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Chinese Healthcare System in Welfare State Typology

Master's thesis

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Declaration

1. I hereby declare that I have compiled this thesis using the listed literature and resources only.
2. I hereby declare that my thesis has not been used to gain any other academic title.
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In Prague on 2/5/2021 Wang Ren

Abstract

The author studied the welfare state typology in China from a health care perspective. This study aims to figure out what type of welfare typology works in Chinese health care system through comparative welfare state typology, specifically the decommodification principle proposed by Esping-Andersen (2019) and health care decommodification index put forward by Bambra (2006). Studying the classification of Chinese welfare state typology by analysing the Chinese health care system and comparing it with other countries in the world within the scope of welfare state typology, helps China enhancing the public administration. The author found that China belongs to medium decommodification group which means it is the same decommodification level as Conservative-Corporatist regimes, but also indicates there's a huge improvement potential to high decommodification group in the future.

Keywords

Welfare State Typology; China; Chinese Health Care System; Health Decommodification Index

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1 Introduction

Understanding the finest precepts of social governance is vital in improving public administration. A welfare state regime directly benefits all the citizens especially in health care and education areas (Marshall, 1950). Since the implementation of the economic reform in 1979, the Chinese government has carried out a series of profound changes in all aspects of the society. As an effective way of promoting social equity in the context of the rapid economic progress, the functionality of social welfare system is highly concerned by the government. Thus, a precise understanding of China's welfare state could help further improve public administration. Together with the impact of globalization of world governance, it's necessary to have a proper understanding of China's welfare systems in relation to its welfare typology. However, there were only few academic discussions about the Chinese welfare state typology both in English and Chinese literature. This is why this thesis deals with the topic of Chinese welfare state research.

It's worth mentioning that health, education and social care are the main delivery services of the welfare state. (Bambra, 2005) Thus, the author studied the welfare state typology in China from a health care perspective. The interrelation of all factors affecting public governance must be mainstreamed to aid access to quality health care since a productive and healthy nation relies on coordinated efforts in all public and private sectors. This study aims to figure out what type of welfare typology works in

Chinese health care system through comparative welfare state typology, specifically the decommodification principle proposed by Esping-Andersen (2019) and health care decommodification index put forward by Bambra (2006). Bambra modifies Esping-Andersen's theory by discussing the welfare state typology from a healthcare point of view, which helps the author identify and target the relevant criteria and indicators necessary for analyzing the Chinese health system. Understanding China's health care system helps determine the progressive growth in the state's pursuit to provide affordable and quality health care to all citizens. Thus, the following questions would have to be answered in this study to guide the author conduct the findings on the main aim.

1. Which indicators are relevant for the Chinese health care system classification?
2. What's the status quo of the health care system in China?
3. Which welfare state group does China belong to in comparison with 18 OECD countries around the world?

2 Theoretical Background

This chapter gives a theoretical foundation in order to study the Chinese health care system welfare state typology. In the beginning, different theories will be elaborated. Among them, the author will further introduce the three worlds typology by Esping-Anderson (1990 and the evolved critique by Bambra (2004) as it covers the health care provision, which the health decommodification index will be explained. In the end, the author will operationalize three welfare regime indicators in this paper.

2.1 Definitions about Welfare State Typology

In the past decade, the world has witnessed growing research on welfare state typology characteristics and health inequalities, but the picture is still inconsistent. Welfare state typology has been defined in different ways.

1) Welfare state typology can be defined as a response to the knowledge of individualism that has left societies and individuals unprotected since the start of the 19th century (Castel, 2017). It is the product of a powerful and organized class struggle.

2) It can also be identified as social security that is embodied by the social risks and public administration of welfare. Welfare state typology is linked with the social security system based on the universality principle as it aims at eliminating issues

related to poverty which came as a disgrace to the contemporary society after the Second World War (Croissant, 2004). In-state welfare typology, power is organized and it is consciously used to make changes in market forces in three directions: social services, narrowing the scope of social uncertainties, and minimum income security. It forms a clear declaration of survival willpower of people by controlling risks. Expressing this will of declaration is made possible by democracy (Clarke, et al. 2007).

Welfare state typology is based on systematic power balancing and the relationship between capital and labor through the struggles of the working-class and expansion of the scope of social policies, regulation of rights and activities of private sector like housing, education, health, and social security provided to people and their families. Welfare state typology is embodied in the society, family, mass democracy, nation-state, international systems, capitalism, and industrial society (Scruggs, & Allan, 2006). This makes welfare state typology a form of the state providing minimum income guarantee to people and their families to protect them against social risks.

Gencer (2018) studied the Chinese welfare regime with a focus on the social security system. A critical analysis of China's current typological system of welfare management revolves around a hybrid of a partly liberal welfare-state system, conservative-corporatist model governing, and the social-democratic and social insurance system, which shapes the social behavior of Chinese citizens. The analytical dimension offers insights into the quality of Chinese social state welfare. The elderly

population of China needs the development of procedures and social policies that guarantee enough health programs because this population is at risk of health issues due to underlying health issues such as, weak immune systems, comorbidities, and malnutrition. There are social schemes in China that cover aged rural and unsalaried residents in China (Ringen, & Ngok, 2017). In addition to that, the aged residents in China have benefited from enough pensions that financially assist them to seek primary healthcare attention when they need it.

2.2 Three Worlds of Welfare Capitalism by Esping-Andersen

The publication of Esping-Andersen's book *The Three Worlds of Welfare Capitalism* (1990) drove the trend of comparative studies into the classification and operation of social welfare states. In the *The Three Worlds of Welfare Capitalism* (1990), Esping-Anderson explains how the state can be involved in the transformation of capitalist society through state welfare. Esping-Anderson argues that there is a strong relationship between the state and the market (Bambra, 2004). He considers both Marxist and leftist critiques of welfare and how they break down or perpetuate notions of inequality. Welfare should be charged based on what they do but not based on how much they spend or the much they offer

Esping-Andersen (1990) thought previous research depends too heavily upon the comparison of aggregate welfare state expenditure. He provided empirical grounding

to previous research and identified three approaches through which social welfare states can be categorized, which led to the theoretical evolution in social typology. The United Nations (2020) mentioned that Esping-Andersen came with a new notion known as "ideal types" that improved the aspect of the comparative welfare-state study.

In *The Three Worlds of Welfare Capitalism* (1990), Esping-Andersen tried to criticize the previous theoretical approaches to welfare states that he considered misleading. His argument was pegged on the fact that the former models were just comparing the disregard redistributive characters and social spending. Powell and Yörük (2017) further asserted that the aspect of the political class's coalitions should be considered the most conclusive way that causes differences between welfare states. In chapter one of Esping-Andersen's book, the author explained that the term 'regime' defines how welfare production is allotted between households, markets, or states. He emphasized that the political-class coalitions led to three ideologies, commonly referred to as liberalism, socialism, and conservatism, which could be seen as the background for developing the model of the Three Worlds typology and provided the relevance for designing the welfare states of different countries. What's more, the welfare states should be seen as much more implicit and contestable since it just entails the state's responsibility in securing necessary safety nets for the citizens.

According to Esping-Andersen (1990), three principles are identified when it comes to classifying welfare-state regimes, which are known as decommodification, social stratification and the role of family, market, and state in defining people's social welfare.

Decommodification refers to 'the extent to which individuals and families can maintain a normal and socially acceptable standard of living regardless of their market performance' (1990). Decommodification means the welfare allocated to employees immune from market dependency. It does not count on workers' relations to the cash nexus on the labor market. Decommodification reflects the degree to which individuals' social rights are detached from market and to which extent individual welfare shapes labor markets (Esping-Andersen, 1990). Decommodification is analyzed and calculated in terms of the social welfare of the sick, unemployed and more. Social stratification structure mainly aims to redefine and streamline all forms of inequalities, equity, and fairness. It measures how key welfare policies organize social relations in terms of class and social order. Welfare states differ the effects of social policies on social structure. The three entities, specifically the family/households, market, and states, play a role in defining people's social welfare.

Based on decommodification, social stratification and the role of family, market, and state, the Esping-Andersen typology classify the welfare states into three models: the liberal model, the conservative-corporatist model and the social-democratic model.

Liberal Model

The liberal model is related to the welfare-state regimes in Anglo-Saxon countries. According to Gao (2017), the liberal approach comprises weak social rights since they are extended depending on market participation. In most cases, the public welfare regulation and provision remain at least since citizens should fund the welfare and healthcare needs. Huang (2020) further claimed that the liberal regimes could be described as dualistic and selective as they offer highly beleaguered and means-tested social security and support programs for needy citizens with the social stigma. However, those in the upper socioeconomic class depend on isolated market elucidations, such as purchased insurance, corporation welfare, and social amenities. The lingering welfare is associated with low decommodification and an increased level of social stratification. Strikingly, the liberal model is characterized by low levels of benefits and feeble social rights that promote market dependence.

Conservative-Corporatist Model

The conservative-corporative approach was associated with Continental Europe. According to Powell (2015), the regime provides for performative social rights, where the benefits depend on past contributions and employment records. Ideally, social insurance emphasizes achieving contractual equality and fairness in promoting equity and equality. Powell and Yörük (2017) further mentioned that when considering the

institutional contexts, the welfare rules are associated with occupationally segregated social insurance arrangements associated with organizational social service system provisions, such as church organizations and NGOs. The compliance with the need to maintain status differential provides the corporatists' solidarity sphere. According to the United Nations (2020), the conservative-corporatist model involves social insurance coverage that depends entirely on continuous and long employment careers. At the household level, men are considered the breadwinner, while the social rights of women are indirect and derived. Powell (2015) mentioned that the model's familistic attributes emanate from the ancient Catholic teachings, such as the principle of solidarity and the emergence of the Christian democratic governments, especially in Continental Europe. Overall, the welfare state is considered as distinct as it combines very obvious income transfer that places men as breadwinners. At the same time, the model has very few social care services.

Social-Democratic Model

The social-democratic model was related to the context of Scandinavia. Yi and the United Nations Research Institute for Social Development (2017) elaborated that such a model serves to enhance the achievement of universal social rights for all, regardless of citizenship. Besides, Powell and Yörük (2017) cited that welfare represents a highly redistributive and service-intensive unit, which employs and accommodates the whole society. The state's role is to provide family self-servicing, where it should care for the

elderly, sick people, and children. Besides, the market serves as a welfare provider, which increases the extent of decommodification. Overall, the model depends on the universalistic principle of solidarity.

2.3 Welfare State Typology Related to Healthcare by Bambra

Esping-Andersen's literature *The Three Worlds of Welfare Capitalism* (1990) makes tremendous contribution to social typology. As theories of welfare regimes evolved, there have also been many critiques of Esping-Andersen's theory because many social services are not taken into consideration, like healthcare. Bambra (2005) tried to make up for the deficiency through the proposition of a healthcare decommodification index. She used Esping-Andersen's decommodification-centered approach in recommending practical methods to manage social and healthcare services.

Bambra extends the concept of decommodification to cover health care provision supplement Esping-Andersen's welfare state typology. Health decommodification refers to 'the extent to which an individual's access to health care is dependent upon their market position and the extent to which a country's provision of health is independent from the market' (Bambra, 2005). Bambra puts forward the health care decommodification index that can be applied as an approach to classify social welfare states.

Bambra's healthcare decommodification index mainly focuses on the 'public/private mix of health provision, the ease of access to public provision, and the coverage provided by the health system' (2005). Three measures have been assessed to form the health decommodification index: private health expenditure as a percentage of GDP, private hospital beds as a percentage of total bed stock and the percentage of the population covered by the health care system. Bambra (2005) chooses these factors because they assess 'the financing, provision and coverage of the private sector', which reflects mixed role of market in the health care system.

Bambra, in her (2005a) study on the worlds of welfare, compares 'the decommodification levels of cash benefits with the main area of service provision: health care'. Through the comparisons between the levels of decommodification levels of cash benefits with that of healthcare, Bambra highlight the importance of welfare services in social typology. Sole social service or program cannot ensure the accurate classification of welfare states. Social services need to be taken into consideration. The research also suggests that when social services are added into the comparative analysis of welfare state regimes, there are five welfare state models: 'social democratic model, liberal model, Conservative model, and sub-groups within both the liberal and conservative regimes' (2005a).

Bambra (2006) also compares the health care outcomes (in terms of infant mortality rates) of welfare states and welfare state regimes. The research shows that different

welfare states have various health status. A negative relationship between health outcomes and labor market decommodification has been found from this research.

Yu (2012) develops the health care decommodification index proposed by Bambra (2005a) by analyzing data from 18 OECD countries and 5 East-Asian countries. The author also demonstrates how the health care decommodification index can be applied to the analysis of the marginalization of East-Asian countries in comparative welfare studies (2012).

2.4 Operationalization of Welfare Regime Indicators

From Esping-Andersen's and Bambra's studies, it can be seen that any single social provisions or social services cannot accurately classify social welfare states. This thesis mainly focuses on the welfare system in China. The organization in the healthcare system, its financing parties and healthcare reforms in China are discussed to assess the health care status.

Bambra supplemented Esping-Andersen's decommodification index in terms of healthcare. Therefore, Bambra's healthcare decommodification index will be applied to analyze the healthcare system in China. Three factors are used for analysis: private health expenditure as a percentage of GDP, private hospital beds as a percentage of total bed stock and the percentage of the population covered by the health care system.

3 Methodology

Different studies employ different data collection systems to achieve the intended outcomes based on the research's objectives. The central factor in most studies is the ease in collecting data and the most appropriate approach that serves the practicality and relevance of the investigation regarding trending and emerging issues that require an in-depth study. In this regard, the research used mixed method which combine quantitative and qualitative methodologies to gain relevance.

This study will employ a mixed methods approach to study the Chinese welfare system. A case study is applied to the Chinese health care system by combining qualitative and quantitative approach. By studying the health care system under Esping-Andersen (1990) and Bambra (2004) 's welfare state typology theories, it would reflect the whole image of Chinese welfare system classification. Firstly, a quantitative content analysis of Chinese health care system will be conducted by unitizing the healthcare status in China, organizations in the Chinese healthcare system, expenditure and financing parties and the assessment of the Chinese healthcare system. Efficiency, quality and resilience of the system will also be analyzed through a qualitative method.

Subsequently, based on Bambra's healthcare decommodification index (Bambra, 2015b), quantitative method is used to assess, in which healthcare group China belongs, based on an index score that is compared with many other countries around the world.

The researcher selected a mixed-method due to its flexible application in this study. This methodology will enable the researcher to analyze welfare systems in China and make a viable conclusion. The primary sources of information will be academic journals, books, articles, and other relevant materials published in recent years from 2010 to 2021. Detailed information will be specified in the section of 3.3.

3.1 Sampling

All study can apply a laboratory experiment, field experiment, case study, or survey strategy, among others. Engel and Jann (2014) believe that researchers that used experiments and lab analyses, produced more accurate results when testing variables, especially when they are few. While the experiments produce reliable results, the findings are often difficult to apply to a larger population. Therefore, this study used a case study strategy. As Hair (2015) explained, case studies help conduct detailed descriptions of the characteristics of a few phenomenon, organizations, or entities. Thus, intending to describe the social welfare topology of the health system of China, the case study approach seemed the best. The study could not use a survey strategy because the current COVID-19 situation restricted people from physical interactions. The overall goal was to use China as a detailed case study.

Quantitative studies require the calculation of the estimated sample size, which, in the real sense, represents the overall population under study. However, in this investigation,

the Chinese people's sample size that demands healthcare services surpasses the over one billion people. This research is primarily policy oriented. Data from reports, journals and articles reflecting healthcare status in China and many other countries around the world has been collected and analyzed to classify Chinese welfare sector in comparison to other countries.

3.2 Data Analysis

Since the study applied a mixed method approach, data analysis was conducted using qualitative and quantitative content analysis. Neelankavil (2015) explained that this type of analysis helps interpret large volumes of verbal data. However, Engel and Jann (2014) disapproved of the method by claiming that it is less appropriate for reconstructing meaning for the open-ended study questions. Most importantly, the content analysis provides a systematic and objective manner of describing a phenomenon.

Firstly, this thesis identifies main research questions and theory backgrounds. Chinese health system is analyzed with targeting on three indicators used in Bambra's health decommodification. By studying the Chinese health system, the author would have a big picture to understand the health care delivery of Chinese welfare state service.

Secondly, the quantitative analysis method used in this research is the same based on Esping-Andersen (1990) and Bambra (2005). By way of the numerical description of

the relationship of an individual country's score to the mean (and standard deviation) for two of the three factors (private health expenditure as a percentage of GDP, private hospital beds as a percentage of total bed stock and the percentage of the population covered by the health care system) that make up each index. On the basis of the scores of China and other countries, a score of 1 for low decommodification; 2 for medium; and 3 for high decommodification will be given. Worth to mention is that during the classification of these three factors, the author defined the data on the basis of one standard deviation from the mean with adjustment where necessary for extreme outliers. For the third factor the percentage of the population covered by the health care system on the basis of 100 percent coverage providing a weighting of 10, so a 92 percent coverage will provid a weighting of 9.2, and so on. (Esping-Andersen, 1990)

Furthermore, the author's health index has two modifications compared Bambra. 1) Besides the 18 sample countries already used in Bambra's study, this study included China's data to locate China's health decommodification status in the index. 2) this study took data from a more recent time 2018, since Bambra's study was from 1998 which cannot show the result effectively as many of countries experienced significantly health care reform in the past 20 years. Sources of data are from two groups: international and national. First and second factors are generally from OECD database, the third one from WHO database. However, some exceptions are precisely specified when data appears as some countries' data are not available in neither database. The author collected those supplementary data from the Australian Institute of Health and

Welfare (2019), Statistisches Bundesamt (2021), Eurostat (2020), Ministry of Health Labour and Welfare (2019), National Bureau of Statistics (2020) and Nation Healthcare Security Administration (2019). In addition, the author used the EU average for some extremely hard-finding data as it's the same way Bambra (2004) applied in her study.

4 Healthcare System in China

In this chapter, it will analysis the Chinese healthcare system from few aspects including health status, organization, financing and health reform. In the end, the assessment of healthcare system will be summarized regarding the efficiency and quality of service and the resilience of the system to understand the current status quo.

4.1 Overview

As in any country, a healthcare system is essential for China. This is because the development and growth of a country are pegged on, among other factors, the people's health. Potentially a more health population, will better the economic growth, which in turn increases the prosperity of the people. Confirming whether this hypothesis is true should be put to the test via the statistics in recent years, especially a graph that shows the trajectory of the health coverage in the country. An development of the population covered by the Healthcare System in China (HSC) is shown in Figure 1.

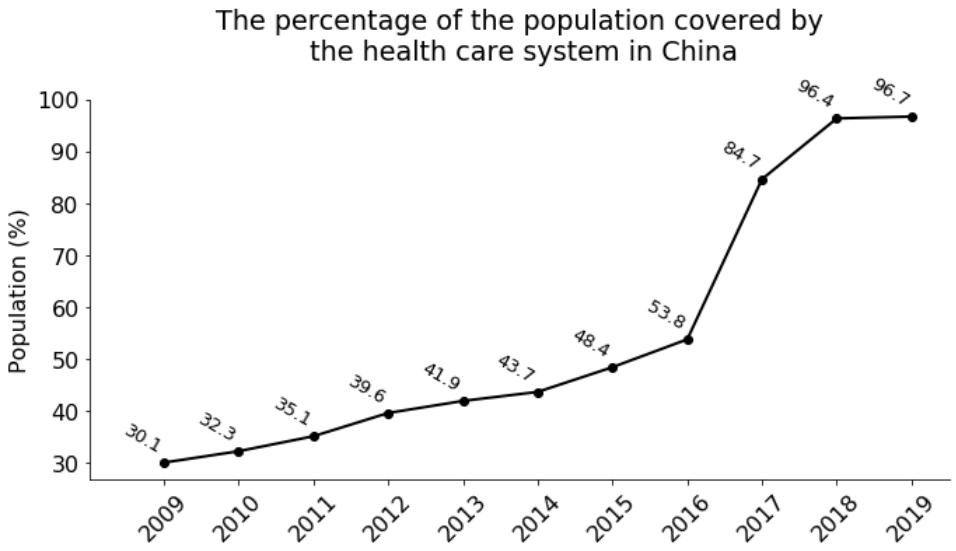

Figure 1: The percentage of the population covered by the health care system China.

Source: (Nation Healthcare Security Administration, 2019)

The figure is constructed from data found in the Nation Healthcare Security Administration (2019), a sub-ministry-level government agency dedicated to the management of the healthcare security work, shows the percentage of Chinese population covered by the health system in China. This metric is the most basic factor when analyzing the healthcare system in any country, even before looking at other factors such as the typology of the range of healthcare services offered and their quality. The graph covers the period between 2009 and 2019. In these ten years, China has substantially improved the percentage of the population covered by the healthcare system. Whereas it stood at 30.1% in 2009, the percentage of the population covered had increased to 96.7% by 2019. It increased progressively from 2009 up to 2016 and then experienced a sudden spike in numbers covered. These are due to many factors, especially the healthcare reforms undertaken in the country, most of which will be

discussed later within following sections. China's achievement of the 96.7% coverage rate of its healthcare system in the population is commendable.

4.2 Health status

China's population is the largest worldwide. Furthermore, alongside the USA, China has been one of the strongest economies in the world. (Sun et al., 2018) The health status in China is impressive when looked at from the context of coverage. With the continued improvement in the health coverage in China, the country death and birth rates decreased, whereas chronic diseases increased. This is seen in the percentage of deaths in the country. Of the approximately 10 million deaths, 85% of them were a result of chronic diseases in 2020. These chronic diseases contribute to 70% of China's disease burden. (National Bureau of Statistics, 2020) This shows a challenge for the HSC including diseases management programs, prevention orientation etc.

China's health system is rated 144th globally by the WHO in 2000 but has since improved. Compare with OECD average, the ratio of patients to doctors in China is low, standing at 1.6 per 1000 (Dougherty, Chen, & Zhang, 2017). The concentration of doctors is higher in urban areas like Beijing and Shanghai and lower in the sparsely populated rural areas. Health services in Chinese hospitals, especially public hospitals, are offered in local languages such as Mandarin and Cantonese. The quality of healthcare services between urban and rural area offered also differs. According to the "Statistical Bulletin on the Development of China's Health Services in 2011", the per

capita health expenditure in 2010 was 1490.1 yuan, of which 2315. 5 yuan was in urban areas and 666.3 yuan in rural areas. The per capita health expenditure in rural areas is less than 30% of that in cities. (Hai, Chao and Li, 2015) Whereas the health access is high in urban centers, it is significantly lower in the rural areas with the lack of enough personnel, sparsely distributed healthcare centers, and the lack of high-quality services.

4.3 Organization

The HSC has been revolutionized and mechanized, such that the country has one of the most advanced technology systems to augment its healthcare workers (Scott et al. 2020). However, it has not always been this way (S. Sun et al., 2021). The pre-evolutionary China healthcare system has been in existence for nearly 3,000 years. However, all these were informal. It was not until the mid-twentieth century where the healthcare system became more organized and formal. In this early period, the Chinese healthcare system relied on traditional Chinese medicine (TCM). In the early establishment of China as a republic, its leader Mao emphasized the importance of preventive healthcare. Specifically, the common saying in this Han period was, "The Sage does not cure the sick but prevents illness from arising" (Burns & Huang, 2017). Therefore, the healthcare in this period was placed more on the individual to take care of his health and that of his family, and less on the healthcare from trained professionals.

Post-liberation

After the liberation in 1949, there were some changes in the country's healthcare system. According to Burns & Huang (2017), this was the post-Mao period. First, there was an introduction to western medicine. However, this did not mean abandoning traditional Chinese medicine but using the two types of medicine to augment each other. For this reason, medicine was focused on serving peasants, workers, and soldiers.

Modernization and redistribution of resources in the 1970s

In the 1970s, there was an increased rate of modernization of the healthcare sector. However, such modernization took place indirectly and as a result of other policies put in place and implemented by the government. Burns & Huang (2017) argue that specifically, the Chinese government focused on modernizing four areas: science and technology, agriculture, industry, and national defense. This modernization had to be achieved by 2000. Though these areas were not directly related to healthcare, they led to the modernization and advancement of many other sectors of the economy. The advancement in technology was incorporated into the healthcare sector. Scientific advancement was further expanded to cover healthcare with increased research into diseases most prevalent in China and researching potential medicine. It is, however, during this period that focuses on primary healthcare began to wane (Meng, Mills, Wang, Han, 2019). Instead, the focus on secondary and tertiary healthcare increased.

Another major historical development in the healthcare organization in China was the redistribution and allocation of resources. By this time, approximately 80% of China's population resided in rural areas (Trading Economics). However, most of the resources were allocated to urban area healthcare institutions and systems by this point. The outcome was the development and re-emphasis of rural health policies.

Changes in affordability and access in the 1990s

Another important historical change took place in the 1990s as a result of the focus on rural areas. Tao, Zeng et al. (2020) argue that the result was that there were issues of affordability and access. With no formally recognized public healthcare insurance coverage schemes, most of the payments for healthcare services were out-of-pocket. They were, therefore, out of reach for a huge percentage of the population. This is because most of China's population lived below the poverty line as their economy had not grown to the current 2021 level. Rural areas economy was also highly undeveloped and informal. Apart from cost, access was another issue, as there was a huge gap between the access to healthcare in rural areas compared to the urban areas. The changes and reforms in the healthcare system, therefore, focused on increasing access and accessibility. This period represented the major changes in the country's healthcare system. This led to the development of healthcare insurance coverage, especially the basic health insurance cover. Access to healthcare has also substantially improved. By

2019, 96.7% of China's population were covered by the healthcare system (see Figure 1).

4.3.1 Main Institutions

It is important to note that the coverage of public healthcare in China is developing rapidly in recent years (See Figure 1). This is made possible by the country's social insurance plan. These achievements are due to the country's healthcare system and the eventual delivery of services.

The central government

The central/federal government in China has significant control of the country's healthcare system. Yip et al. (2019) explain that the control and range of China's central government are done through the country's health ministry. It's also worth mentioning another important national institution on healthcare area named Nation Healthcare Security Administration (2019) besides the Ministry of Health. In order to improve the health care insurance system and medical services, the State Council proposed to integrate some of the health care insurance and medical-related responsibilities of the Ministry of Human Resources and Social Security, the National Health and Family Planning Commission, the National Development and Reform Commission, and the Ministry of Civil Affairs and establish the Nation Healthcare Security Administration as an agency directly reports to the State Council. The agency was established in 2018.

Among the many roles of the Ministry of Health, one includes drafting health regulations, policies, and laws. It also proposes regional health programs and formulates working programs and policies in rural health. Furthermore, it also guides reforms in medical institutions and drafts key national development programs on medical science. As the evident from the above description, the central government, through the Ministry of Health and Nation Healthcare Security Administration, mainly administers regulatory, advisory and supervisory roles.

The local government

However, the local government in the provinces does most of the implementation of these policies, programs, and laws developed by the central government. According to Li & Fu (2017), these local governments (provinces) manage their hospitals and health centers based on their needs and specific issues. This is because health priorities vary from one province to another. One major role of these local governments is the management of public insurance programs. It ensures that qualified individuals receive the necessary health insurance. The type of treatment and associated bureaucracy is also formulated and implemented by the local government. A demonstration of this took place in January when a local government in China barred patients from receiving class III hospital care before going through CHS to be treated for chronic diseases (Wang & Claudia, 2010). In conjunction with the central government and the individual, the local government contributes to the NRCMS and URBMI (Yang, Chen, Du, & Wang, 2018).

The contributions, however, vary according to the wealth of a region/province. Local governments are therefore crucial in the delivery of healthcare in China.

4.4 Financing

4.4.1 Health Expenditure

When the healthcare reforms started in China in the 1990s, one of the areas that needed changing was financing. There was a need to increase expenditure on healthcare to target infrastructure, personnel, and the health insurance plan. By 2009, the expenditure on healthcare as a percentage of China's GDP had increased to 4.3%. Between 2009 and 2018, the increase in this metric of the percentage to the country's GDP has progressively increased though marginally. The 4.3% position in 2009 increased to 4.8% in 2014 and then eventually to 5.4% in 2018. Though the increase was progressively slow, it is an impressive and commendable undertaking since it has neither decreased nor stagnated.

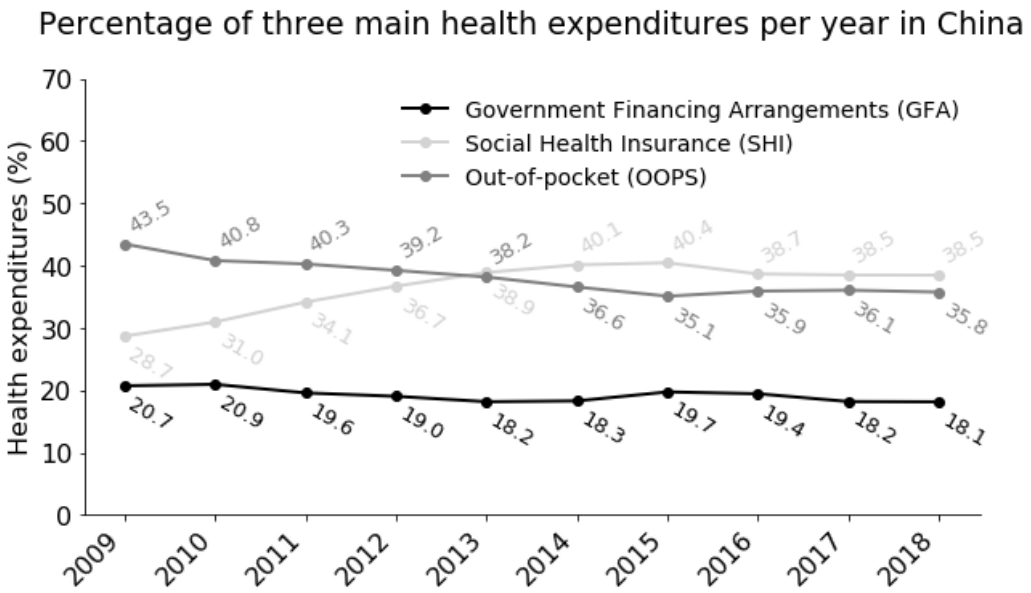

Figure 2: Percentage of three main health expenditures per year in China

Source (WHO, 2021)

Figure 2 shows a further breakdown of the three main resources of financing, shown as a percentage of the total 4.3%-5.8% health expenditure described above. This figure breaks down the generalized percentages into three: government financing arrangements (GFA), social health insurance (SHI), and Out-Of-Pocket (OOPS). Between 2009 and 2018, the GFA has marginally decreased from 20.7% to 18.1%. Whereas the OOPS started at 43.5% in 2009, it has been reduced to 35.8% in 2018. Relatively speaking, this was a substantial decrease, though it is still higher than the (GFA). The decreases in the GFA and OOPS on healthcare expenditure as a percentage of China's GDP were due to the SHI increase. From 28.7% in 2009, it reached a peak of 40.4% in 2015 before marginally decreasing to 38.5%. Therefore, social health insurance has helped subsidize healthcare costs in China, even though out-of-pocket payment is still high.

4.4.2 Health Insurance

Healthcare insurance in China has been divided into three main tiers. According to Zhao, Wang, Shen, & Wang (2018), they are the basic cover for urban enterprise employees, the basic cover for other urban residents, and the rural cooperative medical insurance for the farming population. The main aim of introducing these health insurance plans was to increase affordability, cover, and population access. These were in line with China's 2009 health reforms to provide effective, safe, convenient and affordable healthcare services by 2020 (WHO, 2019).

For the employees in the urban areas, the basic health insurance cover for urban enterprise employees, requires the employee and the employer to contribute 2% and 6% of the former's salary respectively. The self-employed resident, they can qualify to this scheme if they make all the required contributions. In this case, this is 8% of their salary. The non-enterprise residents are covered under the basic cover for other urban residents (InterNations GO, 2021). They contribute to the partnership with the state. The population in the urban areas who are unemployed or are on social assistance receive a subsidized healthcare insurance cover from the state.

The rural areas have also been covered through the rural cooperative medical insurance. According to Lai et al. (2018), rural cooperative medical insurance targets the farmers who make up virtually all the population in the rural areas. This cover is highly

subsidized because a significant percentage of the contributions to the schemes come from the central and the local governments. The contribution of the local government, however, varies according to the wealth of the government. The reimbursement, especially in the rural areas, has also improved in outpatient and inpatient treatment. These reimbursements have decreased the per-capita inpatient OOP expenditure by 36.7% (192.8 yuan). For the inpatient OOP expenditure, the reduction has been by 29.9% (201.9 yuan) in 2015 (Miao, Gu, Zhang, He, Sandeep, & Wu, 2018). With these reimbursements, the outpatient frequency increased, and hospitalization frequency decreased.

4.4.3 Out-of-pocket (OOP)

China has vision-2030, whose aim is to reduce out-of-pocket payments. The OOP payments as a percentage of health expenditure in China reduced from 43.5% in 2009 to 35.8% in 2018. Though the reduction of OOPS is commendable, the percentage is still high. Vision 2030's aim of reducing and eventually eliminating OOPs is because it impoverishes individuals and increasing healthcare problems. OOPS puts strain on households as they have to pay for healthcare aside from the other basic needs such as food, shelter, and education. The structure of these OOPs is not scaled on income since it does not consider the household's income as it might lead to a higher financial burden for the poorer population, but it is instead implemented using a standardized approach. The current levels (35.8%) of out-of-pocket payments are too high and can be catastrophic to a household. World Health Organization (WHO) advises that the OOPS

should be lower than 30% of the total health expenditure. In this way, households are better protected from disparity of healthcare services and health financing risk.

4.5 Health Reforms

The first healthcare reforms took place in the 1990s. With the continued advancement in technology and the widening of healthcare services, there was a realization that inequity was present. The inequity present was due to the lack of access to healthcare services and the inability to afford them. The changes instituted focused on increasing access, especially in rural areas, through a partnership with the local governments (Tao et al., 2020). However, the changes and improvements were only marginal.

The first major milestone of healthcare reforms in China was in 2006. This was when the China Central Political Bureau Committee workshop met. In the workshop attended by Chinese President Hu Jintao, the government acknowledged that the healthcare system and the services provided to the citizens was its responsibility (Li, 2011). Consequently, the president pledged that the government would take on more responsibility for the healthcare system, especially regarding cost.

The next major healthcare reforms in China took place in 2009. This was known as the healthcare reform phase 1. The main aim of this reform, as identified by the state council, was to provide universal basic and primary healthcare for all the country's population. At the time, China's population was 1.3 billion people (Tao et al., 2020).

Eventually, the reform hopes to provide equity for access to healthcare for both the rural and urban dwellers.

This was a five-year reform plan to run until 2016. According to Tao et al. (2020), the main aim of this reform was to fasten the improvement of the universal health insurance system. Since public hospitals were far inferior to private hospitals, this reform was meant to actively promote the reforms in these public hospitals to improve the quality and variety of services offered.

In 2014, China underwent another round of healthcare reform, known as health care reform phase 2. The 2014 reforms sought to deepen the 2009 reforms. This was to be achieved through the establishment of the "5+1" systems. It entailed the formation of a tiered healthcare delivery system (Tao et al., 2020). A drug supply security system was also to be created. This is to run between 2016 and 2030.

4.6 Assessment of The Healthcare System

To assess the HSC, the efficiency and quality of services and system resilience will be taken into account. In this section, the author will discuss the current healthcare system combining with three healthcare decommodification indicators mentioned in the second chapter.

4.6.1 Efficiency and Quality of Services

Efficiency

The public HSC is not as efficient as the private healthcare system (Wang and Zhang, 2019). Even then, the efficiency of private healthcare has not substantially improved in recent years. In China, the public healthcare system is usually synonymous with long queues. This is because there are not enough trained healthcare personnel, especially doctors available. Moreover, the medicine is sometimes lacking or insufficient. Such inefficiency is present in urban areas but is mostly synonymous with the rural areas' district hospitals. The private hospitals are also not as efficient as they could be, and the quality of services offered can be inadequate. One key metric is the percentage of private hospitals vis-à-vis the private hospital beds in China. These are presented in the figure below (Figure 3). It’s noteworthy that the healthcare expense in private hospital is not connected with the public insurance plan which means the patients have to pay by themselves once they decided to enjoy the private healthcare except the pharmacy part. (Nation Healthcare Security Administration, 2019)

As evidenced by the figure, the market share of private hospitals increased from 30.8% in 2009 to 65.3% in 2019. Within the same period, the private hospital beds increased from 10.5% to 27.5% (Figure 3). This shows that even though more of the Chinese are relying on and going to private hospitals for treatment, the bed capacity has not

increased at the same rate. Therefore, it can be deduced that this points to a system that focuses on quality and offers premium service to a few patients at high costs, rather than to mass patients at subsidized costs.

Corporatism

Despite the current weaknesses in quality and efficiency of the Chinese healthcare system, both private and public, there has been an improvement compared to history, especially from 1950. The corporatism of healthcare contributes to these improvements in efficiency and quality. In China, the corporations of its healthcare system are largely due to the Chinese medical association. Even though the health ministry impacts the healthcare system through policy, regulations, and laws, most of these come after consultation with associations such as the Chinese medical association (CMA). CMA has 82 specialist societies with a combined total of 430 members. It has specialized in organizing meetings, conventions, and conferences (UICC, 2021). CMA plays an active role in China's medical training, education, and exchanges. These have thus improved the quality and standard of medical services offered by its members. It has also influenced government policy and regulation both for private and public hospitals. These have contributed to the universalism and benefit equality offered by the three insurance sub-categories of healthcare insurance.

Healthcare Inequality

One of the areas that are conspicuous from China's healthcare system is healthcare inequality. Healthcare inequality in China can be seen mainly from the medical services' access and the quality of medical services on offer. The quality of medical services in China's urban areas differs from that in rural areas. China's urban areas have a higher population and are not sparsely populated, as is the case in the rural areas. Therefore, the quality of healthcare services in the urban areas in China's cities, such as Shanghai and Beijing, is better than what is available in rural. These rural areas are sparsely populated, and there is a lower rate of nurses per 1000 people than the urban areas. The cities are better equipped abundant medical resources and health workers. This thus causes a high level of healthcare inequality, thus creating an imbalance in the efficiencies and quality of services received between urban and rural area.

Healthcare inequality is also witnessed in the expenditure on healthcare in China, especially throughout OOP payments. With the OOP payments, rural areas pay much higher than those in urban areas. This is caused by the fact that the OOPS is not corrected to income or wages. Since the rural areas largely populated by farmers have lower income than the urban dwellers, a higher percentage of their income goes to healthcare through OOPS. Moreover, these OOP payments increased the poverty gap by approximately 146.6% while leading to the rise of poverty headcount by 3.96% in rural areas (Puteh & Almualm, 2017). These situations, therefore, increase the income inequality present in China.

4.6.2 Resilience for the System

The resilience of the Chinese healthcare system looks at its absorption capacity. This means it looks at the ability of the healthcare system to absorb shocks and sustain gains. A healthcare system is resilient if it consistently offers the same level of services measured in quality, quantity, and equity.

First, resilience looks at the percentage of the population covered by the healthcare system. The coverage has consistently increased over the years, such that 96.7% were covered in 2019 compared to 30.1% in 2009. Such a high percentage of coverage increases the resilience of the healthcare system. With more people being covered, the healthcare system, professionals, and infrastructure benefit from economies of scale and economies of scope. When many people use one dialysis machine, it is used more effectively and becomes more cost-efficient than when used by a few people. By this metric, the healthcare system in the country is therefore resilient.

The private health expenditure, when taken as GDP's percentage, reveals weaknesses in the resilience of the healthcare system with regards to quality and equity. Private health expenditure (OOPS) reduced from 43.5% in 2009 to 35.8% in 2019. However, this is still higher than the recommended rate of below 30% by WHO. Moreover, the private exposure to healthcare is standard and not adjusted to income. The poor and low-income earners, especially in rural areas, may fail to fulfill their individual

insurance contributions. This decreases the quality of healthcare services. When such individuals eventually get sick, they will have to pay out of pocket, with reimbursement being only 30%. This does not, therefore, breed equity, thus showing a healthcare system that is not resilient.

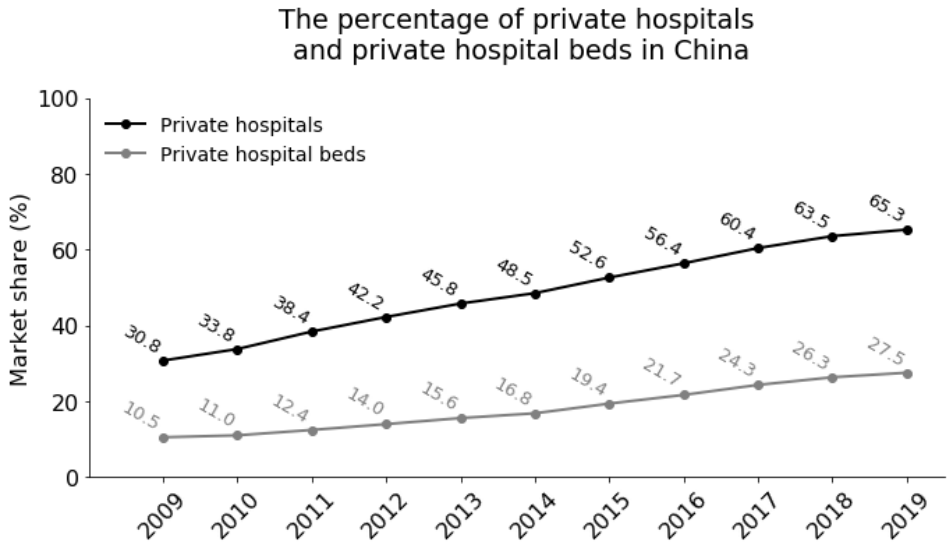

Figure 3: The share of private hospital number and private hospital beds in China

Source: National Bureau of Statistics (2020)

The private hospital beds within China increased from 10.5% in 2009 to 27.5% in 2019 (Figure 3 above). This means that the beds in public hospitals represent 72.5% of the total bed stock in China in 2019. This shows that the healthcare system is resilient though the trend showing the consistent increase in private hospital beds is not encouraging. There is higher equity in the public health system and with more quantity of services. Healthcare insurance and reimbursement also work well and more efficiently in public hospital beds than in the private sector. However, the quality of

services in private hospital beds is higher than that in public hospital beds. This quality metric could jeopardize the system's resilience, especially since the quality in rural public health hospitals is significantly lower, thus promoting health care inequality.

5 Classification of Chinese Welfare State

This chapter will mainly focus on the classification of Chinese healthcare system based on Esping-Andersen's comparative welfare-state study and Bambra's health care decommodification index. Three indicators within Bambra's index will be analyzed firstly according to Chinese health care status. Data reflecting health care status quo – private health expenditure as a percentage of GDP, private hospital beds as a percentage of total bed stock and the percentage of the population covered by the health care system – in China and 18 OECD countries is collected and processed to classify the Chinese welfare state. Based on the data analysis results, the Chinese welfare status in comparison with 18 OECD countries, key findings and further insights are discussed to close the chapter.

5.1 Healthcare Decommodification Index

Based on the principles of decommodification, social stratification and the role of family, market and state, Esping-Andersen classifies social welfare states into three models: the liberal model, the conservative-corporatist model and the social-democratic model. Bambra makes up the deficiency of Esping-Andersen's theory by taking health care, one of the most important social services, into consideration. Bambra extends the concept of decommodification to cover health care provision. Decommodification means the welfare allocated to employees immune from market dependency. According to Bambra's health care decommodification index, three indicators, including private

health expenditure as a percentage of GDP, private hospital beds as a percentage of total bed stock and the percentage of the population covered by the health, need to be analyzed to classify Chinese health care system.

Table 1: Analysis of Bambra's health care decommodification index

Indicator	Why this indicator	Correlation between indicator and decommodification
The private health expenditure as a percentage of GDP	Reflects the extent of private financing by identifying the extent of a country's total income that is spent on private health care (Bambra, 2005)	Negative correlation: the higher the private health expenditure as a percentage of GDP is, the lower the decommodification level.
The private hospital beds as a percentage of total bed stock	Reflects the extent of private provision at a practical level within a health care system (Bambra, 2005)	Negative correlation: the higher the private hospital beds as a percentage of total bed stock is, the lower the decommodification level.
The percentage of the population covered by the health	Reflects the extent of general access provided by the public health care system (Bambra, 2005)	Positive correlation: the higher the population covered by the health is, the higher the decommodification level.

Source: Compiled by author based on Bambra (2004)

Private health expenditure as a percentage of GDP in China is 35.8% in 2019, far lower than that in 2009 (See Figure 2). However, the proportion of private financing in GDP in China is still higher than the recommended level of 30% by WHO, which embodies weaknesses in the resilience of the health care system with regards to quality and equity

in China. Therefore, when it comes to vulnerable groups like low-income earners, they may fail to access high-quality health services because of high private expenditure.

As for the private hospital beds as a percentage of total bed stock, it increased from 10.5% in 2009 to 27.5% in 2019 (See Figure 3). This means that the beds in public hospitals account for 72.5% of the total bed stock in China in 2019 (See Figure 2), which reflects resilience in Chinese health care system. The trends of increasing private hospital beds and its relatively higher service quality compared with public health hospitals might lead to health care inequality and jeopardize the system's resilience.

The percentage of the population covered by the health grows dramatically from 30.1% in 2009 to 96.7% by 2019, which is a commendable achievement (See Figure 1). This development is due to many factors, in which the reforms undertaken during these ten years played an important role.

To understand the status quo of Chinese health care system with a focus on the above three indicators, the author also studies health status, financing parties, health reforms and makes an assessment to the health care system. China has made continuous improvements to its health care system. During the past decades, the health coverage has increased tremendously. The country death and birth rates decreased whereas chronic diseases increased. As for organizations, the health care system is controlled by the central government, which is responsible for drafting health regulations, policies,

and laws. However, the local government in the provinces does most of the implementation of these policies, programs, and laws, which are crucial to the delivery of the health care in China. The financing to expenditure in health care as a percentage of GDP grows slowly from 4.3% in 2009 to 5.4% in 2018 (WHO, 2021). Three tiers of health insurance also help to increase affordability, cover, and population access. Out-of-focus has decreased a lot, but still at a high level compared with WHO standard. Therefore, a series of health care reforms have also been conducted to improve the health status in China. As a result, both private and public health have witnessed a great improvement compared to history. However, the health inequality, inefficiency and lack of resilience in Chinese health care system still exist due to reasons like unequal resources allocation, which need further endeavors to improve the overall health status.

5.2 Data analysis and Results

Bambra analyzed data reflecting health care status in 18 countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, UK, and USA. This study also includes China's data to locate China's health decommodification status in the index. As all 19 countries' health care system have evolved tremendously during the past decades, data of 2018 is collected and analyzed to classify China's health care system more accurately. Most of data are collected from the OECD database.

The analyzing method applied in this chapter is the same as what used in Bambra's research. By way of the numerical description of the relationship of an individual country's score to the mean or the first two of the three factors that make up each index. On the basis of the scores of China and other countries, a score of 1 for low decommodification; 2 for medium; and 3 for high decommodification will be given. For the third factor the percentage of the population covered by the health care system on the basis of 100 percent coverage providing a weighting of 10, 92 percent coverage providing a weighting of 9.2, and so on. (Esping-Andersen, 1990) Three factors in Bambra's health care decommodification index are assessed and the data analysis results are in the following table.

Table 2: Health Index Data (2018)

Countries	Private Health Expenditure (% of GDP)	Factor 1 (Score)	Private Hospital beds (% of Total Bed Stock)	Factor 2 (Score)	Public Health Care System Coverage (% of Population)	Factor 3 (Score)
Australia	3.1	1	35.62[c]	1	100	10
Austria	2.6	2	30.54	2	99.9	9.99
Belgium	2.5	2	74.11	1	98.7	9.87
Canada	3.2	1	0.66	3	100	10
Denmark	1.6	3	6.49	3	100	10
Finland	2.1	2	5.23	3	100	10
France	1.8	2	38.48	1	99.9	9.99
Germany	1.8	2	16.47	2	89.4	8.94
Ireland	1.8	2	18.7[d]	2	100	10
Italy	2.3	2	29.85	2	100	10
Japan	1.7	2	70.42[e]	1	100	10
Netherlands	1.8	2	100	1	99.9	9.99
New Zealand	1.9	2	15.63	2	100	10
Norway	1.5	3	24	2	100	10
Sweden	1.6	3	18.7[d]	2	100	10
Switzerland	4.2	1	18.7[d]	2	100	10
UK	2.2	2	0	3	100	10
USA	2.6	2	78.48	1	34	3.4
China	2.2[b]	2	26.3	2	96.4	9.64
Adjusted Mean[a]	2.1		19.02		N/A	

Sources: OECD (2021), Australian Institute of Health and Welfare (2019), Statistisches Bundesamt (2021), Eurostat (2020), Ministry of Health Labour and Welfare (2019), National Bureau of Statistics (2020), Nation Healthcare Security Administration (2019).

[a] Adjusted for extreme outliers: Factor 1 (Switzerland); Factor 2 (Belgium, Japan, Netherlands, USA).

[b] Data from 2017 (OECD, 2021).

[c] Data from 2016-2017 (Australian Institute of Health and Welfare, 2019).

[d] EU Average.

[e] Data from 2019.

Table 3: Health Decommodification Index

NO.	Countries	Index Score	Health Index*
1	Australia	20.0	Low
2	Austria	40.0	Medium
3	Belgium	29.6	Medium
4	Canada	40.0	Medium
5	Denmark	60.0	High
6	Finland	50.0	High
7	France	30.0	Medium
8	Germany	35.8	Medium
9	Ireland	40.0	Medium
10	Italy	40.0	Medium
11	Japan	30.0	Medium
12	Netherlands	30.0	Medium
13	New Zealand	40.0	Medium
14	Norway	50.0	High
15	Sweden	50.0	High
16	Switzerland	30.0	Medium
17	United Kingdom	50.0	High
18	United States	10.2	Low
19	China	38.56	Medium
	Mean	37.6	
	Standard Deviation	11.8	

*High > Mean + SD

Medium: between (Mean-SD) and (Mean+SD)

Low < Mean - SD

Through the analysis of three healthcare decommodification indicators of China and 18 OECD countries, it can be seen that, in terms of health care system, China is in the medium decommodification group. A wide range of scores can be found in the above two tables. The health decommodification index score ranges from 10.2 to 60, which reflects various decommodification levels in different countries. The scores of some countries, like Denmark, Norway, Sweden, and the United Kingdom are extremely high,

which embody high level of decommodification in health care sector. However, in countries like United States and Australia, the health care decommodification standard is relatively low.

Table 4: Typology Comparison

Worlds of welfare	Health care (Bambra)	Health care in 2019
Liberal	**Group 1**	**Group 1**
Australia	Australia	Australia
Canada	USA	USA
Ireland		
New Zealand		
UK		
USA		
Conservative	**Group 2**	**Group 2**
Austria	Austria	Austria
Belgium	Belgium	Belgium
France	France	France
Germany	Germany	Germany
Italy	Ireland	Ireland
Japan	Italy	Italy
Netherlands	Japan	Japan
Switzerland	Netherlands	Netherlands
	Switzerland	New Zealand
		Switzerland
		China
Social Democratic	**Group 3**	**Group 3**
Denmark	Canada	Denmark
Finland	Denmark	Finland
Norway	Finland	Norway
Sweden	New Zealand	Sweden
	Norway	UK
	Sweden	
	UK	

Source: Esping-Andersen (1990), Bambra (2004)

Compared the author's research results with Esping-Andersen's and Bambra's consequences, both similarities and differences can be found. The welfare state classification of 18 OECD countries varies a lot. Three research analyze data of 18 OECD in different years, specifically in 1980, 1998 and 2018. The welfare state and health care status evolved from 1980 to 2018, which may lead to different data analysis results. Based on the same methodology, distinct indicators are applied to classify welfare state in three research. This can also bring about different classification consequences.

In Esping-Andersen's typology, Australia, Cananda, Ireland, New Zealand, UK and USA are placed within the low decommodification liberal regime. However, Bambra's health care typology places Canada, New Zealand and UK in the high decommodification group. UK is also classified into high decommodification group in the author's research. In all three studies, Denmark, Finland, Norway and Sweden are categorized into high decommodification group, which reflects that citizens in these four countries enjoy affordable and high-quality health care during the past decades. In comparison to 18 other OECD countries, China is classified into medium decommodification group, which records the progressive improvement in health care system in the past and huge space for progress in the following years.

5.3 Discussion on the classification of Chinese healthcare system

This thesis studies the welfare state typology in China from the perspective of health care system. The index scores reflect various decommodification level in different countries. Three indicators from Bambra's health care decommodification index are assessed. It can be seen that the private financing as a percentage of GDP in Australia, Switzerland and Canada are relatively high, which shows a lower level of decommodification in health care sector. However, the private financing as a percentage of GDP in Denmark, Norway and Sweden are lower than the average number. When it comes to the private hospital beds as a percentage of total bed stock, Canada, Denmark and Finland shows a lowers proportion, which means more public hospital beds and higher resilience of their health care system. As for public health care system coverage of population, it is pretty clear that except for the United States, most citizens in other countries are able to access public health case provisions and services.

From the assessment and combination of three factors, it can be seen that Australia and the United States are allocated to the low decommodification group. Australia is allocated to this group because of high private health expenditure while USA due to low public health coverage. The percentage of private hospital beds are much higher than the average level. Denmark, Finland, Norway, Sweden and UK are placed into high decommodification group from the perspective of health care system. The percentage of private health expenditure in GDP and the proportion of private beds in total bed stocks are relatively low in these countries. 100% of their population in these

four countries are covered by public health system, which means all of their citizens can enjoy public health care services and provisions.

12 out of 19 countries in this research, including China, are placed into medium decommodification group. The percentage of private health expenditure in GDP and the proportion of private beds in total bed stocks in China are relatively close to the average number of all 19 countries. The public health system coverage in China is up to 96.4, only a bit lower than most developed countries.

Countries in medium decommodification group in Bambra's health care index enjoy the same decommodification standard as those in Conservative-Corporatist model based on Esping-Adersen's typology. China also has identical features with countries in Conservative-Corporatist regime. According to Gencer, Conservative-Corporatist welfare regimes "are characterized by occupationally divided social insurance schemes complemented with corporate systems of social service provision (NGOs and church organizations)" (2017). The same is true for China, where social security system and private insurance system are complementary. However, Conservative-Corporatist countries feature equity over equality, and feature high dependence on male breadwinner (2017). China does not highlight equity alone and households depend on both male and female breadwinners. Through the analysis of the status quo of Chinese health care system, China has its vision for 2030 in the health care sector, which is to achieve universal social welfare by improving equality, efficiency and resilience of

health care system. It is expected that Chinese citizens continue to improve health conditions in the following decade. The average life expectancy will reach 79.0 years in 2030, and the average healthy life expectancy will increase significantly.

Considering the health care system status decades ago in China, great achievements have already been made and the same decommodification level with many western countries has been reached in terms of health care status. However, being in medium decommodification group means China not only enjoys the same decommodification level as Conservative-Corporatist regimes, but also has great potential to make progress in health care system to ascend to high decommodification group. The resilience of Chinese health care system can be improved through a larger proportion of public hospital beds and improved public health services. China can introduce new and insurance-covered healthcare access systems to achieve six major factors as recommended by Bambra (2005a). The factors or aims relate to safety, efficiency, timeliness, patient-centeredness, and equity. Bambra (2005a) explained that equity aims at providing quality care to everybody irrespective of their race, ethnicity, and specific personal attributes that are unrelated to the patients' reason for care-seeking. Another target that all healthcare organizations should meet is safety. Besides, consolidating the health financing system is necessary. Wang and Liu (2020) explained that China should achieve universal health coverage to integrate the financing sources for preventive and curative care. Increasing GDP are supposed to be invested into public health system to reduce private expenditure and ensure higher public health

coverage. In this way, the health care inequality can be relieved and the efficiency of this system can be greatly improved.

This thesis studies three main questions: based on which indicators to classify Chinese health care system, the status quo of Chinese health care system and which welfare group China belongs to. These research questions have been answered to help the author achieve the main goals. By analyzing the decommodification principle proposed by Esping-Andersen and health care decommodification index put forward by Bambra, three indicators are applied for classifying China's welfare state typology: private health expenditure as a percentage of GDP, private hospital beds as a percentage of total bed stock and the percentage of the population covered by the health care system. Through qualitative research, it is found that China has made tremendous progress in health care system during the past decade to provide affordable and quality health care to all. The population covered by health care grows dramatically. The country's death and birth rates decreased, whereas chronic diseases increased. The percentage of private health expenditures in GDP and out-of-pocket payment decreased. Public and private health care are supplementary to each other. The service quality and availability of both public and private health care have been improved. However, inequality, inefficiency and lack of resilience still exist in the system, which call for further endeavors. Through quantitative research, it is found that compared with 18 OECD countries, China belongs to medium decommodification group and it not only means the same

decommodification level as Conservative-Corporatist regimes, but also indicates huge improvement potential to high decommodification group in the future.

6 Conclusion

Currently, China is striving to improve its GDP, which also entails a transformation in social welfare, especially in the health care sector. Studying the classification of Chinese welfare state typology by analyzing the Chinese health care system and comparing it with other countries in the world within the scope of welfare state typology, helps China enhancing the public administration. Furthermore, consolidating the health financing system and introducing new and insurance-covered healthcare access systems can empower the healthcare system transformation. After primary literature searching, the author found only a few related studies were being carried out regarding this topic. Therefore, this thesis studies the welfare state typology in China from a health care perspective by applying the decommodification principle proposed by Esping-Andersen and the health decommodification index put forward by Bambra.

This thesis studies three main questions: based on which indicators to classify Chinese health care system, the status quo of Chinese health care system and which welfare group China belongs to. These research questions have been answered to help the author achieve the main goals. By analyzing the decommodification principle proposed by Esping-Andersen and health care decommodification index put forward by Bambra, three indicators are applied for classifying China's welfare state typology: private health expenditure as a percentage of GDP, private hospital beds as a percentage of total bed stock and the percentage of the population covered by the health care system. Through qualitative research, it is found that China has made tremendous progress in

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However, there are two other principles in Esping-Andersen's welfare state typology theory besides decommodification. In the recent decades, many scholars have modified Esping-Andersen's and Bambra's theories from different perspective. Future Chinese welfare state typology research from the perspective of health care system can also take these amended theories into consideration, which can further promote the improvement of Chinese health care system.

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