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BUREAUCRATIC INSTITUTIONS AND INTERESTS IN THE MAKING OF CHINA'S SOCIAL POLICY

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ABSTRACT

Explanations of China's post-Mao social policy have concentrated on the political, social, fiscal and economic goals of 'the state' or its governing elite. In a study of urban health insurance policy, this paper argues that bureaucratic interests and institutions within the Chinese state are also influential. It first shows how bureaucratic interests within the central government have influenced the adoption of a new national social health insurance framework. It then shows how that framework has been modified following local implementation experiences that have allowed other bureaucratic and non-bureaucratic interests to be expressed. This examination of both central and local helps explain the adoption of a basic social health insurance system that provides for only the urban working population, subsidizes civil servants, and is administered locally. It shows the policy process in this sector to have been particularly protracted and incremental and argues that further incremental policy change is likely.

INTRODUCTION: EXPLAINING SOCIAL POLICY IN THE ERA OF ECONOMIC REFORM

The enormous societal impact of China's post-Mao market-oriented economic policies is now well-recognized. Social and geographical mobility and wealth have all increased, along with unemployment and inequality. At the same time, social policies have begun to restructure the old welfare system, for example introducing in urban areas contributory old-age, unemployment and health insurance and broad but minimal poverty relief. To date, studies

have explained such post-Mao social policies as the result of the state or its leaders' efforts to prevent social unrest, respond to social need, and reduce spending and responsibilities. Thus, leaders' are said to be attempting to limit the erosion of safety nets because they fear that unrest will threaten the political system (Croll, 1999; Leung and Wong, 1999). However, in other work policies emerge from a 'black box' unitary and apparently benevolent state to deal with problems that have emerged in the course of market transition (see for example Chow, 1995; Lee, 1995). In contrast, others explain policy as the result of a parsimonious state determined to cut back spending and responsibilities with little regard for social need (Wong, Linda, 1994).[1]

Such discussions offer rich insights into the variety of factors influencing social policy in the post-Mao period, but they can also seem contradictory. Some of the apparent contradictions can be explained, however, by looking 'inside' the state. Because policy making in China today takes place in a centralized one-party system, there is little public debate or space for open lobbying (Lieberthal, 1995). Although non-state actors can have influence (Bernstein, 2000; White, 1993; Zweig, 1997), policy making is relatively closed. As studies of other sectors have shown, the actors within the central state involved in making policy decisions include not only the core elite of top leaders and their staff, but also 'leadership small groups'[2], research centers, and commissions and the line ministries whose activities they coordinate.[3] These individuals and bureaucratic agencies have their own interests and organizational missions, and strive to defend them in the policy making process (Lieberthal and Oksenberg, 1988; Shirk, 1993; White, 1993).

China's top leaders, particularly those on the Politburo Standing Committee, have broad political responsibilities and tend to have an interest in their own political position. They take a broad view and are likely to be concerned with threats to the regime. Studying these leaders may therefore show why new policy initiatives appear and explain the general direction of policy. A second tier of leaders have narrower more specialized roles, and are more likely to

represent particular bureaucratic interests (Lieberthal and Oksenberg, 1988: 28-29).[4] Because of this and since much of the work of formulating and implementing policy is handled by the bureaucracy, attention to bureaucratic institutions and interests can help explain why particular policies are adopted and how they are developed, revised and implemented or rejected (Lieberthal and Oksenberg, 1988).[5] The interests of bureaucratic agencies are usually linked to their 'missions', to protect or promote their role, and to support and defend their subordinate agencies or 'constituencies' (Lieberthal and Oksenberg, 1988; Shirk, 1993; White, 1993).

These actors pursue their interests within particular bureaucratic institutions, notably vertical functional organization, structures of rank, and norms that favor consensus-building. Vertical functional structures, which run from ministries through several layers of local government, create strong competing systemic interests. Bureaucratic rank prevents line ministries having authority over each other and over provincial governments. While there are institutional structures or mechanisms, such as the higher-ranked leadership small groups and commissions, to coordinate among these bureaucratic interests, institutional norms favor policy making through processes of consensus building among these actors and between central and local governments. As a result, one bureaucratic agency's opposition can slow the policy process, making it 'protracted' and 'incremental', with policies evolving as compromises among the most influential interests.[6]

This paper shows, through a study of health insurance, how central state bureaucratic interests and institutions shape social policy. In health insurance policy making large numbers of central state agencies with competing interests operate within these same institutional arrangements, and the protracted and incremental policy process there has produced compromise in the shape of an urban social health insurance program that targets employees, and excludes the non-working population. Health insurance policy is not, however, only the product of central bureaucratic interests. Local governments also can play a role in policy

making by bargaining with the center. Moreover, because opponents are unwilling to speak openly and unable to lobby at the policy formulation stage, the local implementation stage is important in the policy process:

> ‘ … the subtle process of shaping (or sabotaging) implementation becomes the most effective avenue by which individuals, localities, and organizations can express their interests and shape policy …’ (Lampton, 1987: 8).

Particularly with health insurance, the central government has relied significantly on local experiments to develop policy.[7] This has allowed certain interests, especially those of officials and enterprises, to influence policy and slow implementation, making the policy process further protracted and contributing to the institutionalization of incrementalism in this policy area.

The paper examines both central government health insurance policy making and its local implementation. It is based on the study of a combination of published policy documents and interviews with officials and researchers involved in policy making and implementation within both central and local government between 1997 and 2001.[8] Although the closed nature of policy making in China makes its research difficult, these sources, together build a picture of the way health insurance policy has been made. The next section introduces health insurance policy in China in the pre-reform period and outlines the main policy changes in the 1980s and 1990s. Section 3 discusses the central bureaucratic interests and institutions that have shaped post-Mao health insurance policy making, while section 4 examines the interests expressed at the implementation stage, and how these have influenced policy. The paper concludes by discussing which aspects of social policy a study of bureaucratic interests and institutions can explain that other approaches cannot.

HEALTH INSURANCE POLICY IN CHINA: AN INTRODUCTION

Health insurance was introduced in the cities of the People's Republic of China in the 1950s as part of a 'labor insurance' package.[9] Initially, labor insurance was targeted at factories and mines, but it was gradually extended during the 1950s to other types of enterprises. From 1952, similar provisions were made for government and other public sector employees, including officials, school teachers and hospital workers. Under this dual system, enterprises paid the treatment costs of their workers and the state budget paid those of public sector employees. Employers also paid half the medical treatment costs of their employees' dependants, and continued to pay employees' costs after they retired (Dixon, 1981). These urban employees made no direct personal contributions to their health insurance.

Though there are no reliable figures, it is estimated that by 1975 'almost all the urban population' had health insurance (World Bank, 1997: 1).[10] In the context of an egalitarian ideology, there was in principle no difference among urban employees in terms of their entitlement. Provision did vary, however, depending on both the employer and employee. Although empirical data are limited, it is thought that workers in large central state enterprises and with permanent contracts received more generous provision than people working in small local government collectives and those on temporary contracts (Dixon, 1981). For government officials and state enterprise employees, generosity of provision depended on rank and length of service (Davis, 1989: 579; Dixon, 1981). Urban dwellers received a high standard of health care given China's level of development, and a disproportionate share of investment in health.[11]

From the mid-1980s, though this system remained largely in place, actual insurance coverage for urban dwellers declined.[12] Although official figures show the numbers of entitled growing, in fact employers, particularly enterprises struggling in the emergent market economy, have often defaulted on their commitments, and growing numbers of people are either unemployed

or have moved from the state to the new private sector that does not subscribe to the 1950s labor insurance system (Grogan, 1995; Hu et al., 1999). Thus, although spending on enterprise and public health insurance increased by an annual average of 25 per cent between 1986 and 1992, so have individuals' private 'out-of-pocket' payments. It is estimated that in 1993, 16 per cent of health spending in China was accounted for by urban dwellers' private payments (World Bank, 1997).[13]

Health insurance policy after 1980 sought initially to modify and then more thoroughly to restructure the 1950s' system. It began by experimenting with limited measures, developed in the 1990s with experimental comprehensive government-run city-wide schemes, and resulted in 1998 in the decision to establish a new compulsory national 'urban employee basic health insurance system' (hereafter, 'the 1998 program' or 'the national program') (State Council, 1999c). This program was still exclusively urban, workplace-based, and funded by state and enterprises. But it departed from the pre-reform system in important ways. First, individual employees were to pay premiums contributions, and their entitlement would be based on this. They were also to pay a small percentage of costs in co-payments.[14] Second, the scheme provided only for those with employment (or retired), and so not for the non-working population, including dependants. Third, employer contribution rates were set relatively low, meaning that insurance provided for only a 'basic' treatment package.[15] Fourth, there was a single, unified system for enterprise and government employers and employees. Fifth, insurance contributions were to be pooled within cities and administered by municipal governments who would still had some flexibility in setting contributions rates and treatment packages. These developments in the restructuring of state-sponsored 'social' insurance were accompanied by measures permitting a small but growing role for private insurance.[16] Since this paper seeks to explain why policy has evolved as it has since the early 1980s, I will outline briefly the most important policy developments over the last two decades.

In the 1980s, policy evolved from early experiments with measures to make patients shoulder some of their treatment costs to later ones aimed at sharing risk among enterprises. The early experiments included, for example, some enterprises introducing ‘co-payments’, meaning that patients for the first time had to pay a proportion of their medical expenses. Some employers also began to reimburse their employees’ medical care costs rather than pay health service providers directly (Qi, 1996: 127; Zhu, Yong and Fan, 1995: 92). The later experiments organized risk-pooling among enterprises to pay for the treatment of employees’ serious illnesses, and, separately, for the treatment of retirees (Qi, 1996). Individuals employed under the new contract system introduced in 1986 were often required to make contributions for health insurance (Davis, 1988; Davis, 1989). No new unified system was developed, however, so that the extent of employer provisions and costs to individuals could vary significantly between localities and workplaces by the end of this decade (Duojie, 1995). The focus at this stage was more often on enterprises rather than government employees.

In the 1990s, health insurance policy developed through heavily publicized local experiments with more comprehensive compulsory social insurance schemes. In 1994 the central government approved city-wide experiments in the two prefecture-level cities of Zhenjiang (in Jiangsu Province) and Jiujiang (in Jiangxi Province) (State Council, 1999b). These involved risk-pooling of employer contributions, while employees paid premiums contributions into individual medical accounts, and marked a substantial shift from the 1950s system.[17] From 1996, it was announced that this model was to be extended to a further 57 cities (State Council, 1999a). At around the same time, other localities, including Shanghai and Tianjin, began schemes that differed slightly but still had an employee focus, involved city-wide pooling of employer contributions, and usually, but not always, individual medical accounts.[18] The medical treatment packages also varied, with schemes involving higher employer contributions, such as those in Zhenjiang and Tianjin, providing a wider range of treatment than those, like Shanghai, with lower contributions rates. Some schemes,

particularly those with the better treatment packages, included government as well as enterprise employees.

The 1998 national health insurance program retained many of the key features of the local level schemes that had been implemented in the mid-1990s, the most important being compulsory city-level risk-pooling, employer and employee premiums contributions, and individual medical accounts (State Council, 1999c). The program set employer contributions at 6-8 per cent of the wage bill, lower than many of the 1990s local schemes, and raised individual contributions to two per cent of an employee's wage. However within these prescribed limits the program also permitted local governments to set their own premiums rates and the treatment package for which the scheme would pay. Public employees were now required to join the schemes (as they had in Zhenjiang and Tianjin), ending the dual structure of provision that had existed in the pre-reform system and in the Shanghai scheme.

However, the 1998 program also contained some features not found in the 1990s city experiments. First, it introduced subsidies for civil servants. Second, it stipulated that enterprises could establish supplementary health insurance to prevent the lowering of medical provision standards. Third, it included workers laid off from failing state enterprises, who had not been part of most earlier schemes. Fourth, it made private enterprise participation compulsory (it had been optional in some local schemes) while it allowed local governments to decide whether or not to include rural enterprises and very small private ones and the self-employed. The rest of this paper shows how central bureaucratic interests and institutions and resistance during the implementation of local schemes in the 1990s produced this program.

CENTRAL BUREAUCRATIC INSTITUTIONS AND INTERESTS IN THE MAKING OF HEALTH INSURANCE POLICY

There are many actors involved in health insurance policy making within the Chinese central government. Several top leaders, most notably Jiang Zemin, Zhu Rongji, and Li Peng have at times visibly been involved in health insurance policy developments, usually publicly announcing or supporting new policy initiatives. Within the central bureaucracy four government ministries[19], one commission[20], four bureaus[21], one central office[22], one Chinese Communist Party department[23], the national trade union, and the country's biggest private insurance company[24] have been involved in health insurance policy making either by jointly issuing official directives and other policy documents or by participating in health system research or leadership groups (Zhu, Jiazhen and Zhang, 1995). Research institutes such as the China National Health Economics Institute have provided policy advice and research support.[25] The rest of this section sets out the bureaucratic missions and interests of the most important among these agencies. I shall return to discuss the role of the top leaders in the conclusion.

The Ministry of Labor and Social Security (MoLSS) has had a key role. As the former Ministry of Labor and Personnel, and then from 1988 until 1998, Ministry of Labor, it was responsible for pre-reform enterprise labor insurance and its health component. As a result, this Ministry tends to defend the interests of enterprises (World Bank, 1997: 56).[26] In the 1980s, it was involved in attempts to limit health spending by introducing employee co-payments, and it has also tended to emphasize the importance of redistribution and 'risk pooling' (Yin, 1997; Zhu, Yong and Fan, 1995).[27] All these may be traced to its experience of working with enterprises with growing labor insurance spending. Since its restructuring to form the MoLSS in 1998, it has been responsible for 'social insurance', which includes health as well as old-age, unemployment, work injury and maternity insurance. A new central Health Insurance Bureau was created beneath it. Its mission since then has been the successful

development of social health insurance. Note that the 1998 reorganization perpetuated the Ministry's responsibility for labor, leaving social relief for the urban poor with the Ministry of Civil Affairs. The MoLSS has thus been absolved of any responsibility for the long-term non-working population, including dependants.[28]

The Ministry of Finance is the bureaucratic agency responsible for balancing central government revenues and expenditures, and it is therefore involved in all policy areas (Lieberthal and Oksenberg, 1988). It is often portrayed as fiscally conservative and 'chief defender of the central state' (Shirk, 1993: 96), seeking to minimize excessive budgetary commitments and avoid deficits. Like the Economic System Reform Commission, charged in the 1980s and 1990s with coordinating urban economic reform, it tends to stress efficiency and advocate a reduced state role.[29] Fiscal pressures in the 1990s mean that Ministry has sought to reduce state investment in health (Interview 99B17).[30] It therefore will have preferred social insurance schemes for the working population to schemes paid for from general taxation that would leave the state with greater responsibilities. The Ministry of Finance is also likely to have backed a decentralized health insurance system because it shifts fiscal responsibilities to local governments.[31]

The Ministry of Health has been centrally involved in developing health insurance, particularly in the late 1980s, when it led a central government research group on health reform (Qi, 1996). However, it soon became apparent that this role created a conflict of interest for the Ministry, whose responsibilities also included, via subordinate health bureaus in the localities, managing health service providers. In this latter role it tended to defend providers' income and in the early 1980s had been behind measures permitting private practice and raising treatment fees (Pearson, 1995). These measures are now said to have contributed to escalating health costs that threatened the viability of the health insurance schemes being tested in the 1990s. Since health insurance was transferred to the MoLSS in 1998 there has been more emphasis on controlling health service providers and containing

supply side-driven health costs (Interview 00B7). Although the Ministry of Health continued to want to play a role in health insurance, its influence was reduced by the creation of the MoLSS and probably also by Ministry of Health staff cutbacks in the late 1990s (Interviews 98B4, 99B17).

Other agencies clearly involved in health insurance policy making include the Ministry of Personnel, the State Drug Administration Bureau, the People's Insurance Company of China (PICC) and the All-China Federation of Trade Unions (ACFTU). Their specific influence on health insurance policy is, however, more difficult to establish. The Ministry of Personnel, since its split from the Ministry of Labor and Personnel in 1988, has been responsible for the insurance of government employees, and has overlapping jurisdiction with the Ministry of Labor and Social Security over other public sector employees (Xia et al., 1989: 104). It defends the interests of these employees and has fought the erosion of their benefits (World Bank, 1997). It is therefore likely to be behind the decision to subsidize civil servants in the 1998 program, aided by the fact that many decision makers are themselves civil servants. The State Drug Administration Bureau, which administers the country's pharmaceuticals industry, seeks to increase drug sales and develop the industry (World Bank, 1997). It plays a role where there is a need to control medicine costs or decide which drugs will be provided under social health insurance schemes.[32] The People's Insurance Company of China, a state-owned company, wants to secure a role for commercial health insurance, and establish itself in this business. The ACFTU stresses the need for fairness and tries to preserve the benefits to its members, including provisions for their dependants (Interview 99S11, White, 1998). However, its subordination to the Party-state means that although many enterprise employees oppose individual premium contributions and co-payments, their interests have been weakly defended.

As indicated above, the different interests of these bureaucratic actors sometimes coincide and are sometimes in conflict. As in other policy areas, where they conflict, fragmented authority

has led to bargaining. As a result, the health insurance policy making process has been protracted (Zhu, Jiazhen and Zhang, 1995: 383). Policy has evolved incrementally from experiments with enterprise risk pooling and co-payments in the 1980s to comprehensive city-wide social insurance schemes for the employed in the early 1990s.[33] This trajectory is the one that would be most acceptable to the key bureaucratic players: the early enterprise risk pooling and individual co-payments helped the Ministry of Labor solve the problems of some enterprises, but would not have harmed hospital income or drawn on state finances and so would not have been opposed by the Ministries of Health and Finance. Thus it was retained at the heart of the emergent 1990s system. Similarly, the adoption of urban social insurance only for those with employment trod the line of least resistance, being financed along similar lines to the pre-reform system by employers and the state and therefore acceptable to the Ministry of Labor and the Ministry of Finance (Interview 00B7). The Ministry of Health may have been persuaded that a social insurance system did guarantee income to its hospitals. Individual premium contributions and co-payments, as well as the removal of provisions for dependants, were also acceptable to these bureaucratic agencies, and had no powerful opponents.

By the early to mid-1990s, consensus-building at the central level achieved movement in the direction of urban social insurance, particularly for enterprises. At this stage, a number of localities began to implement variations of this basic model. The use of local schemes can be traced to a combination of technical difficulties, bureaucratic interests, and unresolved political issues. First, health insurance is the most technically complex of the social insurance programs. It is difficult to forecast spending, objectively allocate funding, and administer a workable, sustainable scheme. As a result, as a representative in the Beijing office of one international organization argued, central leaders and officials genuinely may have been unsure about how to proceed and therefore devolved policy development to local governments (Interview 98B4). Second, local schemes may also be a way for particular parts of the central bureaucracy to promote their preferred policies by gathering support in the

localities.[34] For example, the Ministry of Finance benefited because localities were likely also to seek to minimize local budgetary investment as well as because the creation of a national scheme, under which it would have greater commitments, was delayed. Wealthier localities, which are unwilling to subsidize the health bills of poor regions, also preferred to establish their own schemes.[35] Finally, the crucial political issue, of how to balance the needs of on the one hand those financing the system (the state, enterprises and employees) and on the other health service providers and patients, remained. While funders want value for money and a limit to their expenditures, health service providers need to pay doctors and nurses' salaries, while patients want the best care possible. The question of how much funders could afford or were prepared to pay, and what health services that funding could provide, was a political issue that was difficult to resolve at the central level, was thus devolved to local governments.

POLICY IMPLEMENTATION AND LOCAL INTERESTS

There are many local bureaucratic actors involved in implementing health insurance policy. The most important are the bureaus of Labor and Social Security, Health Insurance (or, in some cities, Social Insurance), Health, Finance, Personnel, and Drug Administration, the lower echelons of the 'systems' that run down from the central ministries. Senior to them in a municipal government are the mayor, and the deputy mayors, one of whom is likely to be charged with this work, as well as local leadership groups and commissions (Interview 99S10). Finally, in an important difference from the central level, there are other actors, primarily enterprises, hospitals, and the beneficiaries of pre-reform labor insurance, notably enterprise employees and government officials, whose participation or cooperation is required for the policies to be implemented.

Since central government bureaucratic 'systems' reach down into local government, the interests of central ministries are replicated in their subordinate bureaus there. Municipal bureaus of Labor and Social Security, like their Ministry, have an interest in seeing the social

health insurance risk pooling succeed because both are responsible for overseeing the management of this pooled income. Their need to ensure a balance between income and expenditures means they have argued in some localities at least against the inclusion of dependants (Interview 99S11). The focus of their work is therefore on getting as many enterprises as possible to participate in the program[36], and on getting value for money from health service providers. Moreover, local bureaus, which get a small percentage of those funds as income to cover their administrative expenses, have a particular interest in meeting contributions targets. Meanwhile, local health bureaus attempt to defend hospital income (World Bank, 1997), while local finance bureaus are concerned to guard against overspending and minimize commitments. Municipal Drug Administration Bureaus' interests are in securing profits for the drugs producers in their locality, which can conflict with Bureau of Labor and Social Security interests in controlling the costs of health treatment and medicine (Interview 99S16).

How enterprises (that is, their managers) react to the new schemes depends largely on the structure of their workforce and whether or not they paid for their employees' medical treatment under the pre-reform system. Of those that did, the ones with an older workforce and high expenditures on insurance are generally willing to join the schemes, as they hope to reduce their expenditures.[37] Those with a younger workforce and private sector enterprises, who have not paid pre-reform labor insurance, are unwilling to join because their expenditures will increase. Similarly, it is reported that employees in failing state enterprises who were no longer able to pay for health treatment are more satisfied with new schemes, even if they involve individual contributions and some co-payments. Those whose health treatment was still paid by their enterprise and who currently still receive relatively high levels of treatment at little personal cost, are unhappy with the shift to the new schemes (Qi, 1996).[38] These include government officials and some state enterprise employees (World Bank, 1997: 55-6). Other actors are indirectly affected by the new social insurance schemes. Hospitals expect constraints on the treatment they provide and the likelihood that health

insurance bureaus (via the agencies that actually manage the pooled premiums contributions) will seek better value for money from them (Interview 99T1).[39] The schemes may also threaten the profits of local medicine manufacturers, many of whom bribe or give large commissions to doctors to sell their medicines (Interview 99S16).

Bureaucratic institutions and interests are also replicated at the local level, though with some important differences. Authority is similarly fragmented, so that equally-ranked bureaus cannot exert authority over each other, and local schemes also evolved consensually.[40] Intrabureaucratic mediation is achieved by local leadership groups, and by the mayor and deputy mayors. However, the rank issue is complicated at this level by the fact that central government or provincial state enterprises located in a city have the same or higher rank than the bureau officials implementing the schemes. As we shall see, this can create problems for officials seeking to enforce enterprise participation in the schemes. Local leaders' preferences resemble those of central leaders in that they also seek to prevent social unrest and develop the economy, key issues on which their performance is judged. But decentralized fiscal and decision making controls means they have to balance the need to pre-empt labor unrest with the interests of the local enterprises, including local medicine manufacturers, who may contribute significantly to the local economy (Interview 99S16).

The basic framework of compulsory social insurance for urban employees with city-level social pooling and individual accounts, had been established at the center. But there was scope for flexibility that allowed some interests to influence the design of the local schemes. At this stage, for example, local governments decided the levels of contributions, the package of health care that would be provided, and who should be included in the schemes. Here a balance had to be struck between the levels of premiums contributions that employers and individuals could afford, the amounts needed to provide a particular health care package, and the levels of funding (via the insurance) that hospitals would get. In different local

experiments, different balances were struck, with (as described above) some schemes opting for higher contributions and a more comprehensive package than others.

During the implementation of the local schemes, interests were most obviously expressed through resistance by certain actors, and the bargaining among on the one hand the local government agencies charged with designing and implementing the local schemes and on the other hand those whose participation was required, such as some local officials and enterprises. Government employees, for example, have tended to resist the erosion of their benefits. As one ACFTU official noted, officials' private interests can influence their policy decisions: "People making policy always think of their personal interests … policy makers are happy to let the enterprises reform their system, but they are not so willing to press for reform of the public system because … then they will have to start making contributions themselves" (Interview 99S11). Thus officials participated in schemes with high employer contributions, but not in those, like Shanghai's, with lower contributions and more basic provision.

Enterprise interests have also been apparent during the design and implementation of the local schemes. As described above, enterprises with a younger workforce were unwilling to join schemes because this increases their health insurance spending . Such enterprises therefore resisted participating in the schemes (Duckett, 2001; Qi, 1996). In Tianjin, a scheme planned for one district was repeatedly delayed because local employers, many of whom were central government state enterprises, were unwilling to participate (Interview 98T2). In Shanghai, the scheme did begin, but the Health Insurance Bureau, unable to simply enforce compliance of high-ranking state enterprises, had to resort to negotiations and a combination of repeated pleas for such enterprises to join the schemes, and threats to withdraw access to essential local services. It also had problems getting some foreign-invested joint ventures and non-ranked private sector enterprises to participate (World Bank, 1997). Officials reported that it was particularly difficult to get small private sector enterprises to enroll because it was difficult to establish wage levels and monitor their employee numbers because of their rapid labor

turnover. Whatever the reason, this lack of local government capacity to enforce compliance contributed to gradual implementation of policy and the already protracted policy process.

Resistance and bargaining meant that implementation was protracted, as evidenced by certain actors, where they participated at all, doing so later than others in the course of implementing the schemes. But implementation experience also shapes the content of the policy. First, opposition, expressed through local resistance (Lampton, 1987), has seen the 1998 national program make concessions to civil servants, who were awarded subsidies so as to maintain their high levels of medical care. Second, the 1998 program also retained social pooling at the city level that prevents wealthier local governments from subsidizing poorer areas. Third, the program set recommended employer contributions rates relatively low, because of fears that high rates would create problems for enterprises and would result in poor implementation.[41] However, as we have seen, because low contributions mean a less generous package of provision (where local governments are unwilling to subsidize programs), there can also be demands for higher contributions. Local governments have therefore retained the flexibility to set levels of employer and employee contributions within the stipulated range, and to include or exclude rural and small private enterprises. State enterprises are also permitted to set up supplementary schemes that would prevent a reduction in the standards of their employees' medical care.[42] The center, rather than dictating levels, has decentralized the negotiation of even the national program, therefore, meaning that social health insurance provision will vary both across the country and within localities.

Many issues are thus still unresolved, and have been devolved for local governments to settle at their own discretion. This means that implementation of the new national program is also likely to be protracted and negotiated. Indeed there already evidence of this. In one southern city, the local version of the national program was rejected by the local people's congress because it would reduce standards of care for some, most likely the elite who are likely to be well-represented in the congress (Liu, 1999). Similarly, in Shanghai, bargaining was evident

as readjustment to conform with the national program began. Here, local officials, resisted the introduction of individual accounts for outpatient treatment and medicine stipulated in the program, because they would be inadequate for those, like themselves, who were approaching retirement and had little saved in their accounts. Other governments, too, have been slow to implement the program, with some major cities such as Chengdu and Shenyang only just beginning to do so in 2001. In Tianjin, where contributions were to be lowered, local Health Insurance Bureau officials was unhappy at the proposed readjustment in part because they expected future policy modifications to raise contributions rates again (Interview 99T7). Thus, incrementalism is now anticipated by actors within the system, increasing the likelihood of resistance and further slowing the implementation process.

CONCLUSION

It is difficult to discern the influence of individual top leaders in the shaping of health insurance policy, though they have clearly pushed developments, particularly during the 1990s.[43] As studies of policy making have already established, this is likely to be due to their concerns with their own personal political survival and that of the regime. Thus their desire to prevent social unrest is likely to be behind policies that limited the erosion of urban enterprise employees' pre-reform labor insurance: urban workers are generally seen to be the most disgruntled part of the population, and unrest is feared more in cities than in the countryside. Indeed the preservation of 'social stability' has been explicit in the official government rationale for the health insurance reforms. Similarly, fears of urban unrest may help explain the inclusion of private enterprises and laid-off workers in the health insurance scheme in the late 1990s, at a time of growing attention to lay-offs and rising unemployment when the private sector was increasingly being looked to to provide jobs for former state sector workers. However, top leaders' fears of social unrest is less helpful for explaining health insurance policy in the 1980s which was aimed at controlling health spending and reducing the burden on some state enterprises, and actually increased individual workers' private health

spending. Nor can it explain why in the 1990s social insurance, which involves making those urban workers pay individual contributions and co-payments and has removed the benefits for their dependants, was chosen, or other features of the new system, such as its inclusion of government employees.

Rational explanations of health insurance reform policies usually see them as a response to rising health insurance spending and the increasingly unequal burden on some state enterprises, as well as the need to provide for people who are not insured. Particularly in Chinese official and academic studies, this explanation of 'the need for reform' has been dominant. But these rational explanations cannot explain why social insurance has been adopted or why dependants have lost their entitlement to insurance. While policies do clearly tackle certain problems, as we have seen, bureaucratic bargaining and policy implementation mean that it is likely to be those that are prioritized by the most powerful intra-state interests, while others are ignored. Thus the problems of uneven state enterprise burdens and the need for new non-state sources of funding, have been addressed while others, such as declining insurance coverage, have not. Explanations of social policy as motivated primarily by the state's desire to cut costs and responsibilities are similarly a reflection of the interests of some actors. As shown above, it is primarily the Ministry of Finance and its local bureaus that are unwilling to fund non-working population, resulting in relatively narrow insurance coverage. These preferences have, however, been fought successfully by civil servants who have secured state subsidies to maintain their pre-reform standards of medical care.

Bureaucratic interests and institutions, and the incremental policy process they create therefore show why health insurance policy has emerged as it has. The early introduction of co-payments and then later, contributions, was due in part to Ministry of Finance unwillingness to increase spending on health while the Ministry of Health sought to protect and increase hospital income. These interests in conjunction with the interests of the Ministry of Labor to deal with the uneven distribution of health spending among enterprises explain the

concentration on urban enterprise employees. Later, the continued preferences of the Ministry of Finance and the Economic System Reform Commission for limited state commitment to subsidize potentially costly national schemes at a time when the central government tax base was weak (Wong, Christine P., 1996), help explain why social insurance was adopted, and why certain social groups (rural dwellers and the non-working population) are excluded. This was aided by the fact that enterprises had long been the funders of the labor insurance system, and overseen by the MoLSS, the agency given responsibility for the new social insurance, leaving the Ministry of Civil Affairs system with the marginalised poor.

The implementation of local schemes also allowed certain interests to be expressed. First, local government leaders and finance bureaus are, like the Ministry of Finance, unwilling take on the responsibility for providing social insurance for the poor (though in Shanghai there was a very limited scheme of health assistance provided through the Bureau of Civil Affairs). Second, some enterprises resisted being brought into the schemes because it increased their health spending. These include relatively new state enterprises with a young workforce, and private enterprises. Both ultimately have been forced to join the scheme, but they seem also to have influenced the decision to set enterprise contributions relatively low in the 1998 program. To counter their arguments that their workers were against joining because their health provision would be less generous under the new scheme, they were permitted to provide supplementary schemes for their employees. Civil servants, some of whom designed the local schemes, resisted participating in schemes that would have lowered their standards of care and were, probably with the backing of the Ministry of Personnel, compensated with subsidies when they were mandated participate in the new national system.

In China's still relatively closed political system and policy process the strongest influences come from within the state. However, that state speaks not with a single voice; it contains a variety of actors, both top leaders and bureaucratic agencies, with a range of different interests. Bureaucratic institutions mean that policy making is characterized by fragmented

authority that results in a protracted and incremental policy process as these actors bargain to achieve consensus. But policy is also influenced by local implementation experiences. Due to the particular complexities of the health sector, as well as to local government interests, local experiences have therefore allowed the interests of hospitals, enterprises and local officials to influence policy. The resistance from some of these actors has added to the incrementalism in policy making and made the policy process further protracted. Indeed, this incrementalism is now anticipated by local actors and has become self-perpetuating as those actors resist implementation in the expectations of future policy changes in their favor. The institutionalization of incrementalism means that social safety nets are developed only slowly and patchily even in the wealthiest coastal areas, but it also means that the current system is likely to be continually modified and perhaps improved and broadened.

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NOTES

[1] Some accounts discuss a combination of such political, rational 'social', and fiscal influences (Cook, 2000; Guan, 2000; Saunders and Shang, 2001).

[2] 'Leadership groups' consist of representatives of ministries with an interest and involvement in a policy area, and are used 'to help top leaders coordinate the activities of their myriad bureaucracies' (Lieberthal and Oksenberg, 1988: 41).

[3] This and the following two paragraphs draw substantially on Lieberthal and Oksenberg's groundbreaking study of policy making in the energy sector (1988).

[4] Lieberthal and Oksenberg (1988: 36-37), writing in the late 1980s, also distinguished the pre-eminent leader and a number of elders. Within the current post-Deng Xiaoping third generation leadership, the most powerful leader, Jiang Zemin, plays a less distinctive role, and the number of powerful elders from the revolutionary era has declined.

[5] I use 'institutions' here to include established organizational structures, mechanisms, practices and norms, in what might be termed a combined empirical and normative approach (Peters, 1999). These institutions shape the behavior of individuals, though in much of what follows below, I talk of bureaucratic interests as aggregates. This is possible because the performance of individual officials within the Chinese bureaucracy is measured, often using quantified targets, against achievement of organizational missions (see for example Whiting, 2001). As we shall see, however, officials do also have personal interests separate from and sometimes perhaps in conflict with those of the bureaucratic organization in which they work.

[6] Lieberthal and Oksenberg (1988: 22-31) discuss the policy process in more detail and identify other features. I concentrate on the protracted and incremental aspects of the process because they have been the most important in health insurance policy making.

[7] Local experiments (literally, 'test points', in Chinese) have been used in other policy areas. See for example White (1993). I use 'local', 'localities' and 'local government' here and elsewhere to refer to levels of government beneath the center. Particularly relevant to this discussion are municipal governments, which can be found at province, prefecture and county level of government administration in China.

[8] I conducted fieldwork in Beijing, as well as in Shanghai and Tianjin where significantly different schemes were implemented. The identities of interviewees have been obscured to preserve their anonymity. Interviews are cited below in the following format: the first two numbers indicate the year of the interview (so 99 indicates 1999, 00 indicates 2000), the letter indicates its location (B indicates Beijing, S indicates Shanghai, T indicates Tianjin), and the final digit the number of the interview that year.

[9] This package included pensions, and provisions in the case of death (Dixon, 1981).

[10] In rural areas a separate cooperative medical system provided low-cost basic medical care (Bloom and Gu, 1997).

[11] By 1993, urban dwellers were 15 per cent of the population but received two-thirds of public spending on health (World Bank, 1997).

[12] Rural cooperative health provision also collapsed after the late 1970s (World Bank, 1997: 3).

[13] Urban dwellers are about 20 per cent of the total Chinese population.

[14] The actual percentage varies for different illnesses and categories of employee.

[15] This does not mean that it does not provide treatment for serious or chronic illnesses, however. Often the priority is such treatment, while lesser illnesses (that are less expensive to treat) are excluded.

[16] I use the term 'social insurance' for compulsory national government-run schemes, as distinct from private insurance.

[17] In the Zhenjiang and Jiujiang schemes, enterprise contributions were calculated at 10 per cent of the payroll (a so-called 'payroll tax'). Individual contributions were calculated at 1 per cent of their wage.

[18] For more detail see Duckett (2001). While the Zhenjiang and Jiujiang schemes are usually described as 'test points' (sometimes translated as 'trials', 'experiments' or 'pilots' in English), some local schemes, such as Shanghai's, are not. However, I treat them together since all have impacted on the development of policy.

[19] Ministries of Labor (called Labor and Social Security from 1998), Health, Personnel, Finance.

[20] The Economic System Reform Commission.

[21] Bureaus for Medicine, Drug Administration, Health Insurance, Material Pricing.

[22] The State Council Health Insurance Reform Office.

[23] The Organization Department, which handles Party personnel matters.

[24] The People's Insurance Company of China.

[25] International organizations, notably the World Bank and The World Health Organization, have also offered advice and assisted with policy development.

[26] Confirmed in an author's interview with a central government health official (Interview 99B17). This interviewee also noted that the Ministry was under pressure from top leaders to minimize social instability.

[27] White (1998) saw the same preference in this ministry's pensions policy.

[28] It is responsible for those receiving unemployment benefit, but entitlement to this benefit is restricted.

[29] See White (1998) on the Economic System Reform Commission.

[30] Indeed, it was also pressing for taxation of hospitals and the conversion of not-for-profit hospitals to for-profit ones (Interview 00B7).

[31] Shirk (1993: 96) argues that the Ministry of Finance can sometimes favor decentralization.

[32] The Bureau was moved into a new Ministry of Medicine in 1998 in an attempt to control health costs (Interview 99B17).

[33] In some of the 1990s trials, only enterprises were included, while in others government employees joined the scheme.

[34] As has been demonstrated with other policies, notably the decollectivization of agriculture.

[35] Fiscal decentralization in the post-Mao period has reduced inter-regional redistribution.

[36] There can be differences in this between localities. In some, local leaders prioritize success in this policy area and so there is pressure on local bureaus to succeed. In others there is not, and so implementation is slower.

[37] Older state enterprises with growing numbers of pensioners would have not only more spending on pensions, but also higher expenditures on health (since the generally there is more spending on the medical treatment of the elderly). As market reforms progressed, this made such enterprises less competitive than younger enterprises who would be able to spend more on developing production.

[38] The introduction of individual accounts was an attempt therefore to sweeten the pill of individual contributions, probably especially to young public sector and enterprise employees who were understood to be resistant to paying into social insurance schemes.

[39] Local programs have been less successful where Health Insurance Bureaus have been placed under the control of the local Bureau of Health, apparently because of problems controlling health insurance spending (Interview 99S16, World Bank, 1997).

[40] One Shanghai official noted for example that "[t]he Health Insurance Bureau documents are usually produced after discussion among all the departments involved, and they usually take on board the ideas of all departments" (Interview 99S11)

[41] Officials in Shanghai explained that they had a relatively good enterprise participation rate in their local scheme because their contributions rate was lower (7.5% of the wage bill) than most others (10-12%). The 1998 program adopted a rate that was close to the Shanghai one (6-8%) (Interview 99S10).

[42] The ACFTU was in the 1990s organizing supplementary schemes in different localities, but these were voluntary for employees and do not involve the enterprises making contributions. In Shanghai they were more likely where employees' salaries were higher (Interview 99S11). Should this be the kind of supplementary scheme envisaged in the 1998 program, then many employees may see their medical care standards fall.

[43] Li Peng was involved in policy developments in the early 1990s, Jiang Zemin and Zhu Rongji later that decade.