

# Health Inequality in China

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## Great leap forward

Tens of billions of dollars have been spent, lavish sport venues erected and the world's biggest airport terminal built<sup>1)</sup>. This is a scene from Beijing just before the 2008 Olympics. If we should choose a phrase that best describes the world today, perhaps the winner will be "China Shakes the World," borrowing from James Kynge's 2006 book title<sup>2)</sup>. China has nearly one quarter of the world population (1.3 billion), and has the second largest economy in the world after the United States, with a gross domestic product (GDP) of over US\$7 trillion when measured in terms of purchasing power parity (PPP)<sup>3)4)</sup>. Also, as

Newsweek columnist Fareed Zakaria noted, "the world's largest publicly traded company is in Beijing" –the state oil company Petrochina<sup>5)</sup>.

Moreover, according to the World Bank, it is estimated that about 212 million people in China were living on less than US\$1 a day in 2001. In 1990, the number of Chinese living in extreme poverty was as many as 375 million<sup>6)</sup>. The World Bank analyzed that massive poverty reduction in China played a key part in the decrease in the number of people living on less than \$1 per day by more than 260 million over the course of 1990~2004 in the developing world<sup>7)</sup>.

1) [http://www.economist.com/world/asia/displaystory.cfm?story\\_id=11841531](http://www.economist.com/world/asia/displaystory.cfm?story_id=11841531) (accessed August 15, 2008).

2) Kynge, J. (2006), "China Shakes the World," Houghton Mifflin Company.

3) WHO (2006), "WHO-China Country Cooperation Strategy at a Glance."

4) [http://en.wikipedia.org/wiki/Economy\\_of\\_the\\_People's\\_Republic\\_of\\_China](http://en.wikipedia.org/wiki/Economy_of_the_People's_Republic_of_China) (accessed August 15, 2008).

5) Zakaria, F. (2008), "The Rise of the Rest," Newsweek.

6) Friedman, T.L. (2005), "The World is Flat," Farrar, Straus and Giroux.

7) The World Bank (2007), "World Development Indicators 2007."

## Both sides of the success story of China

However, this is only one side of the story. According to the Asian Development Bank's Key Indicators Report 2007, China's income gap between rich and poor has been the "second-largest and second-fastest-growing" in Asia since the 1990s. China's Gini coefficient was more than 45, increasing from 40.7 in 1993<sup>8)</sup>. As the China Human Development Report 2005 put it, the average income of the top decile was 11 times that of the bottom decile<sup>10)</sup>. The ADB and China Human Development reports analyzed that major reasons for the widening income gaps are the differences in economic development and investment between urban and rural areas<sup>11)12)</sup>. Indeed, it is estimated that the income difference between urban and rural Chinese increased more than six-fold in the space of 15 years<sup>13)</sup>.

Inequality exists in other dimensions as well

in China. As the ADB report pointed out, it is possible that income inequality is related to inequality in non-income dimensions, including those in health across different population groups, and the report emphasized that in China this is a case in point<sup>14)</sup>. The ADB showed that along with the increase in income inequality, non-income inequalities in China have also increased, and the most notable aspect of the inequalities is found in access to basic health care<sup>15)</sup>.

As "non-income dimensions are essential for well-being," as the ADB report noted<sup>16)</sup>, the examination of these non-income inequalities in China will be a meaningful process that enables us to see the rapid pace of the development of China with a more balanced perspective. The purpose of this paper, in this regard, is to review the current Chinese health care system, and examine, among a variety of non-income inequalities, health inequality in China.

8) The Asian Development Bank (2007), "Key Indicators Report 2007: Inequality in Asia."

9) <http://www.iht.com/articles/ap/2007/08/08/business/AS-FIN-Asia-Economy.php> (accessed August 15, 2008).

10) UNDP (2005), "China Human Development Report 2005: Development with Equity."

11) <http://news.bbc.co.uk/2/hi/business/6936525.stm> (accessed August 15, 2008).

12) UNDP (2005), "China Human Development Report 2005: Development with Equity."

13) Ibid.

14) The Asian Development Bank (2007), "Key Indicators Report 2007: Inequality in Asia."

15) <http://www.forbes.com/afxnews/limited/feeds/afx/2007/08/09/afx4002473.html> (accessed August 15, 2008).

16) The Asian Development Bank (2007), "Key Indicators Report 2007: Inequality in Asia."

## The uninsured and rising health care spending

Chinese health system is now faced with both a large number of uninsured people and growing health care expenses<sup>17)</sup>. It is estimated that more than 70 percent of people lack health insurance. Out-of-pocket payment increased from 20 percent of total health spending in 1978 to 58 percent in 2002<sup>18)</sup>. As a result, the article "The Chinese Health System at a Crossroads" noted, "China has one of the highest out-of-pocket payment shares of total health spending in Asia"<sup>19)</sup>. A study carried out in three Chinese provinces, Guangdong, Shanxi and Sichuan, which, taken together, represent one-sixth of the Chinese population, found that 71 percent of the respondents had no health insurance, and half of the respondents had experienced in the past year when they did not see a doctor when they needed to see one, mainly because of the health care cost<sup>20)</sup>.

From 1978 to 2002, according to a study published by The New England Journal of Medicine, annual per capita health spending increased from roughly US\$1.35 to \$55 in China and its spending on health care in general increased from 3 percent of GDP to 5.5 percent<sup>21)</sup>. Also, its health spending has been growing at a rate 7 percent faster than the growth of GDP over the last two decades<sup>22)</sup>.

### Social inequality in health care

However, the lack of health insurance and the rise of health care spending have not affected all the Chinese people to an equal extent. By 2003, about 80 percent of the rural population was not covered by health insurance, as compared with almost a half of the urban population<sup>23)</sup>. The aforementioned study carried out in three provinces also showed that the percentage of the uninsured

17) Yip, W. & Hsiao, W.C. (2008), "The Chinese Health System at a Crossroads," Health Affairs.

18) Blumenthal, D. & Hsiao, W.C. (2005), "Privatization and its Discontents-The Evolving Chinese Health Care System," The New England Journal of Medicine.

19) Yip, W. & Hsiao, W.C. (2008), "The Chinese Health System at a Crossroads," Health Affairs.

20) Lim, M.K., Yang, H., Zhang, T., Feng, W. & Zhou, Z. (2004), "Public Perceptions of Private Health Care in Socialist China," Health Affairs.

21) Blumenthal, D. & Hsiao, W.C. (2005), "Privatization and its Discontents-The Evolving Chinese Health Care System," The New England Journal of Medicine.

22) Yip, W. & Hsiao, W.C. (2008), "The Chinese Health System at a Crossroads," Health Affairs.

23) WHO (2005), "China: Health, Poverty and Economic Development."

was much higher in rural areas than in urban areas—90 percent and 51 percent, respectively<sup>24</sup>. When it comes to out-of-pocket payment, it accounted for roughly 90 percent of total health spending in rural areas in 2004<sup>25</sup>. The result is hardly surprising given that the majority of the rural population has been uninsured<sup>26</sup>.

As The New England Journal of Medicine study noted, an important predictor of one's access to health services is the wealth of the health care consumer in China, and with the increase in income inequality—the incomes in urban areas are three times higher than the incomes in rural areas—rural residents have fared much worse than urban residents in terms of health care access<sup>27</sup>. Also, the differences in wealth between urban and rural areas have significantly affected the size of health care spending—it is reported, “Shanghai is seven times higher than the poorest rural areas”<sup>28</sup>. Moreover, according to the China Human Development Report 2005, 82

percent of urban residents could get to the nearest medical institution within 10 minutes, while in rural areas only 66.9 percent could, and 7 percent of rural residents needed more than 30 minutes to get to the nearest medical institution. As for the number of available medical personnel, there are 5.2 medical personnel per 1,000 residents in urban areas, while in rural areas there are only 2.4 per 1,000 residents<sup>29</sup>.

### Health disparities between urban and rural areas

Yet, the most worrying aspect is that the inequality in health care in terms of health insurance coverage and other dimensions is clearly reflected in disparities in health outcomes between urban and rural residents. To be sure, as the ADB Key Indicators Report 2007 pointed out, disparities in health outcomes have increased between rural and

24) Lim, M.K., Yang, H., Zhang, T., Feng, W. & Zhou, Z. (2004), “Public Perceptions of Private Health Care in Socialist China,” Health Affairs.

25) WHO (2005), “China: Health, Poverty and Economic Development.”

26) Yip, W. & Hsiao, W.C. (2008), “The Chinese Health System at a Crossroads,” Health Affairs.

27) Blumenthal, D. & Hsiao, W.C. (2005), “Privatization and its Discontents—The Evolving Chinese Health Care System,” The New England Journal of Medicine.

28) Blumenthal, D. & Hsiao, W.C. (2005), “Privatization and its Discontents—The Evolving Chinese Health Care System,” The New England Journal of Medicine.

29) UNDP (2005), “China Human Development Report 2005: Development with Equity.”

urban areas<sup>30</sup> with the increase in inequality in health care.

For instance, child mortality is three times higher in rural areas than in urban areas<sup>31</sup>. Infant mortality was 37 per 1,000 live births in rural areas in 1999, while it was 11 per 1,000 live births in urban areas<sup>32</sup>. Under-five mortality rate in Shanghai and Beijing was 8 per 1,000 live births, as compared with 60 per 1,000 live births in Guizhou<sup>33</sup>. Neo-natal mortality in urban areas was 11 percent, while it was 24 percent in rural areas<sup>34</sup>. In fact, it is reported that infant mortality has increased in recent years in some rural areas, contrasting to the situation in urban areas<sup>35</sup>. In addition, China National Maternal and Child Surveillance estimated that maternal mortality rate in rural areas was 0.06 percent in 2004, as compared with 0.02 percent in urban areas. The maternal mortality rate in Shanghai was 9.6, while it was 111 in Guizhou<sup>36</sup>.

Furthermore, in general, life expectancy is lower in rural areas than in urban areas<sup>37</sup>. Based on the 2000 national census, the average life expectancy was 75.2 years in urban areas, as compared with 69.6 years in rural areas<sup>38</sup>.

Also, immunization coverage is unevenly distributed. For example, rates of vaccine-preventable diseases were more than 5 times higher in rural areas than in urban areas<sup>39</sup>. In terms of nutrition, according to the China Human Development Report 2005, “children in rural areas have fared worse than children in urban areas.” In 2000, for instance, the proportion of malnourished children under five years old in urban areas was 3 percent, while it was 14 percent in rural areas<sup>40</sup>. Moreover, as for chronic diseases, they have affected differently between urban and rural areas. In particular, the China Human Development Report 2005 reported, “people

30) The Asian Development Bank (2007), “Key Indicators Report 2007: Inequality in Asia.”

31) UNDP (2005), “Human Development Report 2005: International Cooperation at a Crossroads.”

32) Blumenthal, D. & Hsiao, W.C. (2005), “Privatization and its Discontents—The Evolving Chinese Health Care System,” The New England Journal of Medicine.

33) UNDP (2005), “Human Development Report 2005: International Cooperation at a Crossroads.”

34) UNDP (2005), “China Human Development Report 2005: Development with Equity.”

35) Blumenthal, D. & Hsiao, W.C. (2005), “Privatization and its Discontents—The Evolving Chinese Health Care System,” The New England Journal of Medicine.

36) WHO (2005), “China: Health, Poverty and Economic Development.”

37) Ibid.

38) UNDP (2005), “China Human Development Report 2005: Development with Equity.”

39) WHO (2005), “China: Health, Poverty and Economic Development.”

40) UNDP (2005), “China Human Development Report 2005: Development with Equity.”

in the bottom quartile in rural areas suffered the chronic diseases nearly three times the national average<sup>41)</sup>.

As an article from The New York Times summarized, it seems that China now consists of two separate nations—“one urban and increasingly comfortable, the other rural and increasingly miserable”<sup>42)</sup>.

### In search of the social causes of health inequality in China

Then, what causes these inequalities in health care and health outcomes in China? More precisely, what are the upstream social factors that have determined a cascade of different downstream conditions, such as development paths, incomes and health care, all the way to the disparities in health outcomes between urban and rural areas?<sup>43)</sup> In order to answer these questions, we should

examine the recent history of health care system in China in a broader social context.

### Communes, Cooperative Medical Scheme, and barefoot doctors

Before the market-oriented economic reforms in 1979, rural and urban areas had different health insurance schemes: Cooperative Medical Scheme (CMS) in rural areas, and Government Insurance Scheme (GIS) and Labor Insurance Scheme (LIS) in urban areas. Through these schemes, the vast majority of Chinese people could be insured. The CMS was the core of health care financing for people in rural areas during the Maoist era, and its financing source was the communes, who were the basis of rural life<sup>44)45)46)47)</sup>. By the year 1980, according to the China Human Development Report 2005, the CMS was provided in almost 90 percent of

41) Ibid.

42) French, H.W. (2006), “Wealth Grows, but Health Care Withers in China,” The New York Times.

43) Gehlert, S., Sohmer, D., Sacks, T., Mininger, C., McClintock, M. & Olopade, O. (2008), “Targeting Health Disparities: A Model Linking Upstream Determinants to Downstream Interventions,” Health Affairs.

44) Ma, J., Lu, M. & Quan, H. (2008), “From a National, Centrally Planned Health System to a System Based on the Market: Lessons from China,” Health Affairs.

45) Yip, W. & Hsiao, W.C. (2008), “The Chinese Health System at a Crossroads,” Health Affairs.

46) Blumenthal, D. & Hsiao, W.C. (2005), “Privatization and its Discontents—The Evolving Chinese Health Care System,” The New England Journal of Medicine.

47) Lim, M.K., Yang, H., Zhang, T., Feng, W. & Zhou, Z. (2004), “Public Perceptions of Private Health Care in Socialist China,” Health Affairs.

rural areas, and 85 percent of the rural residents were protected by the scheme<sup>48)</sup>. At the center of the CMS, were “barefoot doctors,” who were usually “middle school graduates trained in first-aid” and responsible for delivering basic health care to the rural population. The services they provide were basically free<sup>49)</sup>.

To be sure, as the article from The New York Times put it, the CMS and urban social safety nets, like GIS and LIS, made a great achievement in improving public health in China<sup>50)</sup>. For example, between 1952 and 1982, infant mortality decreased from 200 to 34 per 1,000 live births, and life expectancy increased by as much as 33 years<sup>51)</sup>.

### Black cat, white cat, all that matters is that it catches mice<sup>52)</sup>

48) UNDP (2005), “China Human Development Report 2005: Development with Equity.”

49) Forney, M. (2003), “China’s Failing Health System,” Time.

50) French, H.W. (2006), “Wealth Grows, but Health Care Withers in China,” The New York Times.

51) Blumenthal, D. & Hsiao, W.C. (2005), “Privatization and its Discontents—The Evolving Chinese Health Care System,” The New England Journal of Medicine.

52) [http://en.wikipedia.org/wiki/Deng\\_Xiaoping](http://en.wikipedia.org/wiki/Deng_Xiaoping) (As Thomas Friedman noted in his book, “The World is Flat,” Deng Xiaoping tossed over the decades of Communist ideology with the famous quotation at the Guangzhou conference in 1961: “I don’t care if it’s a white cat or a black cat, it’s a good cat so long as it catches mice.”) (accessed August 17, 2008).

53) Sen, A. (1999), “Development as Freedom,” Anchor Books.

54) Yip, W. & Hsiao, W.C. (2008), “The Chinese Health System at a Crossroads,” Health Affairs.

55) Blumenthal, D. & Hsiao, W.C. (2005), “Privatization and its Discontents—The Evolving Chinese Health Care System,” The New England Journal of Medicine.

56) UNDP (2005), “Human Development Report 2005: International Cooperation at a Crossroads.”

### and the collapse of socialized medical system in rural areas

However, the 1979 economic reforms and the introduction of the “Household Responsibility System” in Chinese agriculture in the late 1970s dissolved the rural communes and, as a consequence, dismantled the CMS during the 1980s. With the collapse of the CMS, the financing of health care became much more difficult in rural areas. The main reason is that China radically changed its policy on financing health care toward reducing the central government’s role. Between 1978 and 1999, the central government reduced its share of health spending from 32 percent to 15 percent<sup>53)54)55)</sup>.

One critical effect of this change was the shift of the burden of financing health care services to households<sup>56)</sup>. As mentioned

before, China's 2003 National Health Services Survey indicated that only 21.4 percent of rural population had health insurance<sup>57)</sup>. Moreover, high health care expenses have become a major cause of poverty in rural areas: out-of-pocket payment has been estimated to significantly increase "the number of rural households living below the poverty line" by 44 percent<sup>58)</sup>. In two decades, China's universal basic health care was transformed to unaffordable basic health care<sup>60)</sup>.

### Social opportunity and capability improvement

Amartya Sen suggested in his book *Development as Freedom* that "social opportunities—arrangements that society makes for health care and other dimensions—influence individuals' substantive freedom to live better." These arrangements, Sen asserted, are important not only for their private lives, such as leading a healthy life, and avoiding

preventable morbidity and premature mortality, but also for more active participation in economic activities. That is, better basic health care and other social arrangements increase the individuals' capability to earn a decent income and be free of income poverty. In this regard, "the more inclusive the reach of basic health care and other social opportunities, the more likely it is that the potentially poor would have a better chance of overcoming income poverty"<sup>61)</sup>.

It seems Sen's assertions hold true for the case of China and its current status of health inequality. That is, the collapse of the socialized medical system can be an obstacle to economic participation for some rural residents, which, in turn, can be associated with the deepening income poverty of the rural residents. Given that many urban Chinese are now enjoying ever increasing wealth with the rapid economic growth, it is plausible that the failure to provide basic health care in rural areas contributes to the growing income inequality in China.

In this respect, the health inequality between

57) Yip, W. & Mahal, A. (2008), "The Health Care Systems of China and India: Performance and Future Challenges," *Health Affairs*.

58) UNDP (2005), "Human Development Report 2005: International Cooperation at a Crossroads."

59) Liu, Y. (2004), "Development of the Rural Health Insurance System in China," *Health Policy and Planning*.

60) Yip, W. & Hsiao, W.C. (2008), "The Chinese Health System at a Crossroads," *Health Affairs*.

61) Sen, A. (1999), "Development as Freedom," Anchor Books.

urban and rural areas can pose a serious challenge to the sustainable development of China. Therefore, it would be important to approach the health inequality issues in light of enhancing social opportunities, and to this end, I believe, the strong involvement of Chinese government is essential, and certainly government interventions should be directed toward addressing the upstream social determinant—the collapse of socialized medical system—of health inequality.

### Government, universal basic health care, and the New Cooperative Medical Scheme in rural areas

The Chinese government has begun to deal with the health inequality problems<sup>62)</sup>. The government under President Hu Jintao has identified health as a "top social priority" and promised "a bigger government role in public health, with a goal for everyone to enjoy basic health care service to continuously improve

their health and well-being"<sup>63)</sup>. Basic health care service, according to the Chinese Minister of Health Chen Zhu, means "cost-effective health care and medical services that are compatible with the current stage of China's social and economic development and are affordable to the government, society, and individuals." This, Minister Chen added, will require increasing "government investment in and strengthen government regulation and oversight of the health care sector"<sup>64)</sup>.

Along this line, it is expected that the central government increases its funding by 1–1.5 percent of GDP over the course of the next several years, allocated to ensuring universal basic health care<sup>65)</sup>. This, according to the article "The Chinese Health System at a Crossroads," represents three times the current health spending of the government, and, hence, reflects its commitment to strengthening its role in the health care sector<sup>66)</sup>.

China is now on the verge of unveiling a major health care reform, which is to be made

62) Blumenthal, D. & Hsiao, W.C. (2005), "Privatization and its Discontents—The Evolving Chinese Health Care System," *The New England Journal of Medicine*.

63) Yip, W. & Hsiao, W.C. (2008), "The Chinese Health System at a Crossroads," *Health Affairs*.

64) Cheng, T.M. (2008), "China's Latest Health Reforms: A Conversation with Chinese Health Minister Chen Zhu," *Health Affairs*.

65) Yip, W. & Mahal, A. (2008), "The Health Care Systems of China and India: Performance and Future Challenges," *Health Affairs*.

66) Yip, W. & Hsiao, W.C. (2008), "The Chinese Health System at a Crossroads," *Health Affairs*.

public in 2008<sup>67)</sup>. For starters, however, in rural areas the government's commitment to provide basic health care protection came in the form of the New Cooperative Medical Scheme (NCMS). After a pilot project in selected counties in 1994, the NCMS was launched in 2003 as an effort to reestablish the CMS<sup>68)</sup>. Financed and delivered by the government, the NCMS was designed to relieve the financial burden of people in rural areas and to cover in-patient medical services, providing financial protection from catastrophic health expenses<sup>69)70)71)</sup>.

Farmers can participate in the NCMS on a voluntarily basis: in order to enroll in the scheme, each family should pay 10 yuan (US\$1.25) per person annually. There is also a subsidy of 20 yuan per person from the central and local government. When participants in

the NCMS receive services from one of the health care institutions assigned by the region, they are eligible for the reimbursement for part of their expenses<sup>72)</sup>. It is estimated that the reimbursement rate is about 37 percent of total medical expenses<sup>73)</sup>. As of the end of 2007, 86 percent of the rural population were covered by the scheme, accounting for 730 million rural residents. The government aims to cover all of the rural population under the NCMS by the end of 2008<sup>74)75)76)</sup>.

However, there has been resistance by people the scheme was supposed to support—rural farmers<sup>77)</sup>. For instance, many rural farmers have complained that 10 yuan of contribution is still a huge burden, and that, because it does not provide financial protection for routine outpatient medical services, the coverage of the NCMS is not

67) Cheng, T.M. (2008), "China's Latest Health Reforms: A Conversation with Chinese Health Minister Chen Zhu," Health Affairs.

68) Ma, J., Lu, M. & Quan, H. (2008), "From a National, Centrally Planned Health System to a System Based on the Market: Lessons from China," Health Affairs.

69) UNDP (2005), "China Human Development Report 2005: Development with Equity."

70) WHO (2005), "China: Health, Poverty and Economic Development."

71) Yip, W. & Hsiao, W.C. (2008), "The Chinese Health System at a Crossroads," Health Affairs.

72) UNDP (2005), "China Human Development Report 2005: Development with Equity."

73) WHO (2005), "China: Health, Poverty and Economic Development."

74) Yip, W. & Mahal, A. (2008), "The Health Care Systems of China and India: Performance and Future Challenges," Health Affairs.

75) Cheng, T.M. (2008), "China's Latest Health Reforms: A Conversation with Chinese Health Minister Chen Zhu," Health Affairs.

76) Ma, J., Lu, M. & Quan, H. (2008), "From a National, Centrally Planned Health System to a System Based on the Market: Lessons from China," Health Affairs.

77) WHO (2005), "China: Health, Poverty and Economic Development."

adequate<sup>78)79)</sup>. To be sure, it is not surprising that the rural farmers have few incentives for participation in the scheme, considering the relative rareness of both catastrophic illness and in-patient medical services<sup>80)</sup>. Thus, as an article from *The Economist* noted, "the NCMS is only a slight relief, if at all, for the rural population"—at least for now<sup>81)</sup>. Therefore, in order for the Chinese government to tackle the health inequality issues more effectively, there should be the government's extensive efforts, as an important part of the major reform of the health care system, to improve and perfect the NCMS in terms of both financing and delivery.

Although the central government has not yet unveiled a new health care framework, on which the principle of universal basic health care would be put into practice and implemented in a more comprehensive way, simply the fact that the principle has been placed among one of the top national agendas has many meaningful implications, in particular, in that universal basic health care can serve both as a substitute for the upstream

social safety net vanished with the collapse of the socialized medical system in rural areas, and as a critical social arrangement through which people can lead a life with their full potential, as Amartya Sen emphasized<sup>82)</sup>.

### Toward a Xiaokang society: social cohesion and health

China has set the development goal of building a "Xiaokang" society in an all-round way. According to the China Human Development Report 2005, the term Xiaokang, originated from the Book of Songs, refers to "a level of development between satisfying basic needs and achieving genuine prosperity"<sup>83)</sup>. Under the ideals of Xiaokang, the Chinese government is committed to achieving a great leap forward improvement in the lives of the entire Chinese population by the year of 2020<sup>84)</sup>.

Yet, what is the most important aspect of a Xiaokang society is its emphasis on social harmony<sup>85)</sup>. As Émile Durkheim, a French

78) French, H.W. (2006), "Wealth Grows, but Health Care Withers in China," *The New York Times*.

79) [http://www.economist.com/world/asia/displaystory.cfm?story\\_id=10727824](http://www.economist.com/world/asia/displaystory.cfm?story_id=10727824) (accessed August 17, 2008).

80) WHO (2005), "China: Health, Poverty and Economic Development."

81) [http://www.economist.com/world/asia/displaystory.cfm?story\\_id=10727824](http://www.economist.com/world/asia/displaystory.cfm?story_id=10727824) (accessed August 17, 2008).

82) Sen, A. (1999), "Development as Freedom," Anchor Books.

83) UNDP (2005), "China Human Development Report 2005: Development with Equity."

84) WHO (2005), "China: Health, Poverty and Economic Development."

sociologist in the 19<sup>th</sup> century, put it, “a cohesive society is one that is characterized by the abundance of mutual moral support which leads one to share in the collective energy and supports one’s own when exhausted.” Also, Durkheim argued, “individuals are bonded to society by two forms of integration: attachment, the extent to which one maintains ties with members of society, and regulation, the extent to which one is held in the fabric of society by its values, beliefs, and norms”<sup>86</sup>.

I believe that in order to build a Xiaokang society in an all-round way in China, social cohesion with mutual moral support needs to be ensured in the first place, and, in this regard, we should take Durkheim’s view on social cohesion into serious consideration. Moreover, this process of achieving social cohesion would be successful only when there

are government’s effective interventions and elaborate supports with a strong commitment to providing the platform of strong social bonds and social fabrics.

Furthermore, I think the platform for achieving social cohesion is where all the government’s efforts, ranging from implementing universal basic health care and revamping the New Cooperative Medical Scheme to reducing health inequality between rural and urban areas, will run in parallel with the goal of improved social opportunities, and where, given that the right to health is a critical indicator of social harmony<sup>87</sup>, the government’s initiatives to ensuring “basic health care protection for all” will be placed at a well-deserved place under the China’s overarching goal of building a Xiaokang society. [CSST](#)

85) UNDP (2005), “China Human Development Report 2005: Development with Equity.”

86) Berkman, L.F. (editor) & Kawachi, I. (editor) (2000), “Social Epidemiology,” Oxford University Press.

87) Cheng, T.M. (2008), “China’s Latest Health Reforms: A Conversation with Chinese Health Minister Chen Zhu,” Health Affairs.