Socio-Economic Rights | Section I

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Dilemma between Economic Incentives and the Public Provision of Welfare: SER Trade-offs in China's economic development and its healthcare reforms, 1979~2022

Abstract

China experienced drastic economic development over the past decades, beginning with its Open-Door policy in the 1980s which led to its entrance into the world capitalist liberal trade economy. Throughout the process, both the public and private sectors underwent substantial structural reforms and transformations which led to changes in the citizens' lives in relation to their access to social welfare and services. As a country that has ratified the International Covenant on Economic, Social, and Cultural Rights (ICESCR), China's healthcare system will be examined in this paper under the extent to which it has fulfilled the state's obligations discussed by the ICESCR regarding the principles of substantive equality and non-discrimination. A comparison will be made between rural and urban areas' healthcare provisions, and the population of rural migrant workers who work in urban areas will be of special concern.

Introduction

The right to health is a crucial aspect of human rights that provides fundamental functions and purposes for an individual to live their life. Individual health and well-being uphold instrumental utilities for the essential functions to a realization of a good life, as well as containing intrinsic moral values to human living. An individual's ability to realize their right to health is deeply embedded in social, political, and economic structures which often generate conditions and patterns for justice and injustice in the process of realizing rights. Yamin identifies social and political determinants of health which outlines the social processes and institutional actors that play a role in generating the underlying dynamics of social and economic inequalities.[1] These include the arrangement of social institutions such as the health system and their process of administration, legal frameworks such as domestic labor law regarding their treatment of health, or international policies and practices which set the norms of global patterns of health. This paper seeks to discuss the realization of health rights under rapid social and economic structural transformations. It attempts to look at how the systemic pattern of changes socially and economically, under the context of development and economic growth, affects the realization of health rights in relation to the standards drawn by the international human rights framework. The right to health of the SERs (Socio-Economic Rights) of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) will be the focus of this discussion.[2]

China has experienced a rapid development process since the 1980s. It is mainly an economic process, reflected through its entrance into the international capitalist market, liberalization of domestic trade, and the stimulation of private sector growth. During the period of development, China saw substantial economic growth in terms of its GDP (Gross Domestic

[1] Yamin, Alicia Ely, Chapter 9, "The Right to Health", in Dugard et al, *Research Handbook on Economic, Social and Cultural Rights as Human Rights*. Edward Elgar, 2020, pp 159-179.
[2] *International Covenant on Economic, Social and Cultural Rights (ICESCR)*, General Assembly Resolution 2200 A (XXI) (1966), entered into force 3 January 1976.

Product), raising the overall living standards for most of its citizens and alleviating poverty by 320 million people from 2002 to 2012, the line for poverty is drawn under the World Bank's standard of people who live on less than $1.90 a day.[3] China's GDP increased from 0.5% of the global GDP in 1978 to 10% in 2011. Exports grew at 16% a year for the past three decades and amounted to $1.6 trillion in 2010 — which is a 12% share of the world market, replacing Germany as the world's leading exporting country.[4] The growing standard of living and economic growth lead to reforms in the social sector, in terms of the public provision of welfare services such as the healthcare system. The provision of healthcare as a form of social insurance is closely interrelated to the fulfillment of the right to health, and hence will be the main concern of this paper.

On the one hand, aggregated economic growth generates the state's growing capacity to fulfill the right to health. On the other hand, development narratives often contain a concept of 'trade-off', which seeks to put priority on economic growth with a compromise on certain human rights obligations. This paper will draw to a discussion on whether a development narrative of 'trade-off' violates the state's capacity to fulfill human rights obligations in the context of China's development, particularly on the substantive equality and non-discrimination principles that are stressed in General Comment No. 3 of the ESCR.[5]

This will begin with China's development policies since the 1980s and its social changes as a result of policy implementation. The healthcare system will be examined in detail, with a comparison of rural/urban healthcare provision and a detailed analysis of the current status of China's domestic migrant worker's access to health services. Then the reform of the public health system will be examined in relation to development progress in the past four decades. This will be followed by a discussion on the dilemmas faced by the nation-state between equal treatment of welfare provision and economic incentives towards growth, analyzed under the perspective and

[3] "Free exchange: how the other tenth live", *The Economist,* October 8, 2016.
[4] Wong, J. "The 12th Five-Year Programme A Turning Point in China's Socio-Economic Development." *China: Development And Governance.* World Scientific; 2013.
[5] CESCR, *General Comment No. 3: The Nature of State Parties' Obligations*, 14 December 1990.

standards of conventional international frameworks regarding the right to health, including the ICESCR and the related ESCR general comments. This paper will argue that China's unequal fulfillment of health rights in its development era is a result of political priorities during the process of policy framing.

Context

In the 1980s, the rise of Deng Xiaoping as the paramount leader of China led to a series of economic and political reforms which shifted China's economy away from a planned economic system to the gradual incorporation of market fundamentalism. This reform policy opened China up to foreign investments and economic liberalization, leading to a change in the country's economic structure as well as the role of the state — from directly providing communal services to a policy enforcer leading the transitioning economy and society. The reform has generated substantive economic growth until today, as the nation's GDP increased from 0.91 trillion dollars in 1991 to 8.91 trillion dollars in 2015.[6]

The positive economic growth led to a rising level of nutrition amongst the population and overall improved quality of health services. Indicators have shown that the growing economy resulted in a life expectancy that increased from 67.9 years in 1981 to 71.8 years in 2003, and infant mortality fell from 50.2 per thousand births in 1991 to 19 per thousand in 2005.[7] At the same time, the changing employment structure and taxation system also brought about massive changes in the nature of health services. The growing private sector participation and rising costs to access health services catalyzed changes in the formerly centralized medical system. The collapse of the pre-reform communal model of the public healthcare system brought about increasing unequal access to healthcare amongst the population in the initial period of development. By the end of the 20th century, the public administrative system saw an urgent need for a new public health system.

[6] World Bank. *Guide to growth, Employment and Productivity Analysis.* World Bank Open Data, 2017.
[7] World Health Organization Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health,* (WHO 2008), p26.

Health system in the age of transformation

Beginning in 1979, the relationship between labor, capital, and the role of the state in China was altered by the socioeconomic development trajectory. Prior to the market reform, both rural and urban areas' healthcare systems were state-owned in communal models. This was based on three characteristics: 1) fixed in the sense that individuals do not choose the type of treatment they receive, but the level of treatment is decided by the hospital; 2) structured in the sense that the system is sorted into levels of clinics, and individuals are sent to the next level of clinic only if their situation requires so, and 3) centralized in that all facilities and services are publicly owned and operated, also meaning that they are free under the communist ideology. The 1979 reform brought about a huge shift in the public provision of healthcare. By the late 1990s, the coverage gap in healthcare existed in China and approximately 50 percent of the urban population and 80 percent of the rural population were not covered by any form of health insurance.[8]

A close examination of China's structural categorization of households cannot be neglected when discussing China's public provision of welfare services. China's unique household registration system, known as the *hukou* system, draws a distinction between rural and urban areas, and their residing population. In terms of both the legal as well administrative nature. It was formally implemented in 1958, assigning every citizen to either an agricultural hukou or a non-agricultural hukou, or also known as the rural (agricultural) and the urban (non-agricultural). The *hukou* registration location indicates where an individual's welfare responsibility belongs, for welfare services are provided by the local-level government. In the pre-reform period prior to 1979, when social mobility was limited, the *hukou* location would usually be one's place of registration, which would be their place of birth. During the development period, industrialization and the growing job opportunities in urban areas lead to mass rural-urban flow, generating a specific group of the population — the migrant workers. The rising population of migrant workers generates new forms

[8] Ministry of Health – Center for Statistics Information. [Abstract of the Report on the 3rd National Health Service Investigation and Analysis] 第三次国家卫生 服务调查分析报告, in [Chinese Hospitals] 中国医院, No. 1. 2005.

of social issues in the public provision of healthcare, in relation to how the administrative structure separates responsibilities for social welfare provision at five levels: including national, provincial (including the autonomous regions), country, district, and municipal. Responsibility for insurance policy and the medical scheme also belongs under separate sectors of government, leading to complexities within the decision-making process.[9] In particular, whether migrant workers' healthcare should be registered in some form in urban areas has been a central discussion in policy framing in the recent decade.

Migrant Workers

During the age of development, millions of rural citizens migrate to urban and metropolitan cities to seek better living conditions and employment opportunities. Migrants who left their *hukou* registration location to another township rose from 2 million in 1983 to 253 million people in 2014, taking up 18.5 percent of the total population. This migration of rural laborers is one of the main driving forces of China's economic growth over the past four decades. For example, as one of the largest developing cities, Shanghai consists of a population of 9.98 million migrants which accounts for over 39% of its total population in 2020.[10] The massive increase of migrants in a short period emerged a new form of distinction in the household registration system, between a local *hukou* and a non-local *hukou.* The latter refers to the majority of migrant workers who seek employment in urbanized areas, "non-local" indicating that the individual is residing in a location outside of their *hukou* registration location. Because health insurance is administered to the local region which remains unportable to one's *hukou* status, the system of household registration limits the provision of social welfare services to citizens at the administrative level.

This distinction of 'non-local' thus implicitly represents a disparity in the enjoyment of social welfare, including health insurance and pension as the provision of welfare usually concerns

[9] Liu, D. and Darimont, B., The health care system of the People's Republic of China: Between privatization and public health care. *Int Soc Secur Rev*, 66 (2013): 97-116.

[10] Xi, S., Song, Y., Li, X., Li, M., Lu, Z., Yang, Y. and Wang, Y. Local-Migrant Gaps in Healthcare Utilization Between Older Migrants and Local Residents in China. *J Am Geriatr Soc,* 68 (2020): 1560-1567.

only citizens whose *hukou* is registered in the local area. For years this characterization was debated over its effectiveness as a source of rural-urban inequality, sometimes described as the "invisible walls" that divide up rural and urban civil lives.[11] A migrant worker, while possessing the freedom of mobility to move from rural to urban areas, could be denied equal access to rights to welfare in the urban regions to some extent. Administrative policy limits the extent of the enjoyment of social welfare of non-local *hukou* status, and as long as migrant workers do not transfer their *hukou* to an urban one — which requires complex and conditional processes — their extent of welfare enjoyment is limited in urban areas.

Rural vs. Urban

Until the 1980s, the public healthcare system for rural sectors was situated under a communal model, through receiving public service funding from the government and providing free but limited quality services. The institutions provide medical services at three levels, including on the first level free clinics in villages, on second level health centers in townships, and on the third level district or county hospitals. While access to medical treatment in urban areas was organized by and within state-owned enterprises prior to the 1980s. During the economic reform, market fundamentalism led to procedural changes in the public administration system. Public expenditures on the medical system were cut drastically. The free model of a communal public medical system was under difficult circumstances with the emergence of private-sector health services. The first-level clinics in villages collapsed almost completely, while the second and third-level hospitals experienced a transition to private sector services.

This drastic shortfall in terms of resources and funding was experienced by the medical system, of both rural and urban areas during the initial stage of the reform. Overall government budget on health expenditure decreased from 2.4 percent of total expenditure in 1980 to 1.9 percent in 2004, while the annual growth rate of health expenditure was 12 percent from 1978 to 2004,

[11] Chen, Chuanbo. and Fan, Cindy. "China's Hukou Puzzle: Why Don't Rural Migrants Want Urban Hukou?" *China Review*16, no. 3 (2016): 9–39. http://www.jstor.org/stable/43974667.

higher than the 9.4 percent growth of GDP.[12] Rural social health insurance coverage even dropped to 10 percent in 1989, from approximately 90 percent in 1980.[13] Under this backdrop, both rural and urban areas are experiencing transitions in the medical system, while new forms of disparities were also emerging between rural and urban as a consequence of the unbalanced economic growth across regions. Inland provinces that had relatively limited development in both infrastructure and transportation, which are vital factors for economic growth, experienced much lower rates of growth compared to coastal provinces that opened up to international trade and foreign investment. The rural-urban discrepancy in development resembles the rural-urban citizens' enjoyment of welfare, including health insurance. From 1993 until 2003, the source of funding for health expenditures in rural areas was almost entirely self-payment, while for the urban areas the source was more evenly divided over social health insurance, labor insurance scheme, and government healthcare scheme.[14]

Reforms

By the beginning of the 21st century, the state had recognized the urgent need to address the deriving development challenges besides the rapid economic progress — grappling with socio-economic issues alongside economic restructuring and rebalancing. A series of plans was adapted as the official national policy blueprint to outline the countries' ambitions regarding development progress. These were to be implemented in line with the task of systematic reforms, not only on economic and political structures, but also on social welfare.

The Seventeenth National Congress, led by Chairman Hu Jintao in 2006 recognized the need to increase government responsibility and maintain the nature of healthcare as a public good. The 2009 reform of the healthcare system sought to set basic coverage plans for the entire Chinese

[12] Manuel, R. "China′s Health System and the next 20 Years of Reform." In *China: The Next Twenty Years of Reform and Development*: 363–400. ANU Press, 2010, p 367.
[13] World Bank, *Country Study. China: long term issues and options in the health transition* 1992. The World Bank, Washington, DC, 1993. pp. 1–132.
[14] ibid.

population and to "establish a basic healthcare system covering all the population by 2020."[15] This was launched in response to the large mobile population of workers which consists of changes in residential location and regions and where medical insurance was observed to contribute as a major factor to inequality. The government seeks to establish a public health system with universal health insurance which covers all rural and urban residents. The famous Five-Year Plans that are posed by the State Council and the Central Committee of the CCP and which under-led the nation's direction of development gradually shifted its emphasis onto social welfare by the second decade of the 21st century. The 12th Five-Year Plan (FYP) that lasted from 2011-2015 began to tackle improvements in public welfare and services seriously, with discussions on the step forward to providing universal access to basic healthcare and sanitation systems. The current 14th Five-Year Plan (2021-2025) continues to emphasize public welfare and incorporates the provision of a multi-layer social welfare provision framework.

Nonetheless, while the government's incentive towards healthcare policy implementations on the macro-scale does increase the population on basic coverage and access to healthcare, the procedural complexities as well as the general societal transition towards a market economy drive issues around migrant workers' access to health services. As a result of market transformation, a substantial degree of privatization of public hospitals has been seen since the 1990s. The growing autonomy of hospitals largely raises treatment costs which results in many patients being unable to pay for medical costs.[16] Among the pharmaceutical system, the market economy has promoted price competition for essential drugs, and attempts to regulate central procurement of pharmaceuticals by the government have encountered stiff resistance from the sector.[17]

Migrants' use of healthcare is usually associated with their level of income. As the new healthcare system from the 2009 reform covers only the risk of severe illnesses completely,

[15] Zhang F, Shi X, Zhou Y. The Impact of Health Insurance on Healthcare Utilization by Migrant Workers in China. *Int J Environ Res Public Health.* (2020) Mar 12;17(6):1852, p1.
[16] Liu, D. and Darimont, B., The health care system of the People's Republic of China: Between privatization and public health care. *Int Soc Secur Rev*, 66 (2013): 97-116.
[17] Yang, 2009; Duckett, 2010

outpatient treatment is to be self-financed and reimbursed later to be insured. Thus, the lower the migrants' income, the less likely they are to use healthcare.[18] Yamin's idea of 'social determinants' of health (2020) raises similar concerns — where the conditions under which one is born, grows, lives, works, and ages could be responsible for a far greater proportion of health and ill-health than medical care.[19] Reforms thus not only need to look at the provision of healthcare itself but its structural accessibility as well. Health is not always an independent social circumstance one experiences separately from other aspects of life, it is indivisible from other social spheres in the process of *affecting* and being *affected by* a wide range of social actors.

Dilemmas

The dilemmas of the Chinese government's current future direction for healthcare reform reside in its two parallel philosophies towards both universal access to basic healthcare treatment under the tightly regulated market economy, and also the encouragement of competition among the private sector in terms of other forms of treatment.[20] This two-sided philosophy of the state's ambition resembles the prolonged debate among the development sector over whether certain rights 'trade-offs' should be incorporated, in order to compromise for economic priority during take-off stages of development, for that coexistence often seems impossible on the macro-level.[21] From the perspective of the ICESCR, development policies offer a solution to combating structural impediments of rights realizations — such as poverty — yet the economic priority of development incentives could at times conflict with the state's aims of welfare provision.

China's development policy on the infringement of the right to health is two-fold. On the structural level, the characterization of rural-urban *hukou* status and its associated disparities of welfare benefit violates the substantive equality principles as stressed in the ICESCR. On an individual level, migrant workers' exclusion from equal enjoyment of healthcare services suggests

[18] Liu and Darimont, (2013).
[19] Alicia Ely Yamin, chapter 9, "The Right to Health", in Dugard et al, Research Handbook on Economic, Social and Cultural Rights as Human Rights (Edward Elgar, 2020), pp 161-162.
[20] Milcent, C. "Evolution of the Health System: Inefficiency, Violence, and Digital Healthcare." *China Perspectives*, no. 4 (108) (2016): 39–50.
[21] (see Kaldor, 1985; Huntington, 1968)

the violation of the principle of non-discrimination. As China ratified the ICESCR on March 27, 2001, and the Covenant entered into force for the nation on June 27, 2001, the Covenant and General Comments of ESCR are all applicable to the state party. The state obtains a responsibility to respect, protect, and fulfill the rights and obligations outlined in the ICESCR and its relevant conventions.

These obligations include the procedures in recognizing "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[22] Article 2(2) of the ICESCR raises the non-discrimination principle that "the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status", suggesting that the birth origin – the *hukou* registration location, should not become the source of limitation for one's access of social welfare. While Article 3 of the Covenant further discusses the substantive equality principle of how "the States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights outlined in the present Covenant." These two principles together formulate the problematic nature of the rural-urban distinction in the administrative system.

GC 3 (1990) similarly discusses the nature of the state's responsibilities to respect, protect, and fulfill human rights standards,[23] and GC 20 (2009) of CESCR specifically discusses the principle of non-discrimination.[24] GC 14 (2000) which elaborates on the Right to the Highest Attainable Standard of Health also contains a discussion on the state's obligation to non-discrimination and equal treatment specifically regarding the right to health, acknowledging that "the formulation and implementation of national health strategies and plans of action should

[22] Article 12, *International Covenant on Economic, Social and Cultural Rights (ICESCR)*, General Assembly Resolution 2200 A (XXI) (1966), entered into force 3 January 1976.
[23] CESCR, *General Comment No. 3: The Nature of State Parties' Obligations*, 14 December 1990.
[24] CESCR, *Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights*), 2 July 2009.

respect, inter alia, the principles of non-discrimination and people's participation."[25] These suggest a need for attention to China's future healthcare reforms on the equal treatment of rural and urban regions' categorization and individual welfare treatment.

Currently, healthcare is recognized as a necessary public good for ensuring well-being by the Chinese government under the principles outlined in the 12th FYP.[26] China also has the obligation to ensure that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family" under its ratified status of the ICESCR.[27] In April 2005, China's first periodic report on the implementation of the ICESCR was reviewed by the ESCR Committee, within it the government has acknowledged that difficulties have been encountered in implementing the ESCR rights, relating to income gap, work safety, public health, and disparities between urban and rural areas.[28]

The ESCR Committee concluded, however, regarding the "factors and difficulties impeding the implementation of the Covenant", that "there are no significant factors" impeding the nation's capacity to effectively implement the Covenant."[29] The conclusions further discuss the "*de facto*" discrimination of internal migrants which indirectly results from the *hukou* system, and the insufficient implementation of labor legislation, including migrant workers' right to just and favorable working conditions.[30] In the concluding observations on the second-period report, the Committee continues to take note of the *de facto* discrimination against rural-to-urban migrant

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[25] Paragraph 54, CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (11 Aug 2000) E/C.12/2000/4.

[26] Zhang F, Shi X, Zhou Y. The Impact of Health Insurance on Healthcare Utilization by Migrant Workers in China. *Int J Environ Res Public Health.* (2020) Mar 12;17(6):1852.

[27] Article 25, *Universal Declaration of Human Rights.* United Nations, 10 December 1948.

[28] "China is still a developing country. In view of constraints relating to the level of the country's economic and social development, even though the Covenant has come into force in China, not all its articles have been fully realized. The degree of enjoyment of certain rights does not yet reach the requirements of the Covenant. China still has a duty to reduce poverty and the gap between the wealthy and the poor, while it also faces such pressures as population growth and resource depletion". People's Republic of China, *Initial reports submitted by States parties under articles 16 and 17 of the Covenant, PRC InitialReport,* 27 June 2003. para. 13.

[29] CESCR, *Concluding Observations of ESCR Committee on ESCR*, 13 May 2005.

[30] Choukroune L. Justiciability of Economic, Social, and Cultural Rights: The UN Committee on Economic, Social and Cultural Rights Review of China's First Periodic Report on the Implementation of the International Covenant on Economic, Social and Cultural Rights. *Columbia Journal of Asian Law*. 2005;19(1):30-49.

workers in the fields of employment, social security, healthcare, and education, and on the persistence of disparities between the urban and rural populations and among rural-to-urban migrant workers concerning access to social security, including the quality and amount of benefits (para. 24).[31]

Conclusion

In conclusion, while China's industrial development and associated economic growth lifted billions out of poverty and increased the overall net growth in socio-economic rights, it is inherently a utilitarian approach to tackling poverty that contains political priorities and right trade-offs. The increasing rural-urban disparity about growth and income inequality and social benefits discrepancies will and are becoming serious social issues in the subtle interplay between law, policy, and political priorities. Development policies to a large extent affect the government's capacity to fulfill human rights obligations when macro-level growth is considered before human rights considerations.

The fulfillment of the right to health is multi-level. Health is inextricable from systematic factors such as poverty and is intrinsically embedded in social and economic structures. As stated in GC 14, "the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 [right to health]" is acknowledged by the committee.[32] Nonetheless, in the case of China, as the concluding observations of the CESCR suggest, the resulting discrimination is a matter of policy framing rather than economic deficiency.

The factor of privatization and competition incentives of the growing economy marks another aspect that affects the equal treatment of healthcare access. Dwindling coverage and over-marketization of healthcare providers marked the two steering features of the healthcare

[31]CESCR, *Concluding observations on the second periodic report of China, including Hong Kong, China, and Macao, China.* 13 June 2014.

[32] Para. 5, CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (11 Aug 2000) E/C.12/2000/4.

system in the transition to a free market economy, where an individual's ability to access health services becomes increasingly intertwined with their economic (income) and social (*hukou*) status. The structural interplay of a range of actors puts one in vulnerable social circumstances, such as the rural-urban migrant workers population. Not only is the financial domain a determinant of a migrants' exclusion from healthcare access, but also their place of origin, of where their *hukou* registration location is – that distinguishes them as 'rural' in comparison to 'urban', 'agricultural' in comparison to 'non-agricultural', and 'non-local' in comparison to 'local' – the invisible walls framed by national policies that prevent them from equal access to social welfares like healthcare. These are the implicit rights trade-offs of a specific group of population behind China's massive economic growth.

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