroots, middle-class people, and business field when proposing the HPS.⁶¹⁶ It wanted to adopt a gradual approach to improve the existing public healthcare system in order to meet the expectations of the community and provide the safety net for low-income patients.⁶¹⁷ Government Official 1 interviewed said that the government did not encourage the elderly to join the HPS because the old-age premium was expensive.⁶¹⁸ Public hospitals would still be the safety net for the elderly to seek medical care.⁶¹⁹ But the government encouraged those who were able and willing to afford to join the HPS.⁶²⁰ Besides, the government encouraged those with existing medical insurance to migrate to the HPS so that the risk pool under the HPS would be larger and have better ability to spread risks.⁶²¹

Government Official 1 interviewed said that the implementation of the HPS was only viable unless there were 500,000 HPS participants to form a risk pool, the

⁶¹⁵ Interview with Government Official 1.

⁶¹⁶ Interview with Government Official 1.

⁶¹⁷ Interview with Government Official 1.

⁶¹⁸ Interview with Government Official 1.

⁶¹⁹ Interview with Government Official 1.

⁶²⁰ Interview with Government Official 1.

⁶²¹ Interview with Government Official 1.

participation of all private insurance companies in the HPS to bear the risk and the cooperation of private hospitals to provide packaged charging.⁶²² He said that the government did not prefer using tax rebate or any other tax incentives to attract people to join the HPS because it would violate the established tax neutrality principle and further narrow the tax base of Hong Kong.⁶²³ If private hospitals were not interested in providing packaged charging, the government would consider providing more private rooms and private hospital beds in public hospitals so that patients joining the HPS could have greater choice in public hospitals.⁶²⁴ And if private insurance companies were not interested in providing the HPS, the government would consider establishing its own mechanism to provide the Scheme.⁶²⁵ Besides, it would consider establishing a government regulated arbitration mechanism to handle health insurance claim disputes.⁶²⁶

From the above, it shows that different actors, including citizens, civil servants, social workers, insurance consultants, medical professionals, former Legco member, former member of the Public Complaints Committee of the HA, scholars, and the government official, responded differently to the proposed voluntary private health

⁶²² Interview with Government Official 1.

⁶²³ Interview with Government Official 1.

⁶²⁴ Interview with Government Official 1.

⁶²⁵ Interview with Government Official 1.

⁶²⁶ Interview with Government Official 1.

insurance. Most of them shared the view that the free public healthcare system should be maintained because it was a safety net which promoted the ideas of universal access, equality and was a welfare benefit the government having the responsibility for providing it. Besides, they questioned the effectiveness of the proposed voluntary private health insurance to provide participants with enough medical protection and worried about the problems that could be brought by the proposed voluntary private health insurance and packaged charging, such as moral hazard from both the supply and demand sides and the creation of two-tier service structure within public hospitals. Also, they thought that the proposed voluntary private health insurance was not useful to solve the problems faced by the current healthcare system, including ageing population, the lack of medical professionals, deteriorating service quality, and significant public-private imbalance. They argued that rather than implementing voluntary private health insurance, the government should implement preventive care, hospital reform, provide more training for medical professionals, and promote the development of Chinese medicine.

8.5 Historical Institutionalism and the Case Study of Hong Kong: Findings and Implications

The refined theory of historical institutionalism comprises seven explanatory elements:

contextual conditions, ideas, actors, political institutions, timing and sequences, path dependency, and policy feedback. When it is adopted to examine healthcare financing reforms in Hong Kong, it focuses on how the complex interplay of forces, namely contextual influences, ideas, actors, political institutions, timing and sequences, path dependency, and policy feedback, shaped healthcare financing reform process.

Having looked at healthcare financing reforms through the lens of historical institutionalism, this study argues that the case of Hong Kong is an example of path dependency. The Hong Kong government has failed to implement healthcare financing reforms over the past two decades. Its proposals for a coordinated voluntary insurance in 1993, a two-tier mandatory health insurance scheme in 1999 and a mandatory medical savings scheme in 2000 were shelved due to severe political and public opposition. As Gauld (2005b) argued, every time Hong Kong fell back to the status quo on healthcare financing after an exhaustive process of public consultation (p.227). In October 2010, a voluntary health insurance scheme was proposed to supplement public funding, with the government promising that it continued to heavily subsidize healthcare service. At the time of study, the government was still collating and analyzing the views on the reform option gathered from the public consultation. But the new voluntary health insurance scheme, if being implemented

successfully, would only bring incremental change to the existing healthcare financing arrangement that the status quo would be maintained once again. This study argues that the government's attempts to implement healthcare financing reforms in 1993 ended in failure because of (1) the political system becoming more democratic and representative, (2) policy feedback from government's previous commitment to healthcare, (3) the old ideas of free healthcare and equality being championed by citizens and legislators, and (4) a robust economy. Besides, it argues that the government failed to implement healthcare financing reforms in 1999 and 2000 because of (1) a disjointed political system, (2) difficult economic circumstances, (3) the new idea of mandatory contributions lacking public and political acceptance, (4) policy feedback from previous healthcare policies and the mandatory pension scheme, and (5) the institutionalization of old ideas. This study argues that it is the complex interplay of forces constraining the government from implementing healthcare financing reforms.

Firstly, historical institutionalism argues that political institutions play a determinant role in constraining or facilitating the structure of political opportunities for political actors in a given polity (Hall and Taylor, 1996, p.941; Immergut, 1998, p.21) and shaping their strategies and goals in the decision-making process that in turn

shape the political outcomes (Thelen and Steinmo, 1992, p.6; Koelble, 1995, p.236).

During the final years of the colonial rule, the democratization reforms implemented by the colonial administration to decolonize Hong Kong saw the emergence of new political actors, including elected legislators, political parties, business, professional and labour organizations, and civil society groups (Cheung, 2007a, p.53). The transition of the political system from an elite-consensual polity to a consultative democracy led to the colonial government having difficulty in securing a guaranteed majority support from the members in the Legco when implementing the 1993 healthcare financing reform. Legislators were active to gather and reflect public opinions in the Legco to affect the implementation of healthcare financing reform. In the post-colonial era, the disjointed political system caused by the legitimacy crisis of the Tung Administration, the tense Exco-Legco relationship and the disunity within the Exco acted as an impediment for the government to gather political support and reach a consensus on policy decisions for implementing healthcare financing reforms. Different political actors and different segments of people made the government's policy environment more crowded, turbulent and uncertain because they were more vocal and challenged the government's monopoly of decision-making powers both inside and outside the establishment. Political consultations, confrontations and negotiations replaced elite integration and consensus as the rule of the game between

the HKSAR government and the new political actors. In the Legco, legislators questioned government officials in charge of healthcare policies face-to-face. Political parties mobilized the mass to take collective action such as demonstrations to express public grievances. Outside the formal political institutions, pressure groups and civil societies actively pressed for policy changes while extensive media coverage of healthcare financing reforms formulated public opinions. As Cheung (2007a) argued, the introduction of democratization reforms in Hong Kong helped “unleash new players and new dynamics into local politics” (p.53) and created “new institutional tensions and cleavages” (p.53) because of conflicting interests and competing values among political actors. It weakened the government’s capacity for securing majority support and reaching policy consensus. In the post-colonial era, the HKSAR government was “marred by internal cleavages and insufficient coordination and joining up” (Cheung, 2007a, p.57), facing the problem of institutional incongruity (Lee, 1999, p.941). The disunity within the Exco due to intra-elite rivalries between the Chief Executive and the senior civil service and the disconnection and tensions between the Exco and the Legco weakened the strength of political institutions to formulate and implement healthcare financing reforms (Lee, 1999; Cheung, 2010). As Rathwell (1998) argues, the “lack of broad public support for reform [acts as] a major barrier to change” (p.396). Without political support and trust, the HKSAR

government could face high political costs of changing the healthcare funding system.

At last, the status quo of healthcare financing system was maintained.

Secondly, historical institutionalism argues that policy feedback provides resources and creates incentives that can facilitate, strengthen or inhibit the formation or expansion of stakeholder interests (Pierson, 1994, pp.40-1). Besides, it shapes public attitudes towards contemporary public policies (Pierson, 1994, p.45; Gusmano et al., 2002, p.734). Policy feedback from the government's previous commitment to provide and finance medical services since the early 1960s had continuously increased the public acceptance of and demand for the government's involvement in providing and financing healthcare services. Although the colonial government's decision to increase its involvement in healthcare out of political and economic calculation, it produced feedback effect that greatly limited its capacity of implementing healthcare financing reform or deviating from the original path. As Pierson and Skocpol (2002) argued, outcomes "at a critical juncture trigger feedback mechanisms that reinforce the recurrence of a particular pattern into the future" (p.699). The self-reinforcing process made the policy makers feel difficult to reverse course once they had ventured far down a particular path (Pierson and Skocpol, 2002, pp.699-700). Besides, policy feedback from the establishment of a public healthcare

system generated a strong and wide base of public support that the general public had become strong defenders of their interests and opponents of healthcare financing reforms over the past two decades. The exposure model of policy feedback led to the general public feel comfortable with interacting with the current public healthcare system. Besides, the experience model of policy feedback led to the general public supporting the public healthcare system when their previous personal experience showed that they benefited from enjoying free healthcare, universal access to healthcare and equal treatment. In Hong Kong, the policy of providing free healthcare system induced positive feedback effect, thereby reinforcing the status quo. Citizens and legislators favored the maintenance of the free healthcare and disliked the government's proposals for implementing health insurance.

Policy feedback from the establishment of the HA also led to doctors who worked in public hospitals opposing both the mandatory schemes. It was because they worried that the implementation of these mandatory schemes would led to the HA losing government funding, the problem of moral hazard from both the supply and demand sides, and increasing their workload. Historical institutionalism argues that timing is very important. Policy feedback from the government's decision of implementing the MPF gave a bad impression to the public that the MPF scheme

restricted their freedom, increased their financial burden and was unable to give them sufficient retirement protection. The public felt annoyed when the HKSAR government consecutively proposed the mandatory health insurance in 1999 and medical savings schemes in 2000.

Thirdly, historical institutionalism argues that ideas matter in policy making (Campbell, 1998) because they either “favor significant policy change or reinforce existing institutional paths” (Hwang, 2006, p.16). The old ideas of free healthcare, universal access to healthcare, equality and healthcare as a welfare benefit were deeply entrenched in the public healthcare system since the early 1960s. The establishment of the HA further institutionalized these old ideas that created framing effects. These ideas became societal beliefs and were widely accepted and endorsed by the public and greatly reduced the government’s capacity of persuading the legislators and the community to accept and support new ideas. This explained why the programmatic ideas proposed in the 1993 *Rainbow Report*, such as the target group approach, the percentage subsidy approach and the coordinated voluntary insurance, did not generate wide support but severe criticisms. It also explained why the new idea of mandatory contribution towards healthcare failed to get public and political support and acceptance because the idea of compulsion was in conflict with

the equity principle. Besides, the idea of mandatory contribution was incompatible with the economic and social contexts which promoted freedom.

In fact, this study finds that there was a substantive contradiction between the government's thinking and the public's thinking on healthcare financing. The ideology embedded in the economic system shaped the government's proposals for healthcare financing reforms. As Cheung (1994) argued, institutions had "their own values, history and memory" that did not change overnight (p.353). The ideas of laissez-faire and free market were embedded in the economic system of Hong Kong. Both the colonial government and the HKSAR government adhered to the principle of 'small government, big market' and maintained a simple and low tax system to attract investment. Health care was subordinate to the economy. In order to maintain economic competitiveness and a friendly investment environment, the Hong Kong government did not propose any tax options such as widening the tax base or increasing tax rates to reform the healthcare financing system. As Wong (1999) argued, the maintenance of the low-tax policy provided the government with a strong justification to seek other options for financing healthcare (p.157). The government adopted demand-side strategies that emphasized individual responsibility and the principle of 'those who had the means paid more' when proposing financing options.

The coordinated voluntary insurance and increasing user fees proposed by the colonial government and both the mandatory medical insurance and savings schemes proposed by the HKSAR government were financing options that required citizens to shoulder their own responsibility for healthcare. These financing options prevented taxpayers from bearing the brunt of cost shifting from patients. However, the government's idea of asking citizens to bear a greater responsibility for their medical expenses was contrary to widespread public belief that healthcare was a basic right and healthcare service was a welfare service that the government was morally obligated to provide.

The government's official statement that 'no one should be denied adequate healthcare through lack of means' had become the government's fundamental philosophy since 1960. It made the government committed to providing heavily subsidized medical services which did not "discriminate patients on grounds of class or economic means" (Cheung, 1994, p.360). The establishment of the HA in 1990 further accentuated the government's role in and commitment to financing and providing healthcare services (Gauld, 1997, p.29). At the same time, the public perception that healthcare was a fundamental right and legal entitlement for all became further entrenched. Universal healthcare became a norm for all. As Wong

(1999) argued, the universal healthcare originally provided by the government out of economic and political considerations was of “undesirable ideological significance in shaping the public health care system as a social welfare institution” (p.151). Yuen (1997) also argued that the HA became “the victim of its own success” (p.396) because its no-turn away policy and its ongoing service improvements “resulted in a significant increase in patient load in HA hospitals” (Yuen, 1997, p.396). Since the public could receive better healthcare services at HA hospitals by paying a nominal fee, they were not willing to “pay more for what had already become the expected standard” (Gould, 2006, p.22). They strongly opposed the proposed healthcare financing options which deviated from the original healthcare financing model. As Gauld (1997) argued, the healthcare system harbored a multitude of entrenched interests that favored the status quo (p.36). Societal values or historical values “have a strong influence on what sorts of policies are considered feasible to execute” (Walt, 1998, p.377). In Hong Kong, the value clashes between the government and stakeholders led to “considerable resistance to executing policies” (Walt, 1998, p.369). In brief, both the ideas embedded in the economic system and public healthcare system were institutional values that were difficult to alter. While the ideas embedded in the economic system shaped the government’s logic in proposing healthcare financing options, the ideas embedded in the public healthcare system shaped the

public perception of healthcare. The substantive contradiction between the government's thinking and the public's thinking on healthcare financing created an obstacle to reform the healthcare financing system.

Fourthly, historical institutionalism argues that changes in contextual conditions, namely political, economic or social context, can generate the sources of institutional and policy changes. Contextual changes created a window of opportunity for political actors to adopt new goals or strategies. In the colonial era, a robust economy did not provide a window of opportunity for the colonial government to implement healthcare financing reform because a strong economic growth did not justify the government's claim that it was under any financial pressure. Legislators and the general public did not see that there was an urgent need to reform the funding structure of healthcare when the government was still financially capable of financing healthcare. As Gould (2006) argued, the colonial government was "in the absence of any urgent financial needs" to press ahead the healthcare financing reform in 1993 (p.22). In the HKSAR era, Hong Kong suffered a severe economic downturn after the Asian financial crisis of 1997. Amid economic downturn, the government respectively proposed the mandatory health insurance scheme in 1999 and the mandatory medical savings scheme in 2000. However, it failed to obtain wide public and political support but

oppositions. Legislators, political parties and the public complained that it was inappropriate and untimely for the government to propose these mandatory schemes at a time of economic hardship when many citizens suffered wage decline, asset deflation and unemployment. As Cheung (2007a) argued, the risk from change was “perceived to be too high by the public during times of economic recession” (p.60). Besides, it also gave the public an impression that the HKSAR government wanted to shirk its responsibility of financing healthcare at times of economic difficulties. Economic circumstances in Hong Kong did not provide any windows of opportunity or conjunctures for the current healthcare financing policy to move onto a new trajectory.

In brief, the case of Hong Kong is an example of path dependency in which “historical developments are a significant determinant of existing policy arrangements and capacity for change” (Gauld, 2005, p.228). Path dependency “occurs as the institutions and structures surrounding health policy and the health system, such as bureaucracies, policies and regulations, public perceptions and interest groups, become entrenched” (Gauld, 2005, p.228). These entrenchments “obstruct an easy reversal of the initial choice” (Pierson, 2000a, p.252) that the implementation of healthcare financing reforms in Hong Kong had turned out to be very difficult, be it in

the colonial or the post-colonial era. Hong Kong failed to break from its original path of healthcare funding that the status quo remained.

8.6 Conclusion

To conclude, the Hong Kong government had been proposing different financing options to reform the current funding arrangement of healthcare over the past two decades. However, its effort proved in vain because a complex interplay of forces, namely contextual influences, ideas, actors, political institutions, timing and sequences, path dependency, and policy feedback, acted as powerful constraints on its capacity for formulate and implement healthcare financing reforms that the status quo was maintained.

CHAPTER NINE: HISTORICAL INSTITUTIONALISM AND HEALTH INSURANCE REFORM IN SHANGHAI AND HONG KONG: FINDINGS AND IMPLICATIONS

9.1 Introduction

This study uses a refined theory of historical institutionalism to examine the divergent reform paths in Shanghai and Hong Kong from the mid-1980s onwards. It utilizes a qualitative case study approach to respectively examine the development trajectory of healthcare insurance reform in these two places. Shanghai and Hong Kong represent two contrasting cases. The former succeeded in replacing a free healthcare system with a mandatory cost-sharing health insurance system in 2000. The latter, however, failed to implement any health insurance reforms notwithstanding repeated attempts to do so that the healthcare system remains free. This study presents in detail the within-case descriptions and data analysis for each individual case.

A refined theory of historical institutionalism pays crucial attention to the role of political institutions, policy feedback and contextual conditions in affecting policy outcomes. This study finds that Shanghai succeeded in implementing health insurance reform because of the strong political institution along with a highly centralized

decision-making structure, policy feedback from the economic reform and free healthcare system, and changes in the political and economic contexts. On the other hand, this study finds that Hong Kong failed to implement any health insurance reforms because of a more democratic political system, policy feedback from the free healthcare system, and the impact of contingent economic circumstances. After presenting a detailed within-case analysis for each individual case, this chapter presents the cross-case analysis and major findings of this study by placing materials from the preceding chapters in a comparative context.

9.2 Two Case Studies: Comparing and Contrasting the Records of Shanghai and Hong Kong

Recalling Chapter Two on literature review, an intellectual debate on the convergence or divergence of healthcare system over the past two decades has generated much international comparative work in the field of health policy (Hurst, 1991; Ham and Brommels, 1994; Wilsford, 1994, 1995; Freeman, 1998; Hacker, 1998; Giaimo and Manow, 1999; Giaimo, 2001; Bandelow, 2007; Hassenteufel and Palier, 2007; Wendt and Thompson, 2004; Cacace and Schmid, 2008; Wendt and Kohl, 2010). Most of these cross-national comparative health research works are conducted to gain insight into how and why countries differ in the policies they adopt when facing similar

pressures or trying to solve similar healthcare problems. They help generate empirical knowledge for researchers and policy makers about health policy abroad, bring explanatory insight, and contribute to policy formulation and lesson drawing.

In comparing and contrasting Shanghai and Hong Kong, this study notes that it would be difficult to have a formal comparison between these two cases because they belong to diverse political and economic regimes. In order to circumvent this problem, this study utilizes the interpretive case study approach to compare these two cases. The use of the interpretive case study approach means that a theoretical framework is adopted to provide an explanation of particular circumstances or particular cases, which process, thereafter, can lead to a reevaluation of the theory. In this study, the theory of historical institutionalism is used as the basis of case interpretation or a template with which to compare the empirical results of these two case studies. Through the lens of historical institutionalism, the researcher aims toward analytical generalization of the case study results. Recalling Chapter Three on theory, historical institutionalism emphasizes that history matters. It takes time seriously, specifying sequences, tracing and analyzing process over substantial stretch of years to explain policy outcomes (Pierson and Skocpol, 2002, pp.695-8). Therefore, special attention is paid to the chronology when comparing and contrasting the development trajectory

of healthcare policy in Shanghai and Hong Kong. In fact, paying special attention to the chronology also has the advantage of highlighting the commonalities and differences in Shanghai and Hong Kong during different periods of time.

Both Shanghai and Hong Kong shared a common history as two of the five trading ports along the Chinese coast after China's defeat in the First Opium War (1839-1842). The semi-colonial status of Shanghai and the colonial status of Hong Kong contributed to the establishment and institutionalization of public health and healthcare systems in both places in the nineteenth century.

In Shanghai, the authorities in the foreign concessions developed public health at a faster pace and with a wider scope than the Chinese authorities. It was because the former aimed at turning Shanghai into a healthy place for economic growth while the latter lacked the political stability, financial resources and manpower to do so. Since the mid-19th century, the authorities in the foreign concessions had established sanitary infrastructures and public health related institutions to manage environmental sanitation and prevent epidemics. But the Chinese authorities did not establish a public health related institution until 1905 and even then they only provided piecemeal public health. On the other hand, neither the foreign nor the Chinese

authorities had any significant involvement in direct healthcare provision. While the foreign authorities wanted to save public expenditure and avoid tax increases, the Chinese authorities lacked sufficient funding. The Chinese authorities left the tasks of building hospitals and providing medical treatment for the mass to missionaries, local elites and businessmen, Chinese-style practitioners and later private practitioners. It was the establishment of missionary hospitals, summer disease hospitals, Chinese-medicine hospitals, and private hospitals that laid down the foundations of healthcare in China and provided the basis for building a modern healthcare system following the establishment of the PRC.

In Hong Kong, the colonial government, concerned with economic development and anxious to save public expenditure and avoid tax increases, played a negligible role in providing public health and healthcare. It was not until the outbreak of bubonic plague in the mid-1890s that the colonial government became more engaged in maintaining proper sanitary conditions so as to improve the public health of its population and facilitate economic growth. The colonial government provided limited medical services that were restricted to government officials, European citizens and prisoners. It left the tasks of providing medical services for the masses to churches, missionaries, charitable organizations and private practitioners. These groups

established clinics and hospitals. Thus, before the Second World War, the tripartite hospital system was established in Hong Kong, with the government, government-assisted, and private hospitals providing medical services.

From 1949 after the end of the Sino-Japanese War, the Pacific War and the Civil War, China underwent enormous political, economic and social changes. Elite politics were crucial from Mao to the post-Deng era because a state-party system made the political elite powerful enough to direct all policy decisions and to seek to impose any changes. Citizens barely had a chance to become involved in a closed policy-making process that was confined to a small circle of senior government officials. When the CCP under the leadership of Mao came to power in China in 1949, it advocated socialism and egalitarianism. Since the CCP elite regarded the healthcare system as a major pillar of socialism, they made healthcare a priority. The government implemented two types of free healthcare programmes--- the LIS and the GHS --- to ensure a healthy workforce in urban China and nationalized hospitals to make healthcare accessible to the majority of the population. In urban Shanghai, employees of work units enjoyed the LIS and the GIS and hospitals that were previously run by foreign missionaries or privately run by local elites and businessmen became nationalized.

However, when Deng came to power in China in the late 1970s, macro-policy was changed, as the elite advocated marketization and the implementation of economic reform to modernize China. Under the economic reform, the implementation of fiscal decentralization, the establishment of the financial responsibility system, and programmes of enterprise reform brought sharp changes to national economy. These also brought changes to healthcare: local government sharply reducing subsidies to hospitals, hospitals generating revenues on their own, and enterprises paying employees' medical expenses on their own. These changes led to soaring healthcare expenditures, the inability of enterprises to pay their employees' medical expenses, and in time the collapse of the free healthcare systems in China, including Shanghai. In turn, this compelled the central government to implement urban health insurance reform in the 1980s, which it accomplished in a number of phases: exploration, experimental, and implementation. Under decentralization, the Shanghai municipal government also became responsible for implementing urban health insurance reform.

On the other hand, after the Second World War, the Hong Kong authorities only made slow and minor policy changes. In the post-war period, the elite-consensual

polity remained unchanged and the government's decisions were legitimized only by the consensus of business elites who were closely allied with the colonial government. The masses barely had a chance to participate in the closed decision-making system and were expected to be grateful recipients. The colonial government adopted a passive and reactive attitude towards healthcare and it only increased its involvement in healthcare in response to the economic crisis in the 1950s and political crises triggered by the riots in the late 1960s. The provision of free medical services and more hospital facilities was the government's strategy to provide a healthy workforce for facilitating economic growth, strengthening political legitimacy and increasing social stability. The colonial government was involved in healthcare provision not out of any commitment to welfare, but involuntarily, in response to crises, which made it imperative to acknowledge political, economic, and social considerations. In the 1980s, it established the HA as a way to cut costs and deflect citizens' complaints about healthcare. Yet this further confirmed the role of the colonial government in providing healthcare services for its people. Thereafter, in the 1990s, the colonial government was under tremendous pressure to implement healthcare financing reform which it sought to accomplish via a series of reports and proposals.

Thus, both Shanghai and Hong Kong, in response to the pressures associated

with the rapid growth of ageing population, higher user expectations, and rising medical costs, embarked upon a series of health insurance reform in order to finance healthcare in a better way. But the reform process and result in these two places represented polar extremes: broad scale reform versus an enduring stability.

In Shanghai, health insurance reform was implemented in a gradual and peaceful manner because the CCP enjoyed the monopoly on making healthcare policy and it delegated power to the Shanghai municipal government to implement urban health insurance reform. It left no room for public participation or policy opposition. During the exploration phase (1984-1988), Shanghai experimented with co-payment schemes to contain healthcare costs. During the experimental phase (1994-1996), it implemented a pilot hospitalization insurance scheme coupled with a hospital revenue cap policy. And finally in 2000, it witnessed a revolution in healthcare financing in 2000 by officially replacing the free healthcare system with a mandatory cost-sharing health insurance system. The new health insurance scheme which contained an MSA and a SPF required contributions from both the work units and employees. In this study, when interviewing different stakeholders of healthcare,⁶²⁷ it became clear that they all responded differently to the new urban health insurance reform in Shanghai

⁶²⁷ Different stakeholders interviewed in Shanghai included former LIS and GHS beneficiaries, BMI participants, non-BMI participants, doctors, pharmaceutical company managers, private insurance managers, government officials and scholars.

because of having different interests and expectations. Most of the stakeholders interviewed were against the new health insurance reform because of the problems the reform created, including age disparity, soaring medical expenses and fraud conspiracy. However, notwithstanding such popular criticism, Shanghai was officially recognized by the central government as a success story of health insurance implementation and a role model for other parts of China to follow.

On the other hand, in Hong Kong, health insurance reform was implemented in a slow and winding process. It is because a consultative democracy implemented since the mid-1980s made different political actors and stakeholders more vocal and both the colonial and the HKSAR governments found it more difficult to secure guaranteed majority support from the Legco and the community. The HKSAR government was more active and consultative in considering health insurance reform. But it was unable to gather political support for implementing the reform. Vested interests that were deeply embedded in the public healthcare system blocked the health insurance reforms. Citizens responded negatively to the government's proposed financing options by invoking the principles of fairness, state utility and financial hardship. Every time the government found itself back to square one after conducting an exhaustive process of public consultation because it failed to obtain public support for

its proposed healthcare financing options.

The government's 1993 proposals for a coordinated voluntary insurance, their 1999 proposal for a two-tier mandatory health insurance scheme and their 2000 proposal for a mandatory medical savings scheme in 2000 were all shelved due to severe political and public oppositions. As a result, Hong Kong fell back to the status quo on healthcare financing. In the course of this study, many different actors were interviewed.⁶²⁸ These interviewees responded differently to the recent 2010 proposal for a voluntary private health insurance, but most of them shared the view that the free public healthcare system should be maintained.

So, overall, the patterns of healthcare financing reform in Shanghai and Hong Kong --- whilst confronting similar problems related to costs --- are quite different when viewed through the lens of historical institutionalism.

9.3 Historical Institutionalism: the Contribution of the Revised Approach

Recalling Chapter Three on theory, the traditional version of historical institutionalism contains six key characteristics: an insistence that institutions matter; the use of both

⁶²⁸ Different actors interviewed in Hong Kong included citizens, civil servants, social workers, insurance consultants, medical professionals, scholars and government officials.

calculus and cultural approaches to explain political behavior; the claim that history matters; an emphasis on path dependency; an insistence upon the importance of policy feedback from previous policy choices; and the use of in-depth case studies as the research strategy. However, recognizing that traditional historical institutionalism itself is weak in explaining changes in policy paths and pays insufficient attention to the roles of ideas and actors in shaping policy, this study refines historical institutionalism in two ways: firstly, by bringing the approach of institutional dynamism into the theory, and secondly, by taking note of the roles of ideas and actors. These revisions to the theory of historical institutionalism strengthen its analytical and explanatory power.

Firstly, this study refines historical institutionalism by bringing the approach of ‘institutional dynamism’ developed by Thelen and Steinmo (1992) into the theory in order to examine how broad changes in contextual conditions, namely political, economic or social, generate institutional and policy changes. According to Thelen and Steinmo (1992), there are four sources of institutional dynamism. The first source derives from the way changes in the political or socioeconomic context can suddenly transform previously latent institutions into salient arena of conflict and cooperation among political actors (p.16). The second source of institutional dynamism derives

from the way in which changes in the political or socioeconomic context lead to existing institutions performing new tasks, as new political actors emerge to pursue new goals through the existing institutions (Thelen and Steinmo, 1992, p.16). The third source of institutional dynamism derives from the way in which changes in the political or socioeconomic context lead to changes in political outcomes, as existing actors pursue new ideas, goals or strategies within the existing institutions (Thelen and Steinmo, 1992, pp.16-7). The fourth source of institutional dynamism derives from the way in which drastic institutional changes resulting from exogenous changes lead to political actors adjusting their strategies to accommodate such institutional changes (Thelen and Steinmo, 1992, p.17). The theoretical contribution made by this study is that the refined version of historical institutionalism after adding the approach of ‘institutional dynamism’ into it is no longer restricted to explain status quo and institutional stasis. Instead, it becomes more conducive to explaining institutional and policy changes.

Secondly, this study refines historical institutionalism by taking note of the roles of ideas and actors. As mentioned in Chapter Three, Thelen and Steinmo (1992), when introducing institutional dynamism, also acknowledge the roles of ideas and actors in affecting institutional change. However, they did not define the terms “ideas” and

“actors” and nor did they explain in any detail how the roles of ideas and actors affected institutional change. In recent years, Peters et al. (2005) and Steinmo (2008) have also stressed the importance of bringing ideas and actors into institutional analysis to understand institutional change. But similar to Thelen and Steinmo (1992), they do not define the terms “ideas” and “actors” well and nor do they explain in any detail how the roles of ideas and actors affected institutional change. The definitions of ideas and actors are loose and used to mean many different things. But if these two concepts are brought into institutional analysis, then they have to be clearly defined and operationalized so as to enhance the researcher’s ability to collect data more easily and gain new understandings of the usefulness of historical institutionalism in the analysis of healthcare.

In order to rectify the problem of the term “ideas” being poorly conceptualized, this study sharpens the concept of ideas by borrowing from the study of Campell (1998) and Hwang (2006), which identifies and clearly defines three types of ideational forces, namely programmatic ideas, policy paradigms and societal beliefs. In this study, these forces are illustrated in detail, revealing the impact of different types of ideas on governments’ and stakeholders’ attitudes towards health insurance reforms in Shanghai and Hong Kong, and the design and contents of health insurance

models in these two places. While this study emphasizes the importance of new ideas in facilitating changes, it also pays attention to the influences of old established ideas on affecting policy outcomes. Further, this study, by drawing insights from the study of Berman (2001) and Béland (2005a), highlights five conditions under which new ideas can achieve political prominence and public acceptance and in turn trigger institutional changes. These five conditions are: first, influential political actors with second, the ability and determination to promote new ideas, third, the right timing, fourth, a right fit with existing institutional structures, and fifth, being responsive to particular problems. By highlighting the conditions when new ideas can achieve political prominence, this study is able to explain how the relationship among ideas, actors, and institutions affects the success and failure of health insurance reform in Hong Kong

Besides, when bringing the role of actors into the theory of historical institutionalism, this study stresses the importance of identifying key political actors and different stakeholders and examining how and why they affect the health insurance reform process. Healthcare is a complicated issue and involves many stakeholders. These stakeholders have a vested interest in both the existing healthcare system and potential or real changes health insurance reform brings. They can either

facilitate or block the implementation of health insurance reform. Therefore, it is important for this study to examine whether and how different political actors, stakeholders and the public exert their influence over healthcare insurance reform process without downplaying the institutional influences on their goals, strategies and behavior. This study conducted interviews with government officials and different stakeholders in order to examine their views on changes brought by or proposed by new healthcare financing reform. Data collected from these interviews helps give a more complete picture of health insurance reform in Shanghai and Hong Kong.

In sum, this study refines the theory of historical institutionalism by bringing into it the approach of institutional dynamism plus the roles of ideas and actors. Adding these elements into the theory does not mean that the role of institutions in affecting policy outcomes is undermined. Instead, adding these elements makes the role of institutions in affecting policy outcomes more distinct. After all, institutional dynamism explains institutional and policy changes as an interaction between institutions and the broader political and socioeconomic context in which they operate. Besides, political institutions play a determinant role in defining the channels and mechanisms for absorbing and diffusing ideas, distributing power among political actors and shaping their goals and strategies in the decision-making process.

Therefore, one would not overlook the importance of political institutions when talking about institutional dynamism plus the roles of ideas and actors because these concepts are closely linked. While this study argues that institutions are not the sole determinant of political outcomes, rather there is a constellation of factors, it still regards institutions as the most influential factor in explaining policy outcomes. Below is the summary, discussion and comparison of the empirical findings of Shanghai and Hong Kong in relation to the theory of historical institutions

(a) The Case Study of Shanghai

This study argues that the Shanghai municipal government's successful 2000 implementation of health insurance reform, by replacing the free healthcare system with a new contributory health insurance system, was dependant upon four main factors:

- (1) the strong influence of the CCP along with a highly centralized decision-making structure;
- (2) the pace of collapse of the free healthcare system was triggered by a process of rapid policy feedback;

- (3) the crucial changes in the political and economic contexts, which had been initiated by the elite; and
- (4) the elite's ideological shift from egalitarianism to pro-market policies.

Firstly, this study finds that political institutions play a determinant role in facilitating urban health insurance reform. Here three points can be noted: the role of a strong state, the absence of veto opportunities, and the benefits of devolved local power.

In the PRC, the authoritarian political institutions, with the strong influence of the CCP, and a highly centralized decision-making structure, placed the central government in an advantageous position to implement urban health insurance reform without any political opposition. The closed policy-making process was confined to a small circle of senior officials from different ministries. The senior officials involved in bargaining during the policy making process had competing policy options, conflicting perspectives and conflicting interests. However, they would find ways to reconcile their differences and reach a consensus because they knew that the Central Committee to which they reported was the final decision-maker. On the other hand, the closed policy-making process did not provide any veto opportunities for

non-bureaucratic stakeholders in health insurance reform or interest groups to affect policy proposals or policy results. And finally, this study also finds that the Shanghai municipal government benefited from the central government's delegation of power to the local governments, because it enjoyed the autonomy, discretion, efficiency and flexibility to implement urban health insurance reform. Thus in 2000, it implemented the BMI System in Shanghai.

Secondly, this study finds that whilst policy feedback from the LIS and GIS created beneficiaries who could enjoy generous medical benefits, they lacked the strength and power to form political coalitions against the CCP's health insurance reform. The economic reforms implemented since 1978 and the LIS and GHS implemented since the early 1950s induced negative feedback effects, thereby undermining the fiscal and social sustainability of the free healthcare system in Shanghai. The economic reforms, together with the LIS and GHS, created a number of problems: a drastic increase in healthcare expenditures; moral hazard from both the supply and demand sides; and employees being 'underinsured' and 'uninsured'. These problems accelerated the pace of collapse of the free healthcare system in Shanghai. The government was compelled to change its policies and implement urban health insurance reform.

Thirdly, this study supports the claims made by Thelen and Steinmo (1992), that changes in the political or socioeconomic context lead to existing institutions performing new tasks because new political actors emerged to pursue new goals through the existing institutions (p.16). This study finds that elite-initiated changes in the political and economic contexts are crucial. In the PRC, from 1978 onwards, changes in the political context due to the rise of Deng Xiaoping as the new political leader, triggered changes in the economic context. Deng dismissed the ideology of egalitarianism that had been embedded in the socialist economy for more than three decades and endorsed the new ideology of marketization in order to modernize the country. Yet economic reform caused the free healthcare system to malfunction and then collapse. This, in turn, led to the establishment of a new health insurance system able to adapt to the changing environments.

Fourthly, picking up from Thelen and Steinmo (1992), this study finds that new ideas play a role in policy making. The ideological shift from egalitarianism to marketization in the late 1970s transformed the PRC's economic system from a socialist planned economy to a market economy. Deng's endorsement of the pro-market economic policy also affected the ideas adopted to implement urban health

insurance reform. In the PRC, the new ideas of individual MSA, the SPF, co-payment, individual responsibility and social solidarity were championed by the political leader and key bureaucratic actors from different ministries when designing the new mandatory health insurance system. These new ideas achieved political prominence because they fitted into the market-oriented economic context and were believed to be a solution to the intractable problems of moral hazard from the demand side and rising healthcare expenditures.

In brief, health insurance reform in Shanghai represents the case of institutional change. The Shanghai municipal government was able to significantly deviate from the established policy path because of the complex interplay of forces, with strong political institutions playing a salient role in shaping health insurance reform.

(b) The Case Study of Hong Kong

This study argues that Hong Kong government's efforts to implement healthcare financing reform in 1993, 1999 and 2000 ended in failure because of four main factors:

- (1) the political system becoming more democratic, allowing different political actors a greater role, and therefore becoming somewhat ‘disjointed’;
- (2) policy feedback from government’s previous commitment to healthcare;
- (3) the role of old ideas, where free healthcare and equality were championed by both citizens and legislators; and
- (4) the impact of contingent economic circumstances.

Firstly, this study finds that political institutions play a determinant role in structuring the power of different actors and shaping their strategies. During the colonial era, the democratization reforms introduced since 1985 changed the political system of Hong Kong from an elite-consensual polity to a consultative democracy, and the colonial government had difficulty in securing a guaranteed majority support from the Legco members when implementing the 1993 healthcare financing reform, because the latter were active to gather and reflect public opinions. In the post-colonial era, the disjointed political system caused by the legitimacy crisis of the Tung Administration, the tense Exco-Legco relationship and the disunity within the Exco acted as an impediment for the government to gather political support and reach a consensus on policy decisions for implementing healthcare financing reforms. Policy feedback as a result of the democratization reforms led to the emergence of

different political actors and interest groups, which challenged the government's monopoly of decision-making powers both inside and outside the establishment. These actors made the government's policy environment more crowded, turbulent and uncertain. Political consultations, confrontations and negotiations became the rule of the game between the HKSAR government and these political actors. Since the citizens thought that the mandatory and voluntary health insurance schemes proposed by the government would hurt their interests, by asking them to be responsible for their own medical expenses, they strongly resisted the implementation of healthcare financing reforms. Elected legislators who represented citizens' interests also opposed the government's healthcare financing options proposed in the reforms. In brief, a more democratic political system in the colonial era and a disjointed political system in the HKSAR era weakened the government's capacity of implementing healthcare financing reforms.

Secondly, this study finds that history counts. The importance of history is reflected in how policy feedback from previous policy choices affects interest group formation and shapes stakeholders' and public attitudes toward the government's proposals for health insurance reform. Positive feedback effects which flowed from the government's previous commitment to provide and finance medical services

through a public healthcare system established since the early 1960s and later the HA established in 1990 had continuously increased public demand for the government's involvement in providing and financing healthcare services. The general public as anticipated in the exposure and experience models of policy feedback had been strongly and widely supported the public healthcare system over the past two decades. They had become strong defenders of their interests and opponents of healthcare financing reforms. Besides, doctors working in public hospitals were strong defenders of the existing free healthcare system. They opposed both the 1999 and 2000 mandatory schemes because they feared for the HA losing government funding, the problem of moral hazard from both the supply and demand sides, and heavy workload.

Thirdly, this study finds that ideas matter in shaping healthcare financing reforms. The old ideas of free healthcare, universal access to healthcare, equality and healthcare as a welfare benefit were deeply entrenched in the public healthcare system since the early 1960s. The establishment of the HA further institutionalized these old ideas that created framing effects. These ideas became societal beliefs and were widely accepted and endorsed by the public and greatly reduced the government's capacity of persuading the legislators and the community to accept and support new

programmatic ideas proposed in the 1993 *Rainbow Report* and the ideas of mandatory contributions proposed in 1999 and 2000 healthcare financing reports.

This study finds that there was a substantive contradiction between the government's thinking and the public's thinking on healthcare financing. The ideology embedded in the economic system shaped the government's proposals for healthcare financing reforms. The ideas of laissez-faire and free market were embedded in the economic system of Hong Kong. Both the colonial government and the HKSAR government adhered to the principle of 'small government, big market' and maintained a simple and low tax system to attract investment. In order to maintain economic competitiveness and a friendly investment environment, the Hong Kong government did not propose any tax options such as widening the tax base or increasing tax rates to reform the healthcare financing system. The government adopted demand-side strategies that emphasized individual responsibility and the principle of 'those who had the means paid more' when proposing financing options. However, the government's thinking was contrary to widespread public belief that healthcare was a basic right and healthcare service was a welfare service that the government was morally obligated to provide. The ideas of healthcare being a fundamental right and legal entitlement for all were entrenched in the HA. In brief,

both the ideas embedded in the economic system and public healthcare system were institutional values that were difficult to alter. While the ideas embedded in the economic system shaped the government's logic in proposing healthcare financing options, the ideas embedded in the public healthcare system shaped the public perception of healthcare. The substantive contradiction between the government's thinking and the public's thinking on healthcare financing created an obstacle to reform the healthcare financing system.

Fourthly, this study finds that contingent economic circumstances in Hong Kong did not provide any windows of opportunity for the current healthcare financing policy to move onto a new trajectory. In the colonial era, a robust economy did not justify the government's claim that it was under any financial pressure to implement healthcare financing reform. Then in the HKSAR era, a severe economic downturn after the Asian financial crisis of 1997 was regarded by legislators, political parties and the public as an inappropriate time for the government to propose the mandatory schemes for healthcare when most of the citizens suffered wage decline, asset deflation and unemployment. The government failed to break from its original path of healthcare funding and the status quo was remained.

In brief, the case of Hong Kong is an example of path dependency because the government's repeated attempts to implement healthcare financing reforms faced severe oppositions and ended in failure. The government's effort proved in vain because of a complex interplay of forces, with the more democratic and later somewhat 'disjointed' political system being the most powerful constraints on government's ability to implement healthcare financing reforms. As a result, no major change in the funding structure of healthcare occurred in Hong Kong.

(c) Comparing the Empirical Findings of the Case Studies in Shanghai and Hong

Kong:

This study shows that the divergent results of health insurance reform in Shanghai and Hong Kong can be understood through a common theoretical lens of historical institutionalism. This lens stresses the importance of the role of political institutions and history in shaping the development trajectory of health insurance reform in these two places. Implementing health insurance reform is a complicated issue and its success or failure is not confined to a monocausal explanation but a constellation of factors. This study illuminates that whilst factors such as the role of ideas, actors and contextual conditions have shaped the health insurance reform process, their effects

largely depend upon the structure of the political institutions through which healthcare policy must pass.

Comparing the empirical findings of Shanghai and Hong Kong, this study finds that the role of political institutions is the most influential factor determining the outcome of health insurance reform. The success of health insurance reform implementation in Shanghai can be attributed to the strong and highly centralized political institutions that gave the central government leverage to implement a new health insurance model without any political impediments. The closed policy-making process was confined to a small circle of senior government officials and provided no veto opportunities stakeholders outside government to affect the process of health insurance reform. By contrast, the failure of health insurance reform implementation in Hong Kong was due to a more democratic and later disjointed political institution weakening the government's ability to gather political support and reach a consensus on implementing health insurance reform. The consultative democracy implemented since the mid-1980s had made legislators and different stakeholders more vocal and the government implement health insurance reform extremely difficult. Thereafter, the disjointed politics of the SAR government era continued to make reform difficult.

Policy feedback from previous policy choices is another important factor determining the outcome of health insurance reform. It can affect the outcome of health insurance reform by two ways: by affecting interest group formation and shaping stakeholders' and public attitudes toward the government's policies. In both cases, previous health policies fed back to affect the implementation of health insurance reform. In Shanghai, both the LIS and GIS induced negative feedback effects, which undermined the fiscal and social sustainability of the free healthcare system and generated pressure for path changes. The government searched for new alternatives to fund healthcare, leading to the success of health insurance reform implementation. By contrast, in Hong Kong, the free healthcare policy implemented since the 1960s had induced positive feedback effects, which reinforced the status quo. Citizens and legislators favored the maintenance of the free healthcare and opposed the implementation of health insurance reforms.

In both cases, the role of ideas played a role in shaping health insurance reform. Yet the impact of new ideas and old ideas on health insurance reform differs in Shanghai and Hong Kong. In Shanghai, new ideas such as individual MSA, the SPF and individual responsibility were endorsed by the central government and were adopted to design the new health insurance system. However, old ideas of free

healthcare and egalitarianism accelerated the collapse of the healthcare system and were perceived as an impediment to further economic reform. Therefore, they were abandoned by the central government in the 1980s. By contrast, in Hong Kong, new ideas of voluntary and mandatory contribution towards healthcare failed to get public and political support because old ideas of free healthcare, universal access and equality were institutionalized and became societal beliefs that were widely accepted and endorsed by the public. As a result, the implementation of health insurance reform was repeatedly shelved in Hong Kong.

In both cases, changing contextual conditions also affected the implementation of health insurance reform. In Shanghai, changing political and economic conditions that had been initiated by elites facilitated the implementation of health insurance reform. By contrast, in Hong Kong, contingent economic conditions did not provide any window of opportunity for the government to implement health insurance reform. However, the importance of economic conditions in affecting the implementation of health insurance reform is blurred because both a robust economic situation and poor economic situation were used at different times by legislators and the public as a reason to oppose the government's proposals for health insurance reform. Therefore, the role of contingent economic conditions is relevant but as the economic argument

can be made in diametrically opposing ways it has less plausibility in explaining the failure of health insurance reform implementation.

Through the case studies of Shanghai and Hong Kong, this study contributes to the scholarly debate over convergence and divergence of healthcare reform. It shows that healthcare systems in both places do not converge when facing the similar pressures of limited funding and rapid healthcare cost escalation caused by ageing population, heightened healthcare demands, and technological advancement. This study argues that divergent reform results in Shanghai and Hong Kong can be explained through the lens of historical institutionalism, which stressed the importance of the role of political institutions and history in shaping the development trajectories of health insurance reform in both places.

9.4 Historical Institutionalism: the Limitations of the Revised Approach

Historical institutionalism examines the development trajectory of politics and policies, the ways in which institutions shape and structure political behavior and outcomes, and how elites and masses understand their circumstances, make their decisions and take actions. Applying this approach to any polity can generate a

substantive explanation, but it is inevitably a limited and restricted statement in debate.

This study notes that there is the challenge of adopting the theory of historical institutionalism to examine health insurance reform in Shanghai and Hong Kong because the theory takes ideas created in the Western context and deploys them in a quite different situation. But this study demonstrates that the theory can be applied in a context sensitive manner by paying attention to how the political, economic and social contexts are at play in Shanghai and Hong Kong. However, the utility of explanation made by the theory of historical institutionalism in this study is limited by studying two cases only. Recalling Chapter Six on Shanghai health insurance reform, this study shows that the successful implementation of health insurance reform in Shanghai was compatible with the second source of institutional dynamism identified by Thelen and Steinmo (1992), that the change in the political or socioeconomic context led to existing institutions performing new tasks because new political actors emerged to pursue new goals through the existing institutions (p.16). If the theory is applied to examine healthcare reforms in other countries, the research results may identify other sources of institutional dynamism because of the particular contextual differences.

Another challenge of adopting the theory of historical institutionalism to

examine health insurance reform in Shanghai and Hong Kong is how to gather a comprehensive set of data to answer the research question. Since historical institutionalism examines health insurance reform in a place over time rather than a snapshot of time, the process of data collection can be time-consuming, expensive and difficult. Data related to the past may be difficult to collect because of the lack of historical or written record or being subject to the limits of interviewees' memory and knowledge. And of course, insufficient data can compromise the explanatory power of historical institutionalism.

In order to overcome this challenge, this study collected data through different sources, including semi-structured interviews, documents, and archival records. Data triangulation not only provides a cross check on information, it also overcomes the challenge of collecting data through semi-structured interviews. Since data are collected for a smaller sample size through interviews than most surveys, this unavoidably raises the question on how representative the data are. This study does not claim that the sample sizes of semi-structured interviews are representative. But it has given particular care to the sample selection for ensuring that key actors and different stakeholders related to health insurance reform are interviewed in Shanghai and Hong Kong. In fact, this study finds that some of the interviewees were helpful in

providing the insiders' views and the most updated information about healthcare while others helped identify relevant and useful information that would be otherwise be overlooked, especially in the case study of Shanghai.

9.5 Future Studies

The research findings of the case studies of Shanghai and Hong Kong have four implications, which can inform future studies. Firstly, historical institutionalism is very helpful in explaining the divergent development trajectory of healthcare or healthcare reform paths. It shows that the success and failure of health insurance reform is not confined to a monocausal explanation but the complex interplay of forces, including political institutions, policy feedback and contextual conditions.

Secondly, this study shows the roles of ideas and actors can be brought into historical-institutional analysis without undermining the important role played by institutions in affecting political outcomes. Instead, adding these elements makes the impact of institutions on policy outcomes more distinct. It is because institutions define the channels for absorbing and diffusing ideas and shape the strategies and goals of political actors.

Thirdly, historical institutionalism is useful for explaining change when the approach of institutional dynamism was brought into the theory to identify the sources of institutional change. Historical institutionalism is no longer restricted to explain path dependency.

Fourthly, this study shows that the Western theory of historical institutionalism can also apply into the non-Western context to explain the distinct healthcare reform path in welfare states in the East. The theory can be applied in a context sensitive manner by paying crucial attention to how the political, economic and social contexts are at play in a country.

This study has made a theoretical contribution that the approach of institutional dynamism, the roles of ideas and actors were brought into the theory of historical institutionalism. It shows that a refined version of historical institutionalism has a stronger analytical and explanatory power when examining path dependency and path change. Besides, it had made the original contribution to empirical knowledge that the success and failure of health insurance reform implementation in Shanghai and Hong Kong could be understood and explained by the complex interplay of forces, namely political institutions, policy feedback and contextual conditions. It has also filled the

current research gap of the lack of study of healthcare financing reforms in Asia.

Nevertheless, this study has limitations in terms of the number of case studies, generalization and data collection. Firstly, there are only two case studies. They only represent two welfare regimes in the East. Future studies can examine another trading city in Asia such as Singapore. Similar to Shanghai and Hong Kong, Singapore also experienced colonial rule in the nineteenth century and fell to the Japanese occupation during the Second World War. When Singapore gained independence in 1965, it underwent rapid transformation. In the aspect of healthcare financing, Singapore implemented a mandatory medical savings scheme in 1984. It would be interesting to examine how the roles of political institutions and history shape the development trajectory of healthcare financing reform in Singapore. Besides, future studies can examine health insurance system in other welfare regimes in the East, such as Taiwan and Japan, in a comparative perspective. According to Holliday (2000), Taiwan and Japan belong to developmental-universalist welfare regime in which there are limited social rights and the state underpins market and families with some universal programmes. In the aspect of healthcare financing, both Japan and Taiwan implement social insurance system. However, social insurance systems in these two places differ in terms of the pace of achieving universal coverage. While Japan was the first Asian

country implementing a universal social insurance system in 1961, Taiwan implemented a universal social insurance system in 1995. It would be interesting to provide a comparative assessment of the social health insurance experience in these two places through the lens of historical institutionalism. It can contribute to the empirical knowledge about welfare regimes in Asia and further contribute to the intellectual debate over the convergence or divergence of healthcare financing system.

Secondly, Shanghai is just one part of China. There are limitations to generalize the healthcare reform result to other parts of China. Future studies can examine health insurance reform in other parts of China. For example, they can conduct a comparative case study on development, implementation and outcome of healthcare financing reform in four directly controlled municipalities in China, namely Beijing, Shanghai, Chongqing and Tianjin. Since health insurance reform in China is implemented in a decentralized manner, it would be interesting to examine whether local governments in different jurisdictions implements different health insurance models and whether citizens in different places share similar or different views towards health insurance reform. Besides, it would be interesting to conduct comparative study on development, strength and weakness of healthcare systems between urban and rural areas in China through the lens of historical institutionalism.

The in-depth investigation of the similarities and differences of development trajectories and outcomes of healthcare systems in different parts of China is helpful in generating empirical knowledge for policy formulation and lesson drawing.

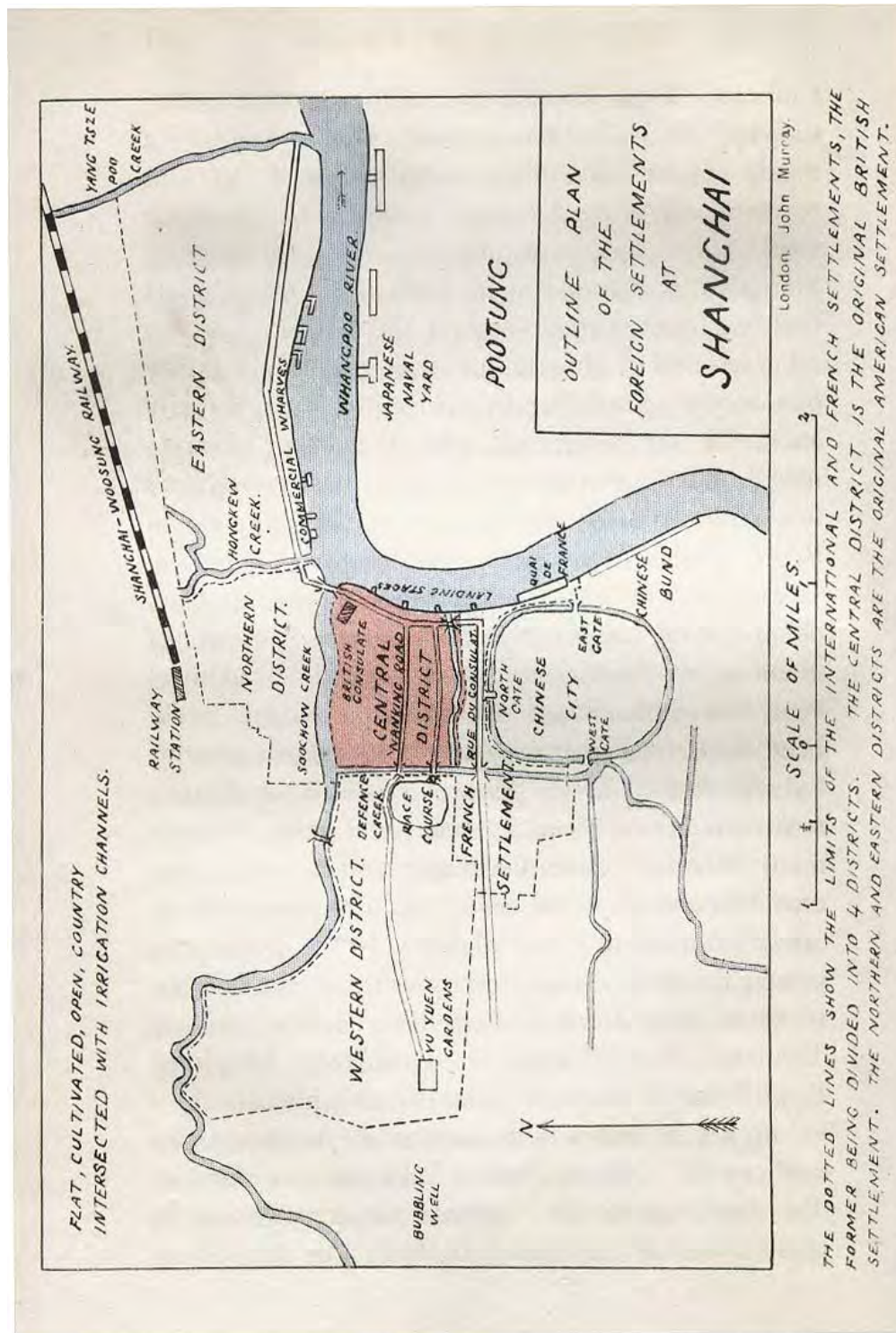
Thirdly, this study adopts a qualitative case study approach to examine health insurance reform experience in Shanghai and Hong Kong. Future studies can adopt a quantitative approach to examine the issue. For example, they can conduct its own opinion survey based on the research questions or make use of secondary materials that report opinion survey findings. They can examine how the public view about health insurance reform in different places. Opinion survey can systematically collect large and representative samples and provide wide range of quantitative data for making generalizations to the larger populated.

This study has used historical institutionalism to investigate situation in Shanghai and Hong Kong and found that the two trajectories revealed different institutional responses to similar problems caused by ageing population, the continued proliferation of advanced medical technologies and the public's increased expectations and demands. It is not clear how further changes will unfold but the further work mentioned above would contribute to this explanatory agenda.

Appendices

Diagram 1

The Map of Foreign Settlements in Shanghai in 1907



Source: The University of Texas Libraries

http://www.lib.utexas.edu/maps/historical/shanghai_1907.jpg

Diagram 2

Three-tiered Medical Institution Network in Urban China

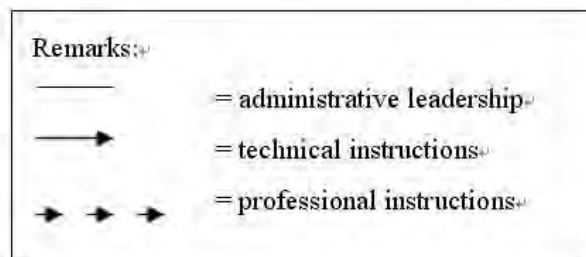
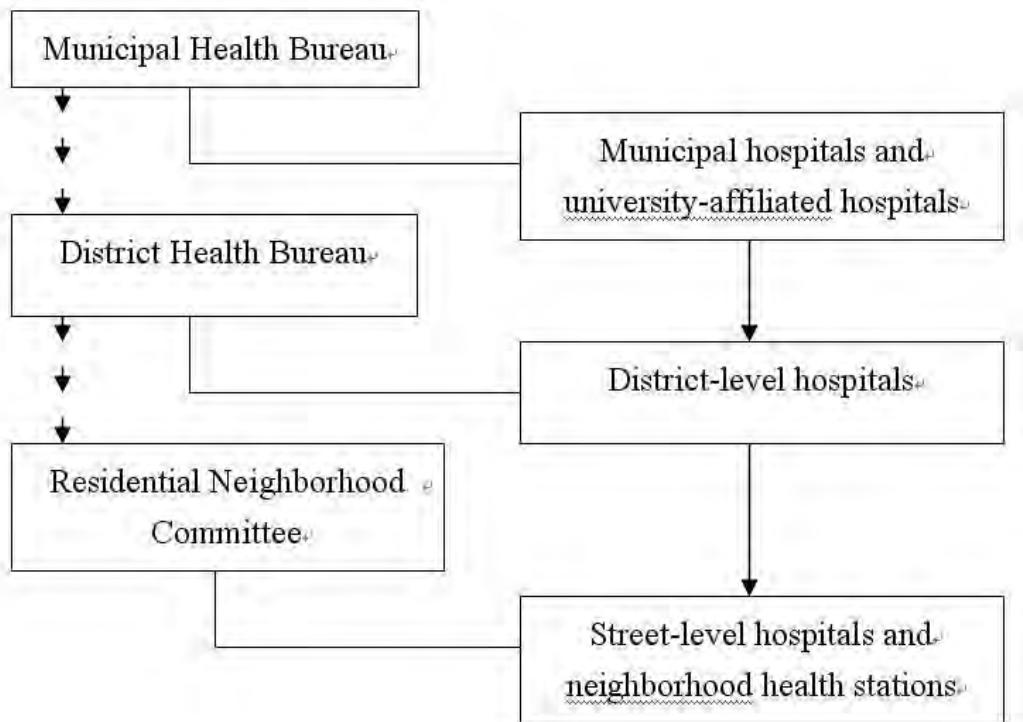


Diagram 3

The “two-jiang” Model in the Zhengjiang and Jiujiang Cities in 1994

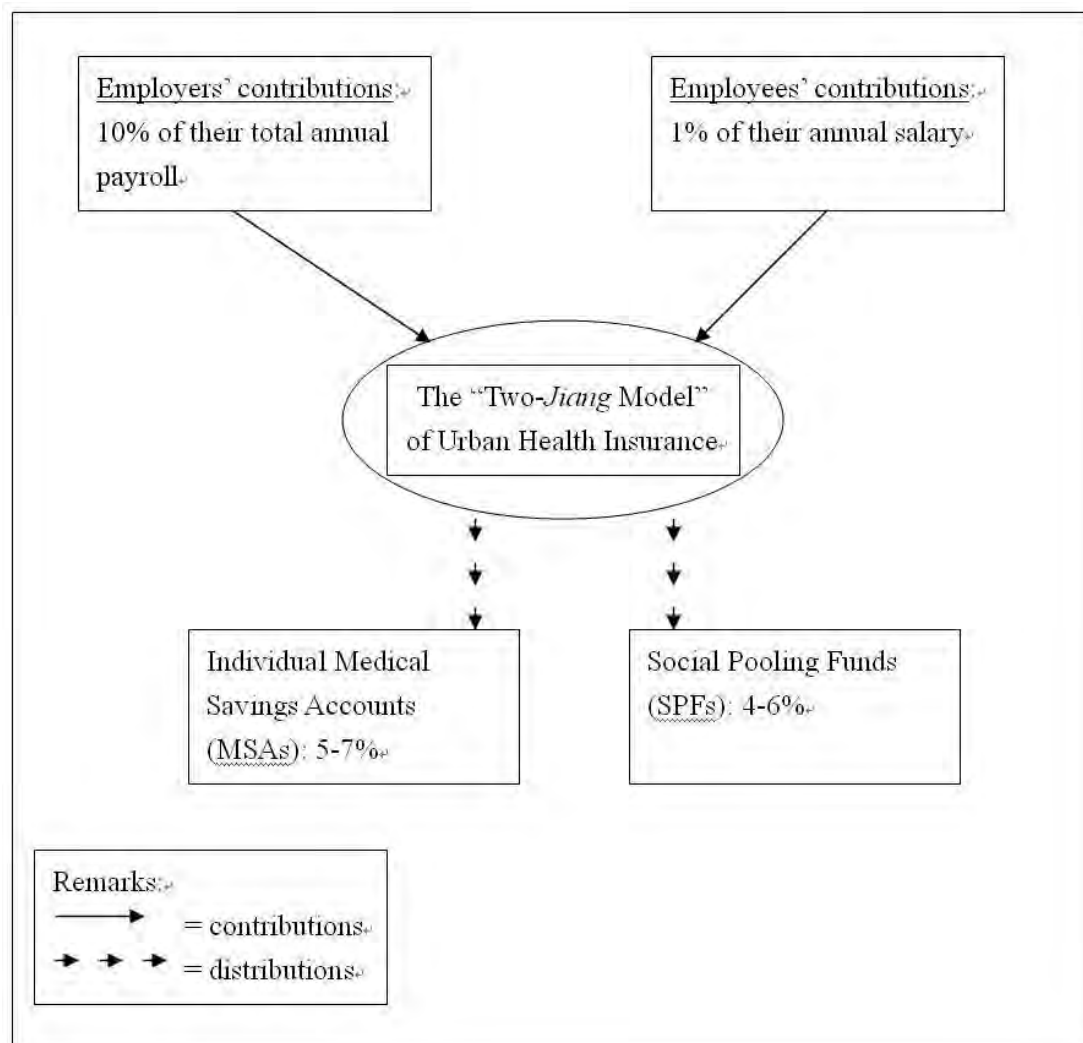


Diagram 4

The Funding Structure of the Basic Medical Insurance System and the Local Additional Medical Insurance Fund in Shanghai

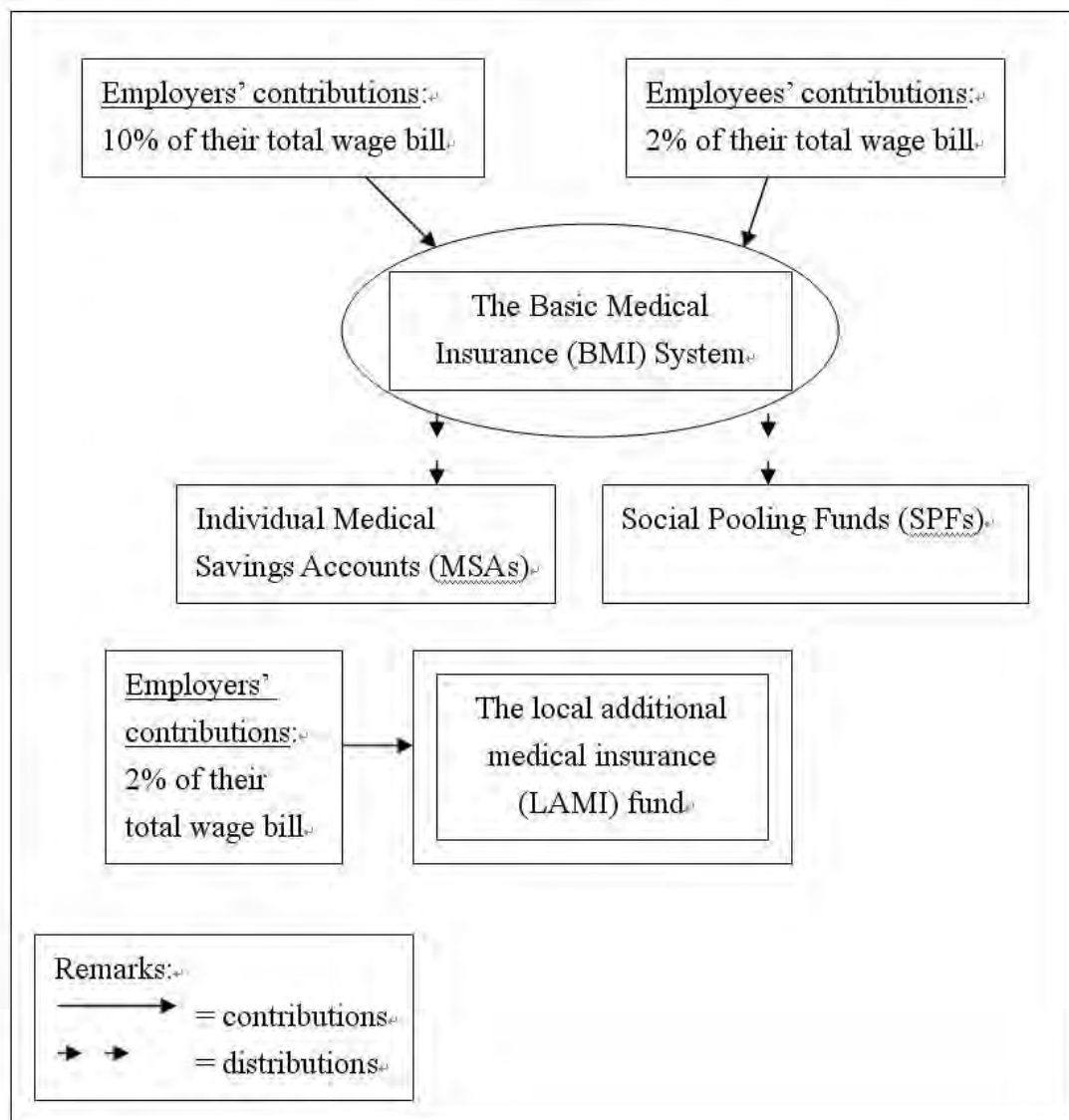
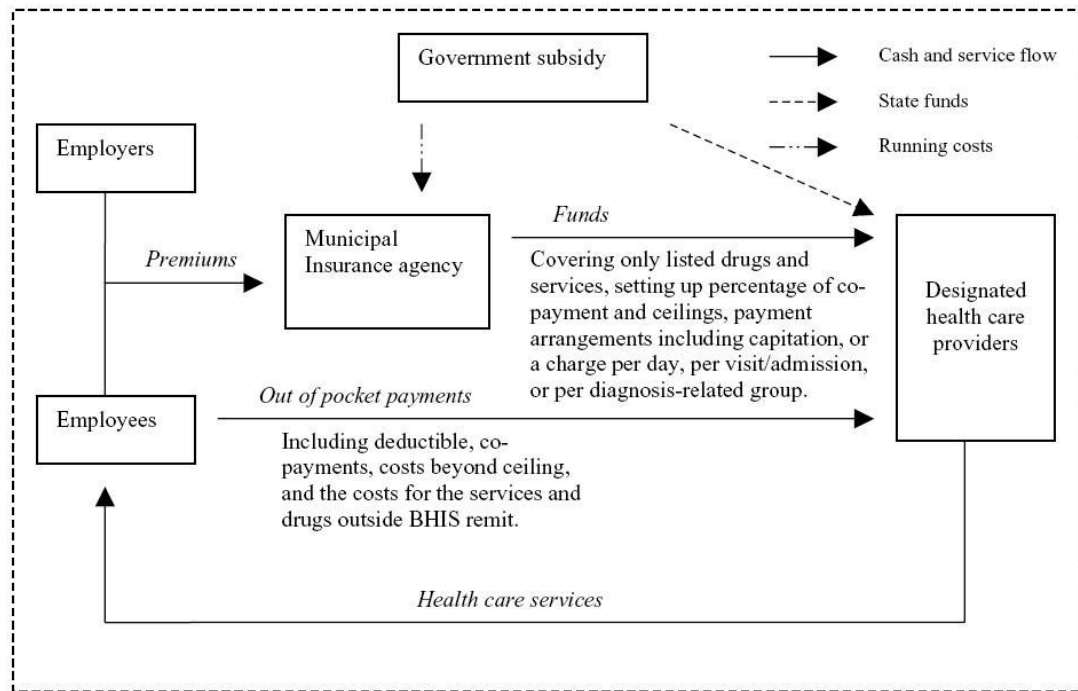


Diagram 5

The Operation of the Basic Medical Insurance System in Shanghai



Source: Xu et al. (2008), p.3.

Diagram 6

The Process of Drug Distribution in the Drug Distribution Channel in China

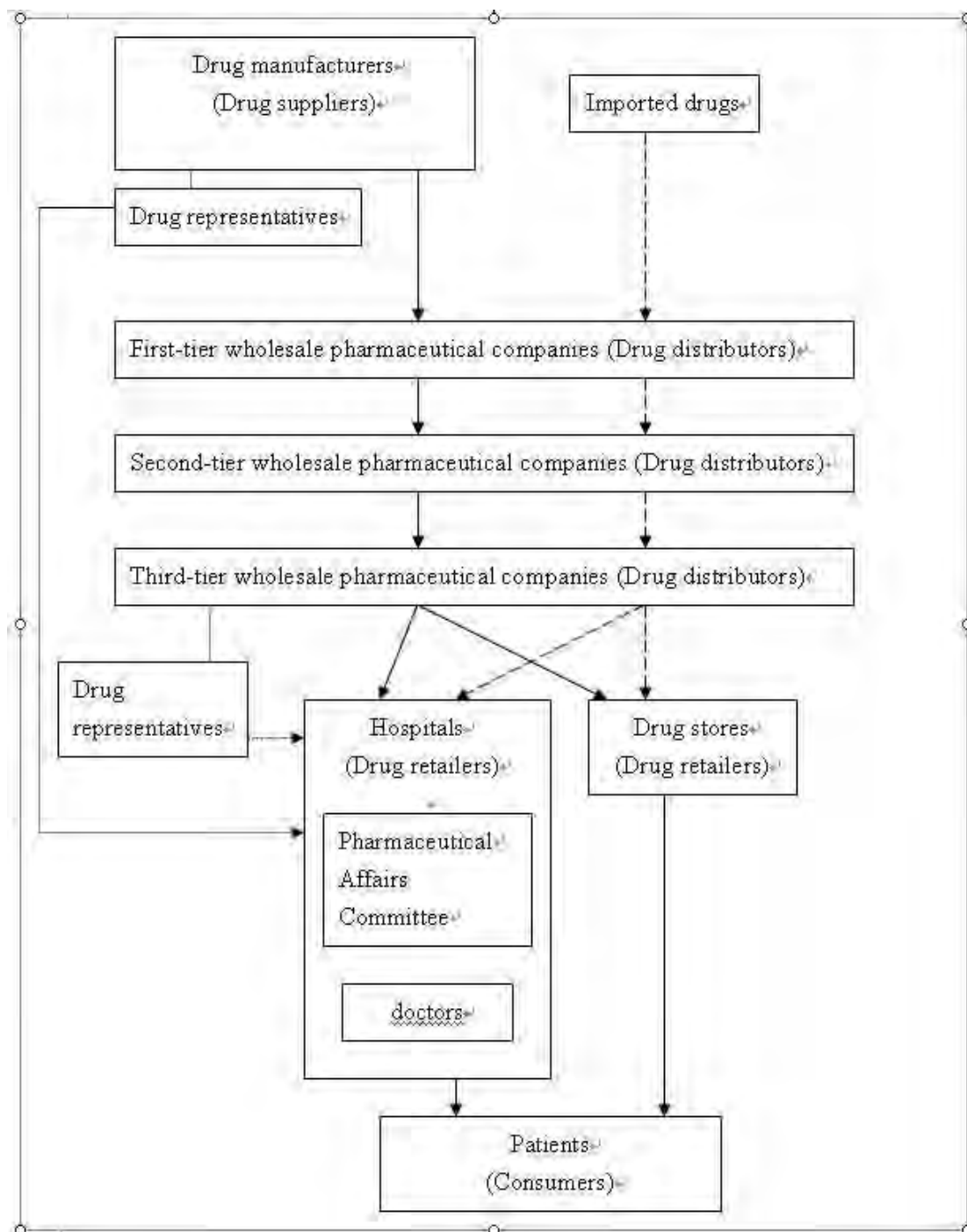
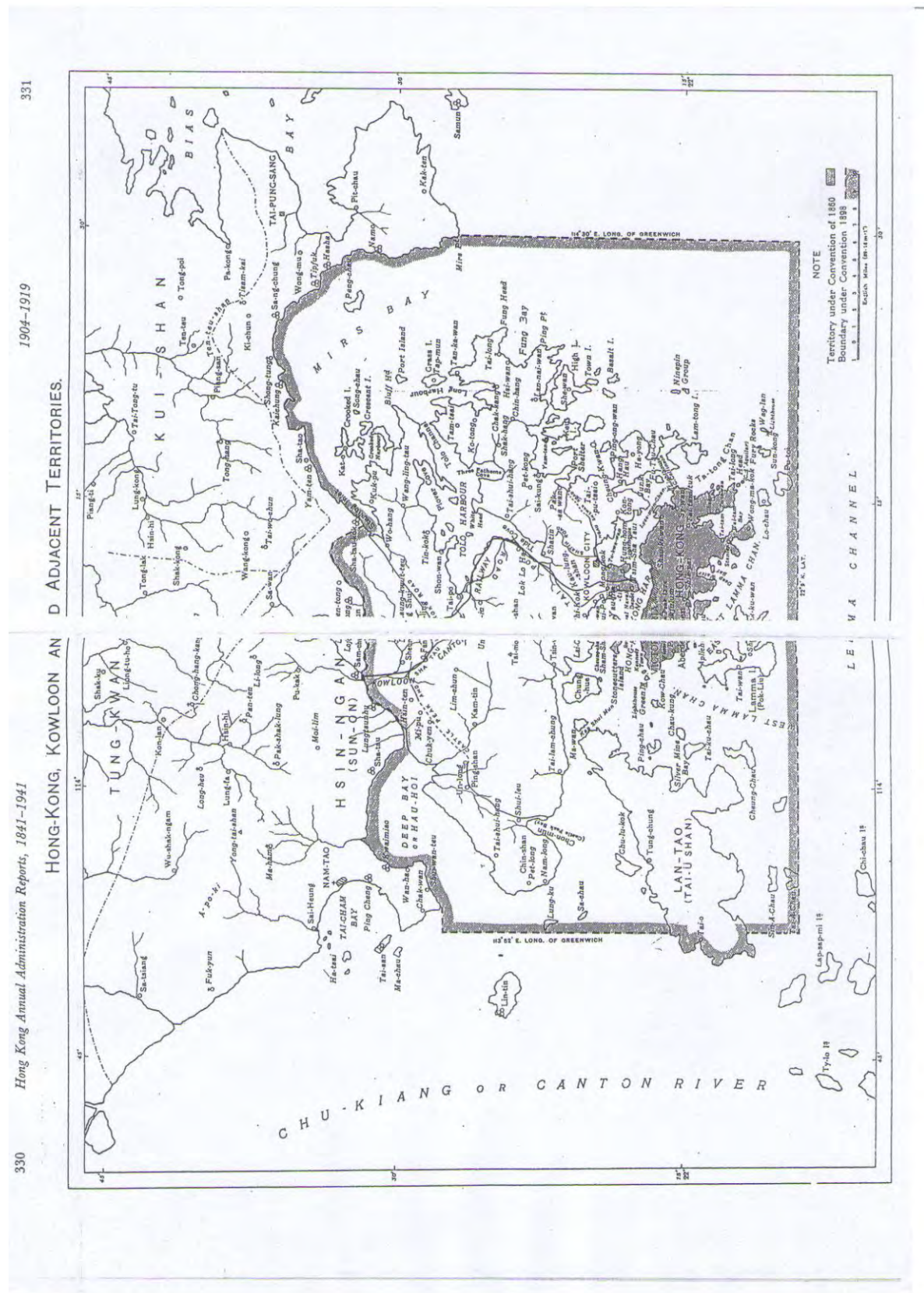


Diagram 7
The Map of Hong Kong (1915)



Source: Jarman (1996), Hong Kong Annual Administration Reports, 1841-1941 (volume 3), p.331

Table 1
Social Legislation in OECD Countries

	Industrial accident	Health	Pension	Unemployment	Family Allowance
Belgium	1903	1894	1900	1920	1930
The Netherlands	1901	1929	1913	1916	1940
France	1898	1898	1895	1905	1932
Italy	1898	1886	1898	1919	1936
Germany	1871	1883	1889	1927	1954
Ireland	1897	1911	1908	1911	1944
The UK	1897	1911	1908	1911	1945
Denmark	1898	1892	1891	1907	1952
Norway	1894	1909	1936	1906	1946
Sweden	1901	1891	1913	1934	1947
Finland	1895	1963	1937	1917	1948
Austria	1887	1888	1927	1920	1921
Switzerland	1881	1911	1946	1924	1952
Australia	1902	1945	1909	1945	1941
New Zealand	1900	1938	1898	1938	1926
Canada	1930	1971	1927	1940	1944
The U.S.	1930	---	1935	1935	---

Source: Pierson (1998). Beyond The Welfare State: The New Political Economy of Welfare, p. 104.

Table 2
The Growth of Social Expenditure in OECD Countries

	Social Expenditure 3% + GDP	Social Expenditure 5% + GDP
Belgium	1923	1933
The Netherlands	1920	1934
France	1921	1931
Italy	1923	1940
Germany	1900	1915
Ireland	1905	1920
The UK	1905	1920
Denmark	1908	1918
Norway	1917	1926
Sweden	1905	1921
Finland	1926	1947
Austria	1926	1932
Switzerland	By 1900	1920
Australia	1922	1932
New Zealand	1911	1920
Canada	1921	1931
The U.S.	1920	1931

Source: Pierson (1998). Beyond The Welfare State: The New Political Economy of Welfare, p. 107.

Table 3
Retrenchment of Benefits in OECD Countries

Type of Benefit	Change	Examples
Old Age Pensions	<ul style="list-style-type: none"> ■ Raising retirement age ■ Increase in qualifying period for a full pension ■ Lowered basis for upgrading of benefits in line with inflation ■ Income testing of pension 	<ul style="list-style-type: none"> ■ The UK, New Zealand, Italy, and Japan ■ France, Portugal, Ireland, and Finland ■ The UK, France, and Spain ■ Austria, Denmark, and Australia
Disability	<ul style="list-style-type: none"> ■ Stricter test of incapacity ■ New time limits, reduced benefits 	<ul style="list-style-type: none"> ■ The UK, the U.S., the Netherlands, and Norway ■ The UK, the U.S., and the Netherlands
Unemployment	<ul style="list-style-type: none"> ■ Reduction in the duration of benefits ■ Reduction in the level of benefits ■ Reduced eligibility 	<ul style="list-style-type: none"> ■ Belgium, the UK, Denmark, and the U.S. ■ Germany, Ireland, New Zealand, and Switzerland ■ The Netherlands, the UK, and Belgium
Family Allowances	<ul style="list-style-type: none"> ■ Declining real value or decreasing eligibility 	<ul style="list-style-type: none"> ■ The UK, Spain, and the Netherlands

Source: Pierson (1998). *Beyond The Welfare State: The New Political Economy of Welfare*, p. 164.

Table 4

Esping-Andersen's Three Worlds of Welfare Capitalism			
	Liberal	Conservative	Social Democratic
Social Rights	(1) Minimal; (2) Entitlement rules are strict and often associated with stigma; benefits are typically modest.	(1) The granting of social rights is hardly ever a seriously contested issue; (2) Attached to class and status.	(1) Extensive; (2) Eligibility rests on being a citizen or long-time resident of the country.
Stratification Effects	A blend of a relative equality of poverty among state-welfare recipients, market-differentiated welfare among the majorities, and a class-political dualism between the two.	The preservation of status differentials.	(1) Universal benefits; (2) All are dependents and all will presumably feel obliged to pay.
Welfare Mix	(1) Citizens bear the main responsibility for their own welfare; (2) The state only has residual duty to help the needy; (3) The state encourages market provision either passively or actively.	(1) The preservation of traditional familyhood; (2) The state only interferes when the family's capacity to serve its members is exhausted.	(1) The market is crowded out; (2) Traditional family responsibilities are socialized; (3) The state is the principal means of realizing the social rights of all its citizens and takes direct responsibility of caring for children, the

			aged, and the helpless.
Examples	The U.S., Canada, and Australia	Austria, France, German, and Italy	Scandinavian countries such as Sweden and Norway

Table 5

The Productivist World of Welfare Capitalism					
	Social Policy	Social Rights	Stratification Effects	State-market -family Relationship	Examples
Facilitative	Subordinate to economic policy	Minimal	Limited	Market prioritized	Hong Kong
Developmental -universalist	Subordinate to economic policy	Limited; extensions linked to productive activity	Reinforcement of the position of productive elements	State underpins market and families with some universal programmes	Japan, South Korea, and Taiwan
Developmental -particularist	Subordinate to economic policy	Minimal; forced individual provision linked to productive activity	Reinforcement of the position of productive elements	State directs social welfare activities of families	Singapore

Source: Holliday (2000). Productivist Welfare Capitalism: Social Policy in East Asia. *Political Studies*, vol.48 (4), p.710.

Table 6

Total Health Expenditure as a Percentage of GDP and Annual Percentage Growth in Real Terms in OCED Countries from 1962 to 1992

	1960	1992	Annual percentage growth in real terms 1960-1992
	Constant prices, health deflator		
Australia	4.9	8.8	4.1
Austria	4.4	8.8	3.2
Belgium	3.4	8.2	5.2
Canada	5.5	10.1	4.8
Denmark	3.6	6.5	4.7
Finland	3.9	9.4	6.2
France	4.2	9.4	6.8
Germany	4.8	8.7	4.3
Greece	2.9	5.4	6.6
Iceland	3.5	8.5	6.5
Ireland	4.0	7.1	5.5
Italy	3.6	8.5	5.9
Japan	3.0	6.9	8.5
Luxembourg	---	7.4	5.8 ⁶²⁹
The Netherlands	3.9	8.6	4.1
New Zealand	4.3	7.7	---
Norway	3.3	8.3	5.1
Portugal	---	6.0	---
Spain	1.5	7.0	9.4
Sweden	4.7	7.9	4.1
Switzerland	3.3	9.3	4.6
Turkey	---	4.1	---
The UK	3.9	7.1	4.0
The U.S.	5.3	14.0	4.8

Source: OECD (1996), Health Care Reform: The Will to Change, p.18.

⁶²⁹ Data are for the period 1970-92.

Table 7**Public Health Expenditure as a Percentage of GDP in OCED Countries from 1962 to 1992**

	1960	1992
Australia	2.4	5.7
Austria	3.1	5.9
Belgium	2.1	7.2
Canada	2.3	7.5
Denmark	3.2	5.5
Finland	2.1	7.4
France	2.4	7.0
Germany	3.2	6.2
Greece	1.9	4.2
Iceland	2.4	7.0
Ireland	3.0	5.2
Italy	3.0	6.5
Japan	1.8	5.0
Luxembourg	---	6.1
The Netherlands	1.3	6.5
New Zealand	3.5	5.9
Norway	2.6	7.8
Portugal	0.9	4.0
Spain	0.9	5.7
Sweden	3.4	6.5
Switzerland	2.0	6.6
Turkey	---	1.4
The UK	3.3	5.9
The U.S.	1.3	6.0

Source: OECD (1996), Health Care Reform: The Will to Change, p.19.

Table 8**Schematic Overview of Healthcare Reform Instruments Adopted by the Policy Makers in Different Countries in the 1990s**

Finance	Allocation Mechanisms	Production
Competitive mechanisms between private insurers	Negotiated contracts	Quasi-autonomous management of public hospitals
Increased private insurance	Patient choice	Competitive mechanisms between hospitals and physicians
Increased social insurance	Giving hospital budgets to primary care providers and/or boards	Decentralizing service delivery
	Mixture of capitated with other GP payment arrangements	GP as gatekeeper
	Reference pricing for pharmaceuticals	Privatizing service providers
	Positive lists for pharmaceuticals	Improved coordination between health and social services, especially for elderly
	Co-payments and deductibles	Quality improvement
	Cross-cutting initiatives	
	Improved information systems	
	Enhanced preventive services	
	Patient rights	

Source: Saltman (1994). A Conceptual Overview of Recent Health Care Reforms. *European Journal of Public Health*, vol. 4 (4), p.289.

Table 9

Key Features of Historical Institutionalism	
<p>Origin: emerged in the early 1980s as a response to both the behavioral and rational choice perspectives, arguing that political action could not be reduced to individual behavior without taking political institutions and history into account.</p>	
<p>Definition of Institutions: Institutions are “formal or informal procedures, routines, norms, and conventions intrinsic to the organizational structure of the polity” (Hall and Taylor, 1996, p.938) that shape the goals political actors pursue and structure power relations that favor some groups while demobilizing others (Thelen and Steinmo, 1992, p.2; Oliver and Massialos, 2005, p.10).</p>	
Key Features	
1. Institutions matter: Institutions play a determinant role in distributing power among political actors in a given polity and shaping their strategies and goals in the decision-making process that in turn shape the political outcomes	
2. Institutions can affect individual behaviors through both the calculus and cultural approach.	
3. History matters: It takes history or time seriously, specifying sequences, tracing and analyzing processes over substantial stretch of years to explain important political outcomes.	
4. The emphasis on path dependency: early stages in a sequence can place particular aspects of political systems onto distinct tracks, which are then reinforced through time.	
5. The importance of policy feedback: provides resources and creates incentives that can facilitate or inhibit the formation or expansion of interest groups (Pierson, 1994, pp.40-1); provides information for interest groups and the public that affect their mind-sets and cognitive processes (Pierson, 1994).	
6. The use of in-depth case studies as the research strategy to “find interesting patterns to explain and to test the plausibility of causal hypotheses” (Skocpol, 1995, p.104).	
Key Concepts	
1. Political institutions	
2. History, timing and sequence	
3. Path dependency	

Table 10
The Rise of Case Study Research in Health Policy

Year	Number of Hits	
	Zetoc	Google Scholar
1980-84	0	35,200
1985-89	1	76,200
1990-94	11	150,000
1995-99	61	356,000
2000-04	61	410,000
2005-10	354	417,000

Source: Exworthy and Powell (2012), Case Study in Health Policy: An Introduction, p.8.

Table 11**The List of Interviewees about Shanghai Health Insurance Reform**

	Interviewee	Date	Time	Place
1.	Government Official 1: a female government official from the Shanghai Municipal Human Resources and Social Security Bureau	6 th July 2010	8:00p.m. -10:00p.m.	Phone interview
2.	Professor 1: an expert in urban health insurance reform in China	1 st July 2010	11:00am-1:00p.m.	A restaurant at a research institute in Shanghai
3.	Professor 2: an expert in urban health insurance reform in China	1st July 2010	3:00p.m.-6:00p.m.	A medical college in Shanghai
4.	Professor 3: an expert in urban health insurance reform in China	2 nd July 2010	11:00am -1:30p.m.	A Chinese restaurant in Shanghai
5.	Professor 4: an expert in political science and international relations	16 th July 2010	2:30p.m.-4:30p.m.	A café in Shanghai
6.	Professor 5: an expert in comparative health insurance	19 th July 2010	2:00p.m.-4:00p.m.	A university office in Shanghai
7.	Professor 6: an expert in comparative health insurance, and a member of	1 st August 2010	11:00a.m.-2:00p.m.	A restaurant in Shanghai

	Shanghai Insurance Society			
8.	Researcher 1: an expert in rural health insurance in China	1 st July 2010	11:00am-1:00p.m.	A restaurant at a research institute in Shanghai
9.	Researcher 2: a researcher at a research institute	6 th July 2010	2:00p.m.-5:00p.m.	A hotel café in Shanghai
10.	Doctor 1: a specialist at a municipal hospital in Shanghai	1 st July 2010	6:45p.m.-9:00p.m.	A Taiwan restaurant in Shanghai
11.	Doctor 2: a specialist at a municipal hospital in Shanghai	5 th July 2010	5:45p.m. -7:00p.m.	A restaurant at a subway station in Shanghai
12.	Pharmaceutical Company Manager 1: General Manager of a foreign pharmaceutical company in Shanghai	21 st July 2010	7:00p.m.-9:30p.m.	A Chinese restaurant in Shanghai
13.	Pharmaceutical Company Manager 2: General Manager of a foreign pharmaceutical company in Shanghai	1 st August 2010	3:00p.m.-5:00p.m.	A coffee shop in a subway station in Shanghai
14.	Insurance Company Manager 1: Regional Manager of a Chinese-foreign insurance company	20 th July 2010	1:00p.m.-1:30p.m.	Phone interview
15.	Insurance Company	20 th July 2010	7:00p.m.-9:30p.m.	A western

	Manager 2: Assistant General Manager of a health insurance company			restaurant at a subway station in Shanghai
16.	Insurance Director 1: Director of a Chinese-foreign insurance company	29 th July 2010	2:00p.m.-3:00p.m.	An office of the insurance company in Shanghai
17.	Citizen 1: Senior consultant of a state-owned business consulting company	26 th June 2010	1:00p.m.-3:00p.m.	A restaurant at a shopping mall in Shanghai
18.	Citizen 2: a manager working at a private marketing company	27 th June 2010	10:00am -12:00p.m.	A university café in Shanghai
19.	Citizen 3: a retired lady who used to work at a research institute	27 th June 2010	6:00p.m.-8:35p.m.	A Chinese restaurant in Shanghai
20.	Citizen 4: a lady who worked at a state-owned bank	29 th June 2010	6:30p.m. -9:30p.m.	An Italian restaurant in Shanghai
21.	Citizen 5: a software developer of a foreign company, responsible for developing a medical insurance software for hospitals in China	29 th June 2010	6:30p.m. -9:30p.m.	An Italian restaurant in Shanghai
22.	Citizen 6: Supplier quality engineer at a joint venture vehicle accessories company	30 th June 2010	6:30p.m. -9:00p.m.	A Chinese restaurant in Shanghai

23.	Citizen 7: a supervisor of a foreign clothing company in Shanghai	23 rd July 2010	6:30p.m.-8:30p.m.	A Chinese restaurant in Shanghai
24.	Hong Kong Citizen 1: Director of a market research and consultancy company in Shanghai	12 th July 2010	11:30a.m.-1:00p.m.	A Taiwan café in Hong Kong
25.	Armed Police Officer 1	23 rd July 2010	8:00p.m.-8:30p.m.	A Chinese restaurant in Shanghai

Table 12**The List of Interviewees about Hong Kong Health Insurance Reform**

	Interviewee	Date	Time	Place
1.	Government Official 1: a male government official from the Food and Health Bureau	27 th October 2010	3:00p.m.-5:00p.m.	A café in a shopping mall in Hong Kong
2.	Former Legislative Council (Legco) Member 1	18 th October 2010	10:45a.m.-11:45a.m.	A private clinic in Kowloon
3.	Former member of the Public Complaints Committee of the Hospital Authority	4 th October 2010 & 11 th November 2010	11:30a.m.-12:30p.m. 11:00a.m.-12:00p.m.	A Church in Hong Kong
4.	Professor 1: an expert in healthcare financing reform	21 st September 2010	10:50a.m.-12:10p.m.	A college office in Hong Kong
5.	Professor 2: an expert in social and welfare policies	18 th October 2010	3:30p.m.-4:15p.m.	A university office in Hong Kong
6.	Professor 3: an expert in biochemistry and Chinese medicine	4 th October 2010	4:00p.m.-5:15 p.m.	A university office in Hong Kong
7.	Doctor 1: a male specialist at a public hospital	9 th October 2010	3:30p.m.-5:30p.m.	A café in a shopping mall in Kowloon
8.	Doctor 2: a male specialist having working experience in both the public and private hospitals	30 th October 2010	4:00p.m.-6:15 p.m.	A private clinic in Kowloon
9.	Nurse 1:	23 rd August 2010 &	6:30p.m.-8:30p.m.	Café in New

	a female nurse having working experience in both the public and private hospitals	7 th October 2010	3:30p.m.-5:30p.m.	Territories Café in Tsim Sha Tsui
10.	Social worker 1: a female social worker of the Social Welfare Department	25 th September 2010	2:00p.m.-5:30p.m.	A Japanese restaurant in New Territories
11.	Social worker 2: a female medical social worker at a public hospital	3 rd October 2010	5:00p.m.-7:00 p.m.	A coffee shop in a railway station
12.	Insurance consultant 1: male	5 th October 2010 & 28 th October 2010	3:00 p.m.-4:30p.m. 3:30p.m.-4:30p.m.	A restaurant in Kowloon
13.	Insurance consultant 2: female	11 th October 2010	11:30a.m.-1:30p.m.	A Chinese restaurant in New Territories
14.	Civil Servant 1: a young female civil servant	14 th August 2010 18 th February 2011	2:00p.m.-3:00p.m. 6:30p.m.-7:00p.m.	A coffee shop in Kowloon A Western restaurant in Kowloon
15.	Civil Servant 2: a middle-aged female civil servant	26 th September 2010 20 th February 2010	1:00p.m.-3:00p.m. 2:20p.m.-2:40p.m.	A Chinese restaurant in Kowloon Phone Interview
16.	Civil Servant 3: a male senior police officer	7 th October 2010	11:30a.m.-2:00 p.m.	A Chinese restaurant in Kowloon
17.	Civil Servant 4: a female inspector of police	10 th October 2010	11:00p.m.-1:30p.m.	A café in Kowloon
18.	Citizen 1:	18 th September 2010	1:00p.m.-4:35p.m.	A café in

	a female university student	20 th February 2011	9:30p.m.-10:00p.m.	Kowloon Phone Interview
19.	Citizen 2: a cleaning lady at the university	23 rd September 2010 19 th February 2011	2:00p.m.-3:30p.m. 8:30p.m.-9:00p.m.	A Chinese restaurant in Kowloon Phone interview
20.	Citizen 3: a female staff working at a bank	24 th September 2010 2 nd March 2011	7:00p.m.-9:00 p.m. 8:45p.m.-9:00p.m.	A Chinese restaurant in Kowloon Phone Interview
21.	Citizen 4: a male manager at a finance institution	26 th September 2010 20 th February 2011	1:00p.m.-3:00p.m. 10:00a.m.-10:15a.m.	A Chinese restaurant in Kowloon Phone Interview
22.	Citizen 5: a male firm owner	28 th September 2010	10:00a.m.-12:00p.m.	A Chinese restaurant in New Territories
23.	Citizen 6: a male manager in a private investment bank	2 nd October 2010 20 th February 2011	2:00p.m.-3:40p.m. 12:00p.m.-12:15p.m.	A restaurant in Kowloon Phone Interview
24.	Citizen 7: a female middle-aged part-time worker at a laundry shop	2 nd October 2010 20 th February, 2011	2:00p.m.-3:40p.m. 3:10p.m. -3: 25p.m.	A restaurant in Kowloon Phone Interview
25.	Citizen 8: a female secondary school teacher	24 th October 2010	10:30a.m.-11:30a.m.	Phone Interview

Table 13**Employees' Individual Savings Account in Basic Medical Insurance in Shanghai**

Age (Years)	% of EAASSP*	% of Employees' Contribution
Above 75	4.5	Not Applicable
Retirement to Under 74	4	Not Applicable
45 to retirement	1.5	2
35 to 44	1	2
Under 34	0.5	2
* EAASSP: Employees' Average Annual Salary of Shanghai in the Previous Year		

Table 14

The Degree of Medical Coverage of Basic Medical Insurance Urban Employees

Date of Birth of employees and employment date	General outpatient and emergency medical expenses			Medical expenses of serious outpatient illnesses	Medical expenses of home care beds	Medical expenses of hospitalization and emergency room stay	
	1 st tier: MSA	2 nd tier: self-payment	3 rd tier: covered by the LAMI fund*	Covered by the social pooling funds (SPFs)		Payment threshold of the SPFs	Above the payment threshold and below the ceiling of the SPFs**
Born before December 31, 1955 and being employed before December 31, 2000	used	10% of the premium base***	70%	85%	80%	10% of premium base	85% covered by the SPFs
Born between January 1, 1956 and December 31, 1965, and being employed before December 31, 2000	used	10% of the premium base	60%	85%	80%	10% of premium base	85% covered by the SPFs
Born after January 1, 1966, and being employed before December 31, 2000	used	10% of the premium base	50%	85%	80%	10% of premium base	85% covered by the SPFs
Being employed after January 1, 2001	used	Self-payment, Cannot enjoy LAMI		85%	80%	10% of premium base	85% covered by the SPFs
Remarks: The LAMI fund*: The local additional medical insurance fund The ceiling of the SPFs** : it is capped at four times of employees’ average annual salary of Shanghai in the previous year (EAASSP) Premium base***: EAASSP							

Table 15
The Degree of Medical Coverage of Basic Medical Insurance for Retired Employees

Date of Birth of retirees, employment date and retirement date	General outpatient and emergency medical expenses			Medical expenses of serious outpatient illnesses	Medical expenses of hospitalization and emergency room stay	
	1 st tier: MSA	2 nd tier: self-payment	3 rd tier: covered by the LAMI fund* in public hospitals	Covered by the social pooling funds (SPFs)	Payment threshold of the SPFs	Above the payment threshold and below the ceiling of the SPFs**
Retired before December 31, 2000	used	2% of the premium base***	Grade I:90% Grade II: 85% Grade III: 80%	92%	5% of premium base	92% covered by the SPFs
Being employed before December 31, 2000, and retired after January 1, 2001, but were						
(i) born before December 31, 1955	used	5% of the premium base	Grade I:85% Grade II: 80% Grade III: 75%	92%	8% of premium base	92% covered by the SPFs
(ii) born between January 1, 1956 and December 31, 1965	used	5% of the premium base	Grade I:70% Grade II: 65% Grade III: 60%		8% of premium base	92% covered by the SPFs
(iii) born after January 1, 1966	used	5% of the premium base	Grade I:55% Grade II: 50% Grade III: 45%		8% of premium base	92% covered by the SPFs
Retirees who were employed after January 1, 2001 and retires afterwards	used	10% of the premium base	Grade I:55% Grade II: 50% Grade III: 45%		10% of premium base	92% covered by the SPFs
Remarks: The LAMI fund*: The local additional medical insurance fund The ceiling of the SPFs **: it is capped at four times of employees’ average annual salary of Shanghai in the previous year (EAASSP) Premium base***: EAASSP						

Table 16**Advanced Medical Equipment in Municipal, District, and Street-level Hospitals in Shanghai in 1986**

Municipal Hospital Medical Equipment (Grade I)	District Hospital Medical Equipment (Grade II)	Street-level Hospital Medical Equipment (Grade III)
X-ray machine (800 milliamperes and above)	X-ray machine (400-750 milliamperes)	X-ray machine (200 milliamperes)
Electrocardiogram (ECG)	ECG	ECG
Intensive Care Monitor	Heart Monitor	B-mode Ultrasonic Apparatus
Head Computed Tomography (CT)	Multi-channel Physiological Instrument	Gastroscopy
Whole-body CT	M-mode Ultrasonic Diagnostic Apparatus	Apple Computer II
Linear Accelerator (LINAC)	RU-mode Ultrasonic Diagnostic Apparatus	Personal Computers with different models
Co-treatment Machine	Fibre-optic Endoscopy	Electric Dental Chair
Mini Electronic Calculator	Duodenoscopy	1/10,000 Optical Analytical Balance
Multi-function Mechanical Ventilator	Colonoscopy	721 Spectrophotometer
Liver Function Test	Bronchoscope	Short-wave Therapy Machine
Hemodialysis Apparatus	Apple II Computer	Laser Treatment Machine
Automatic Biochemical Analyzer	Mechanical Ventilator	
Surgical Microscope	Pathology Testing Equipment	
Surgical X-ray Machine	Blood Gas Analyzer	
	Foetal Monitor	
	Isotope Diagnostic Apparatus	

Source: Zhang and Shao (1998), Shanghai Health Records (Chinese Version), p.110.

* Remarks: The medical equipment level was divided into three levels. Grade I was the highest medical equipment level, which was followed by Grade II, and Grade III. The medical equipment in the table was equipment reaching the Grade I to III level.

Table 17**The Average Medical Expenses among the BMI Participants in Shanghai (2001-2005)**

Unit: RMB

	2001	2002	2003	2004	2005
Employees	381.70	696.34	757.94	869.57	1,016.67
Retirees	3,297.42	3,818.58	3,943.99	4,136.88	4,564.37
Retired Veteran Cadres	14,122.16	17,437.24	19,316.42	22,848.53	26,104.11

Source: Wang (2008). The Empirical Study of the Control of Medical Insurance Expenses in Shanghai, p.302.

Table 18

The Operating Statistics of Insurance Industry from January 2009 to December 2009

Premium Income	Amount (RMB 10,000)	Percentage (%)
1. Life Insurance	4583951.63	69%
2. Property Insurance	1518069.76	23%
3. Medical Insurance	416669.93	6%
4. Personal Accident Insurance	131567.45	2%
Total	6650258.77	100%

Source: Shanghai Bureau of China Insurance Regulatory Commission (2010)

<http://www.circ.gov.cn/web/site7/tab377/i120554.htm>

Table 19

The Balance of the BMI Fund in Shanghai (2002-2009)

Year	Revenues of the BMI Fund (billion RMB)	Expenses of the BMI Fund (billion RMB)
2002	9.04	7.23
2003	12.15	11.70
2004	13.42	11.94
2005	15.10	14.64
2006	17.05	15.61
2007	20.28	17.96
2008	23.65	21.20
2009	26.85	23.11

Source: China Statistical Yearbook (2003-2010).

Table 20

The Degree of Coverage of Basic Medical Insurance for Individual Businessmen and Professionals (Effective since 1st August 2002)

Contributor(s)	Contribution#	General outpatient and emergency medical expenses	Medical expenses of serious outpatient illnesses	Medical expenses of home care beds	Medical expenses of hospitalization and emergency room stay	
					Payment Threshold	Above payment threshold and below the ceiling of the social pooling funds (SPFs)**
individual businessmen and professionals	8% of EAASSP* ; (included an individual medical savings account for the contributors)	Self-payment	85% covered by the SPFs	80% covered by the SPFs	10% of EAASSP	85% covered by the SPFs
Retirees do not need to pay any premiums but have individual medical savings account. Medical insurance fund*** injects money which is equal to 4% of EAASSP into the individual medical savings account of retirees aged below 74, and money which is equal to 4.5% of EAASSP into the individual medical savings account of retirees aged above 75.		Retirees: 1 st tier: individual medical savings account 2 nd tier: self-payment i.e. 10% of EAASSP 3 rd tier: covered by social pooling fund: Grade I: 55% Grade II: 50% Grade III: 45%	Retirees: 92% covered by the SPFs	Retirees: 80% covered by the SPFs	10% of EAASSP	Retirees: 92% covered by the SPFs
<p>Remarks: Contribution#: individual businessmen and professionals can only enjoy the health insurance coverage after paying premium for consecutive six months; retirees also have to wait for six months before they can enjoy any medical coverage from the health insurance.</p> <p>EAASSP*: Employees' Average Annual Salary of Shanghai in the Previous Year</p> <p>The ceiling of the SPFs **: it is capped at four times of EAASSP</p>						

Medical insurance fund***: it is formed by the premiums contributed by individual businessmen and professionals. It is divided into retirees' individual medical savings accounts and social pooling fund.

Table 21

**Basic Medical Insurance for Urban Residents in Shanghai
(Effective since January 2008)**

	Infants, children, primary and secondary school students	Urban residents aged above 18 but under 60	Urban residents aged above 60 but under 70	Urban residents aged above 70
A. The Standard of Fundraising for Basic Medical Insurance for Urban Residents				
Amount of Fundraising (RMB) (per capita per year)	260	700	1,200	1,500
Amount of Personal Payment in Fundraising (RMB)	60	480	360	240
The Remaining Part of Funds After Personal Payment	Shall be underwritten by financial subsidy from the government			
B. The Degree of Coverage of Resident Medical Insurance Fund				
Medical Expenses of Hospitalization (%)	50%	50%	60%	70%
Medical Expenses of Clinic Emergency Treatment (%)	50%	50% of the part of clinic emergency treatment costs in excess of RMB 1,000 that is accumulated annually	50%	50%
Medical Expenses at Grade I Medical Institutions (%)	60% for all insurance participants			

Table 22

The Degree of Medical Coverage by the Comprehensive Insurance of Migrant Workers in Shanghai (Effective since September 2002)

Contributor(s)	Premium base of the comprehensive insurance	Contribution*	Medical Coverage
(1) Employers or	60% of EAASSP#	12.5% of the premium base; 7.5% of the premium base if the employers are overseas construction enterprises	A. No coverage for (1) General outpatient and emergency medical expenses; (2) Medical expenses of serious outpatient illnesses; and (3) Medical expenses of home care beds
(2) Migrant workers without work units		12.5% of the premium base	B. Medical coverage is provided for hospitalization; (1) payment threshold is 10% of EAASSP; (2) the comprehensive insurance fund covers 80% of medical expense which is above payment threshold and below the ceiling; (3) the ceiling is capped at (i) EAASSP if the insurance premium is paid for three months; (ii) two times of EAASSP if the insurance premium is paid for six months; (iii) three time of EAASSP if the insurance premium is paid for nine months; and (iv) four times of EAASSP if the insurance premium is paid for more than a year
Remarks: Contribution*: the premium contribution includes three insurance benefits: industrial injuries, hospitalization, and old-age allowance. EAASSP#: Employees' Average Annual Salary of Shanghai in the Previous Year			

Table 23

**The Degree of Medical Coverage of Small Town Social Insurance
(Effective since 20th October 2003)**

Contributor(s)	Premium base	Contribution*	General outpatient and emergency medical expenses	Medical expenses of serious outpatient illnesses	Medical expenses of home care beds	Medical expenses of hospitalization and emergency room stay	
				No payment threshold		Payment Threshold	Above payment threshold and below the ceiling of the medical insurance fund**
(1) Employers of suburban employees or	60% of EAASSP#	5% of the premium base for health insurance	Self-payment	Employees: 70% covered by medical insurance fund	Not applicable	1 st hospitalization: 10% of premium base; 2 nd	Employees: 70% covered by medical insurance fund
(2) Companies which appropriate lands of farmers				Retirees: 80% covered by medical insurance fund	Not applicable	hospitalization or above: 5% of premium base	Retirees: 80% covered by medical insurance fund
Remarks: Contribution*: Small Town Social Insurance requires every contributors to pay 24% of the premium base in which 17% is for old-age insurance, 5% for health insurance, and 2% for unemployment insurance. The ceiling of the medical insurance fund **: it is capped at four times of the premium base EAASSP#: Employees' Average Annual Salary of Shanghai in the Previous Year							

Table 24

The Evaluation of Five Healthcare Financing Options in the Harvard Report

	Maintaining the Status Quo	Capping Government Budget On Health	Raising User Fees at Public Hospitals and Clinics	Health Security Plan (HSP) and Saving Accounts for Long Term Care (MEDISAGE)	Competitive Integrated Healthcare
Objectives					
1. Equity	Very Good	Worsen	Worsen	Moderately improved	Moderately Improved
2. Quality	Variable Fair	Worsen	Unchanged	Significantly improved	Significantly improved
3. Efficiency	Variable Fair	Unchanged	Slightly improved	Significantly improved	Significantly improved
4. Financial Sustainability:					
(a) managing government budget for health	Poor	Significantly improved	Moderately Improved	Significantly improved	Significantly improved
(b) better targeting government subsidies	Poor	Slightly improved	Slightly improved	Significantly improved	Significantly improved
5. Meeting future needs of the population	Poor	Unchanged	Unchanged	Moderately Improved	Significantly improved
6. Managing overall cost inflation	Fair	Unchanged	Slightly improved	Moderately Improved	Moderately Improved

Source: The Harvard Team (1999). Improving Hong Kong's Health Care System: Why and For Whom?
p.115.

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