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Expansion of Chinese Social Health Insurance: who gets what, when and how?

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This article asks 'who gets what, when and how' from China's recent social welfare expansion. Little research to date examines the overall landscape of China's social health insurance, which has changed dramatically since 2003, and the distributive consequences and implications thereof. Drawing on public survey data and fieldwork for empirical support, this article finds that China's recent social health insurance expansion does significantly expand people's access to social health insurance. However, the expansion, which entails health insurance fragmentation and increasing benefit disparities, not only reinforces existing social cleavages such as the rural–urban divide, but it also generates new divisions within urbanites and workforce. Moreover, multiple social cleavages that cross-cut class differences have been institutionalized into China's social health insurance system. This reflects authoritarian regimes' 'divide and rule' tactic in social welfare provision.

I. Introduction

In the conventional welfare state literature, a counterintuitive finding persists, namely that 'social welfare is not just a mechanism that intervenes in, and possibly corrects, the structure of inequality; it is, in its own right, a system of stratification. It is an active force in the ordering of social relations'.[1] Among the 'three worlds of welfare capitalism', conservative welfare states such as Germany, Austria, Italy and France

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1. Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Cambridge: Polity Press, 1990), p. 23.

consolidate divisions among wage-earners by legislating distinct programs for different occupations and status groups, while liberal welfare states such as Great Britain and most of the Anglo-Saxon world allow for a dualism between the state and the market, in the form of state-provided means-tested assistance and market-based private welfare plans. Most existing studies of social welfare, however, are geographically confined to these categories of advanced industrial democracies, particularly in the European setting. The question of social welfare distribution in an authoritarian regime with a transitional economy, like China, remains an understudied yet intriguing one. What does social welfare distribution look like in China? Does it differ from the stratification attributes found in OECD countries, and if so, by what political logic? This article addresses those questions by drawing upon empirical evidence from China's social health insurance programs.

The investigation starts with a puzzling observation about Chinese social health insurance over the past decade. On the one hand, coverage of social health insurance dramatically expanded during that time period. In 1998, the State Council established a social health insurance program for urban employees, the so-called Urban Employee Basic Medical Insurance (UEBMI). Starting in 2003, a New Rural Cooperative Medical Insurance (NRCMI) program was initiated, which rapidly expanded services into rural China. In 2007, another health insurance program, Urban Resident Basic Medical Insurance (URBMI), was introduced into urban areas to incorporate the urban non-working population into the social insurance system. By 2010, 237.35 million employees (including retirees) were enrolled in UEBMI and 195.28 million urban residents (including college students, teenagers and the elderly without pensions) were beneficiaries of URBMI. Meanwhile, 832 million rural people were covered under the NRCMI. In 2004, when social health insurance expansion began, only 34.4% of the Chinese population was covered by social health insurance. In 2010, after the social health insurance expansion was fully implemented, coverage reached 90.62%. The present expenditure for urban social health insurance, furthermore, is 353.81 billion RMB, more than four times the 2004 level of spending.

On the other hand, the distribution of expanded social health insurance benefits has been highly fragmented and uneven, reflecting and reinforcing existing inequalities or cleavages in society. First, like other large-population states with diverse regional economies, China's healthcare system faces built-in regional disparities by virtue of the country's geographical expanse and uneven development across regions. The regional disparities in healthcare have persisted and even worsened through the recent expansion. Second, since the Maoist era, rural and urban China have operated under quite distinct systems, with urbanites consistently privileged over their rural counterparts in terms of social provision. Third, even within urban China, the employed, working class enjoys various types of healthcare benefits not available to those outside of the labor market due to skill shortcomings, disease, disability or age. Fourth, the Chinese social health insurance system is so fragmented that those in government employment or working in state sectors enjoy much higher and better benefits than those working in other sectors of the economy, especially in the informal sector that is home to increasing numbers of migrant workers.

Based on 11 months of fieldwork and in-depth data analysis, this article finds that China's social health insurance expansion does extend access to basic social health insurance to most people. Yet, the expansion not only fails to correct inequalities resulting from the burgeoning market economy, but also reinforces existing social cleavages inherited from the socialist past, such as the rural–urban divide. Moreover, the fragmented programs and increasing benefit disparities at the heart of the expansion have created new divides within certain social groups, such as urbanites and the workforce. In elucidating the multiple social cleavages embedded in China's social health insurance system, this article sheds light on the politics of authoritarian social welfare more generally, that is, how political leaders in an authoritarian regime distribute resources to maintain regime stability. Of special importance to the survival of the Chinese authoritarian regime is the maintenance of particularly privileged welfare provisions for urban and state-sector employees while preserving an essentially modest social provision for other societal groups. China's fragmented social welfare provision intertwines multiple social inequalities that do not follow a single deep class cleavage and thus consolidates divisions among social groups to prevent alliances that could challenge the regime. Its underlying political rationale echoes authoritarian regimes' conventional tactic: 'divide and rule'.

The rest of the article unfolds as follows. Section II reviews relevant social welfare studies to define this study's contribution to the literature. Section III overviews the development of China's healthcare system in the past decades and introduces the historical background of the recent social health insurance expansion. Section IV analyzes the distribution of the expanded social health insurance benefits with a focus on its stratification consequences and distributive implications. Section V elucidates the political rationale of the stratified and inequitable social welfare system in China. Section VI concludes with a discussion of the implications of China's social health insurance expansion on social mobilization and social welfare development.

II. Received wisdoms: political economy of social welfare expansion

Much scholarship in recent decades has been devoted to studying the expanding coverage of health insurance in various countries, thereby identifying a number of key factors for successful expansion of social health insurance coverage.[2] First, there is the general level of income and the rate of economic growth: more income means, *ceteris paribus*, greater capacity to pay health insurance contributions. Second, the structure of the economy also matters. Most relevant are the relative sizes of the formal and informal sectors, as this ratio affects the administrative costs of social health insurance. Third, administrative costs may be further influenced by the distribution of the population, both demographically and geographically. A fourth factor is the country's ability to administer health insurance, as government stewardship is required to launch and guide a process that leads to compulsory health insurance for all. Finally, the level of solidarity in a society affects the expansion of

2. Guy Carrin and Chris James, 'Social health insurance: key factors affecting the transition towards universal coverage', *International Social Security Review* 58(1), (2005), pp. 45–64.

health insurance coverage, insofar as it becomes very difficult to pool resources when a society is already quite unequal from the start.

Concurring with these findings, studies of social health insurance coverage in China generally show that: (1) economic development plays a valuable role in the development of social health insurance for urban employees; (2) a strong financial and administrative capacity of the government contributes to the progress of social health insurance for urban employees; and (3) higher trade union density is closely related to more rapid expansion of social health insurance for urban employees.[3] However, many questions are unanswered by this line of literature. Do different social groups obtain identical benefits from expanding health insurance coverage? Who pays and who gains from the expansion? The absence of micro-level accounts is one weakness of this literature. Moreover, as this literature sees health insurance expansion primarily as a functional process, it pays insufficient attention to the question of how political power shapes the expansion of social health insurance coverage, particularly the distribution of the expanded benefits. That question of resource distribution—who gets what, when and how—is a central theme of political studies of social welfare.

Unlike the functional account of social health insurance expansion, a new line of literature in comparative political economy attempts to account for the cross-national variation of social welfare from political leaders' strategies for political survival.[4] Studies note that outside a handful of European and North American countries, social insurance programs have largely been adopted by non-democratic regimes. Studies of authoritarian regimes demonstrate that political leaders adopt strategies using both 'sticks' (e.g. repression, terror, etc.) and 'carrots' (e.g. rents, patronage, etc.) to minimize potential threats to regime stability and to mobilize mass support.[5] The distributive outcomes of social welfare, one of the instruments for autocratic regimes to maintain regime stability, depend on specific policy design. This, then, raises interesting questions of political choices: to whom the authoritarian leaders would distribute benefits and what determines the distribution thereof. Mares and Carnes contend that the social policy profile autocracies pursue is premised on their political strategy for survival.[6] If the authoritarian government relies on organizational co-optation of a small group of critical supporters, they will enact 'restrictive' social policies characterized by narrow coverage and generous benefits. Conversely, if the autocrat is brought to power by a broad coalition of interests and chooses a strategy

3. Liu Jun-Qiang, 'Dynamics of social health insurance development: examining the determinants of Chinese basic health insurance coverage with panel data', *Social Science & Medicine* 73, (2011), pp. 550–558. Jay Pan and Gordon G. Liu, 'The determinants of Chinese provincial government health expenditures: evidence from 2002–2006 data', *Health Economics* 21, (2012), pp. 757–777.

4. Isabela Mares and Matthew E. Carnes, 'Social policy in developing countries', *The Annual Review of Political Science* 12, (2009), pp. 93–113.

5. Examples can be found in Scott Gehlbach and Philip Keefer, 'Investment without democracy: ruling-party institutionalization and credible commitment in autocracies', *Social Science Research Network*, Working Paper (2008). See also Beatriz Magaloni, *Voting for Autocracy: Hegemonic Party Survival and Its Demise in Mexico* (Cambridge: Cambridge University Press, 2006); B. Magaloni, A. Diaz-Cayaros and F. Esteves, 'Clientelism and portfolio diversification: a model of electoral investment with applications to Mexico', in S. Wilkinson and H. Kitschelt, eds, *Patrons, Clients and Policies: Patterns of Democratic Accountability and Political Competition* (Cambridge: Cambridge University Press, 2007), pp. 182–205.

6. Mares and Carnes, 'Social policy in developing countries'.

based on organizational proliferation, the social policy will be characterized by high levels of institutional fragmentation on the one hand, and broader coverage on the other hand. Although this literature aims to explain cross-national differences in social welfare provision, it provides useful insight for understanding China's social welfare changes across time as well. This article builds on this literature and demonstrates that Chinese authoritarian leaders not only strategically change the scope of distribution of social welfare benefits but also manipulate the benefits for different social groups to achieve political goals. Moreover, this article specifies the relative gains and losses of different social groups from the social health insurance expansion and explores the political motive underlying the fragmentation and hierarchy of Chinese social welfare.

Despite rich studies of Chinese social health insurance policies,[7] some gaps in the extant literature remain to be filled. First of all, scholarship in the field is in need of updating, as existing publications on Chinese social health insurance do not sufficiently reflect recent dramatic changes in the system, especially those occurring since expansion started in 2003. Secondly, expansion of Chinese social health insurance in general has received less scholarly attention than individual social health insurance programs, such as the NRCMI or UEBMI. While there have been specific or systematic studies of those individual social health insurance programs,[8] none has focused on the overall landscape comprised by such programs. Thirdly, the stratification consequences of social health insurance expansion have been largely neglected in existing literature. Thus, many interesting questions are left unanswered in the literature, regarding, for example, who benefits from the expansion, how much health insurance benefit different groups obtain from the expansion, and what determines the distribution patterns of the expanded social health insurance benefits. To address these gaps in the literature, this article presents a detailed analysis of 'who gets what, when and how' from the expansion of Chinese social health insurance.

III. Pathway to 'universal' social health insurance in China

China's social welfare reform began in the mid-1980s, accompanying its economic transition and openness. The reform is a trial-and-error process characterized by gradualist and incremental changes over the past decades. The pathway to universal

7. See, among others, Juan Du, 'Economic reform and health insurance in China', *Social Science & Medicine* 69, (2009), pp. 387–395; Edward X. Gu, 'Market transition and the transformation of the health care system in urban China', *Policy Studies* 22(3–4), (2001), pp. 197–215; Edward Gu and Tianjin Zhang, 'Health care regime change in urban China: unmanaged marketization and reluctant privatization', *Pacific Affairs* 79(1), (2006), pp. 49–71; Jen-Der Lue, 'The great economic transformation: social dilemmas of Chinese capitalism', *Comparative Sociology* 11, (2012), pp. 274–289; Jay Pan and Gordon G. Liu, 'The determinants of Chinese provincial government health expenditures'; Adam Wagstaff, Winnie Yip, Magus Lindelow and William C. Hsiao, 'China's health system and its reform: a review of recent studies', *Health Economics* 18, (2009), pp. 7–23.

8. Lei Xiaoyan and Lin Wanchuan, 'The new cooperative medical scheme in rural China: does more coverage mean more service and better health?', *Health Economics* 18, (2009), pp. 25–46; Lin Wanchuan, Gordon G. Liu and Chen Gang, 'The urban resident basic medical insurance: a landmark reform towards universal coverage in China', *Health Economics* 18, (2009), pp. 83–96; Gordon Liu *et al.*, 'Equity in health care access: assessing the urban health insurance reform in China', *Social Science & Medicine* 55, (2002), pp. 1779–1794; Liu, 'Dynamics of social health insurance development'.

(*quanmin*) social health insurance[9] in contemporary China can be summarized as consisting of the following steps.

III.1. Pre-reform phase (1949–1988): free healthcare under the 'iron rice bowl' system

During Mao's era (1949–1976), Chinese health insurance and to some extent healthcare delivery were organized around work units (*danwei*). The system was thus called a '*danwei*-based welfare system'. It consisted of three components. The Cooperative Medical Scheme (CMS, *nongcun hezuo yiliao*) financed healthcare for members of the agricultural communes, whereas the Labor Insurance Scheme (LIS, *laobao*) and Government Insurance Scheme (GIS, *gongfei yiliao*) financed healthcare for state-owned enterprise (SOEs) workers and government officials, respectively. As the market transition was initiated in 1979 and then gathered speed, the *danwei*-based welfare system began to malfunction.[10] First, when China reformed its rural economy in 1979 and introduced the household responsibility system, the communes disappeared in rural areas; without that base for funding and organization, the CMS collapsed, leaving around 90% of all peasants uninsured. Second, reform of the SOEs caused many enterprises to fall into financial difficulty, and a large number of SOEs were closed. Consequently, employment levels in SOEs fell sharply, and the workers who did keep their jobs often found their employers unable to honor their commitments to the LIS scheme. Third, the *danwei*-based welfare system placed a heavy financial burden upon work units as well as upon the state. The non-contributory nature of the system resulted not only in the extremely inefficient operation of welfare provision, but also in an unlimited growth of welfare demands. The older an enterprise was, and the more retired workers it had, the heavier the welfare burden it had to bear. This resulted in the absence of a level playing field for different enterprises, even for those in the same industrial sector and same location.[11] The problem was exacerbated by increasing competition between the state and private sector enterprises. The poor financial situation of SOEs throughout the 1990s in turn led to crises in the *danwei*-based welfare system.[12]

III.2. Reform phase I (1988–2003): initiation of social health insurance

The Chinese government faced tremendous pressure for reform, especially because the total expenses of *danwei*-based welfare soared from the mid-1980s onwards. Reform of the *danwei*-based welfare system formally began in 1988. During the early stage of the reform from 1988 to 1994, healthcare reform concentrated on reducing

9. It is debatable whether China's social health insurance coverage, after expansion in 2003, is universal. On paper, every Chinese citizen is entitled to social health insurance of a certain kind, and the enrollment rate for China's social health insurance is over 80%. However, the distribution of health insurance benefits, as this article shows, is not universalistic. This article uses the term 'universal' to describe China's social health insurance after expansion based on its *de jure* universal coverage; it corresponds to the term *quanmin* 全民 used in the Chinese government's documents.

10. Gu, 'Market transition and the transformation of the health care system in urban China'.

11. The World Bank, *Old Age Security: Pension Reform in China* (Washington, DC: The World Bank, 1997).

12. Edward X. Gu, 'Dismantling the Chinese mini-welfare state? Marketization and the politics of institutional transformation, 1979–1999', *Communist and Post-Communist Studies* 34, (2001), pp. 91–111.

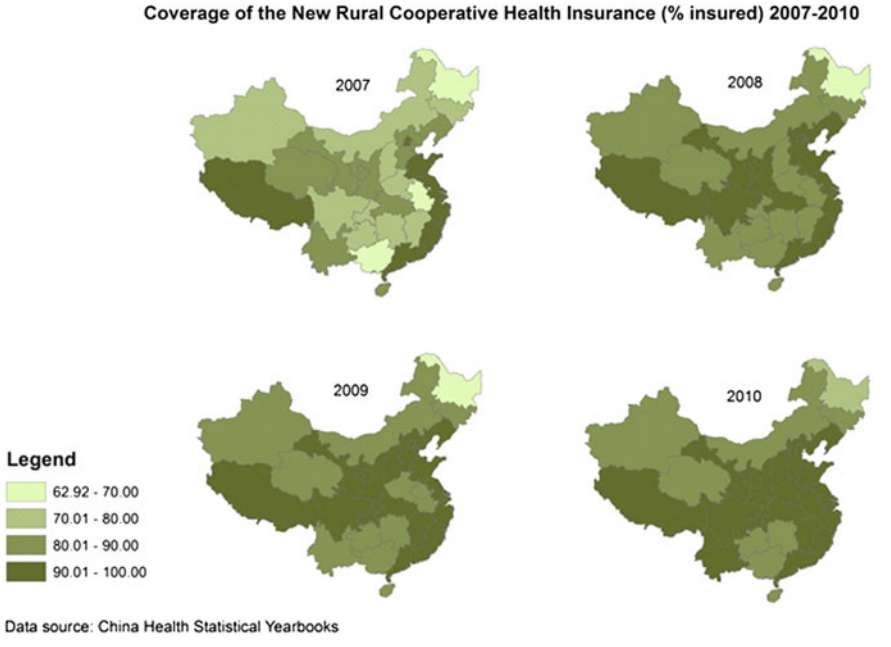
medical care expenses rather than on building a new insurance system.[13] One of the commonly imposed reform measures was that individual patients had to share 10–20% of outpatient fees and 5–10% of hospitalization fees, and expenditure for individual workers was capped at 5% of their annual wage or the level of their monthly wage.[14] These measures were followed by 'risk-pooling' experiments, in which groups of enterprises pooled funds to pay for the treatment of their current employees' serious illnesses or the medical treatment of their retired employees.[15] After the experiments with 'co-payment' and 'risk pooling' of health insurance in some cities from 1988 to 1994, compulsory social health insurance combined with individual premium contributions began to operate in about 60 Chinese cities in 1994. Finally, the Urban Employees Basic Medical Insurance (UEBMI) was established by the central government in late 1998. According to that 1998 policy decision, all cities had to set up contribution-based basic health insurance schemes by the end of 1999. In this health insurance scheme, employers were required to pay 6–8% of their total payroll into a local health insurance fund (HIF) and dedicated health insurance accounts (HIAs) held in the name of each employee. Employees had to pay 2% of their wages into their HIAs. In principal, HIAs could pay for an employee's treatment costing up to 10% of the local average annual wage, after which the HIF was to pay. There was a limit on how much the HIF would pay for any single individual, set at between four and six times the average annual wage.[16]

Compared to the former GIS and LIS, the UEBMI established in 1998 expanded coverage to non-state sectors and enterprises, but its coverage was still limited for many reasons. First, enterprises in poor financial health were not able to pay the employer's portion of health insurance contributions. In particular, private firms and small businesses, whose employees are mostly young migrants, found it too costly to enroll them in the urban employee health insurance. Second, members of certain social groups, especially people without stable and secure employment, the elderly, the disabled and peasants, enjoyed no health security at all due to an institutional design that mainly targeted formal employees (but not their dependents). By 2003, the coverage rate of UEBMI was only 36%, and self-paying patients made up a large share of the healthcare market.[17] Consequently, the 2003 SARS outbreak shocked the Chinese leaders, exposed the inadequacies of the public health protection system, and showed how government's neglect had left the healthcare system unprepared to deal with its core responsibilities.

III.3. Reform phase II (2003–2009): expansion of social health insurance coverage

A series of measures were introduced from 2003 onwards. The first was the New Rural Cooperative Medical Insurance (NRCMI), introduced in 2003 to replace the former CMS and aimed at providing insurance to the rural population. By the end of 2010, in

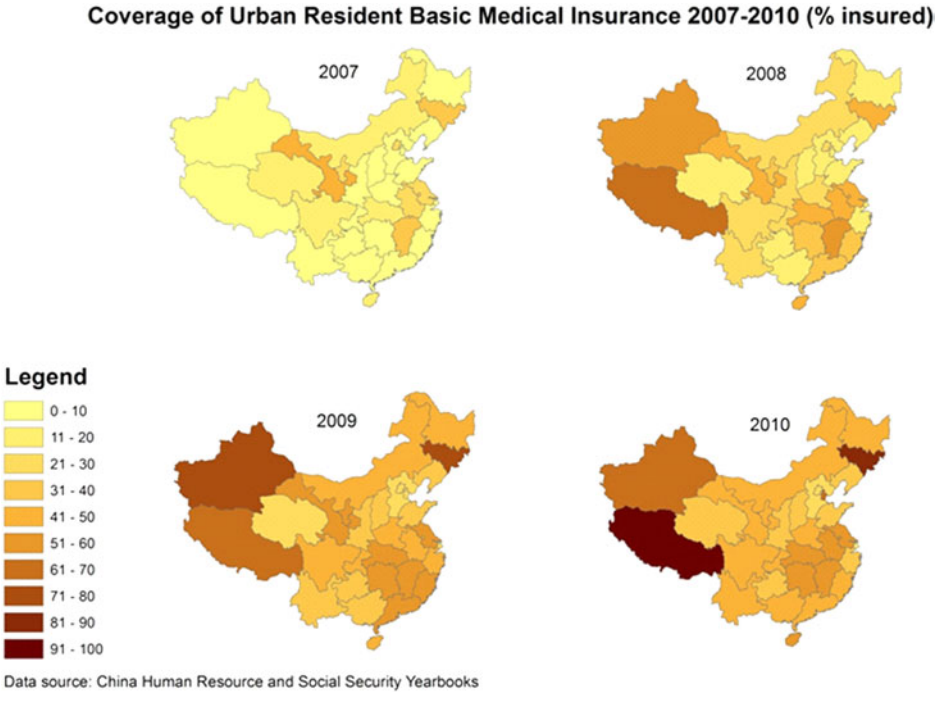
13. *Ibid*.
14. Ma Hong, *Handbook of Reforms in China, 1978–1991* [*Zhongguo Gaige Quanshu, 1978–1991*] (Dalian: Dalian chubanshe, 1992).
15. Jane Duckett, 'State, collectivism and worker privilege: a study of urban health insurance reform', *The China Quarterly* 177, (March 2004), pp. 155–173.
16. *Ibid*.
17. Gu and Zhang, 'Health care regime change in urban China'.



Graph 1. Coverage of the New Rural Cooperative Health Insurance (% insured), 2007–2010.

22 out of 31 provinces, more than 90% of the rural population was covered by the NRCMI program thanks to huge public subsidies (see Graph 1). Secondly, a health insurance program known as Urban Resident Basic Medical Insurance, or URBMI, was introduced in 2007 for the 420 million urban residents not covered by the UEBMI. In 2008, the government announced its intention to roll the URBMI program out in half of China's cities by the end of 2008, and to ultimately extend coverage to 100% of cities by 2010. By the end of 2010, more than half of urban residents in 12 provinces were covered by the URBMI program, with considerable government subsidies (see Graph 2). Target groups for the URBMI are children, the elderly, the disabled and other non-working urban residents.[18] Furthermore, in 2009, the Chinese government unveiled its most ambitious health reform plan to date and committed to spending an additional US $125 billion in the following three years, providing affordable and equitable basic healthcare for all. About 50% of the government's 2009 health reform funding is targeted for subsidization of enrollment in social health insurance.[19] Stimulated by the new influx of funding, the provincial average of UEBMI coverage increased from 68.02% to 95.88% in 2009, despite the presence of discernible regional variation (see Graph 3). At the end of 2010, social health insurance coverage in 26 out of 31 Chinese provinces exceeded 80% (see Graph 4). Since then, a social health insurance system with 'universal' (*quanmin*) coverage has been established in China.

18. Wagstaff *et al.*, 'China's health system and its reform'.
19. Ministry of Finance of the People's Republic of China, *Report on the Implementation of National Essential Medicines Policies* (Beijing: Ministry of Health, 2011).

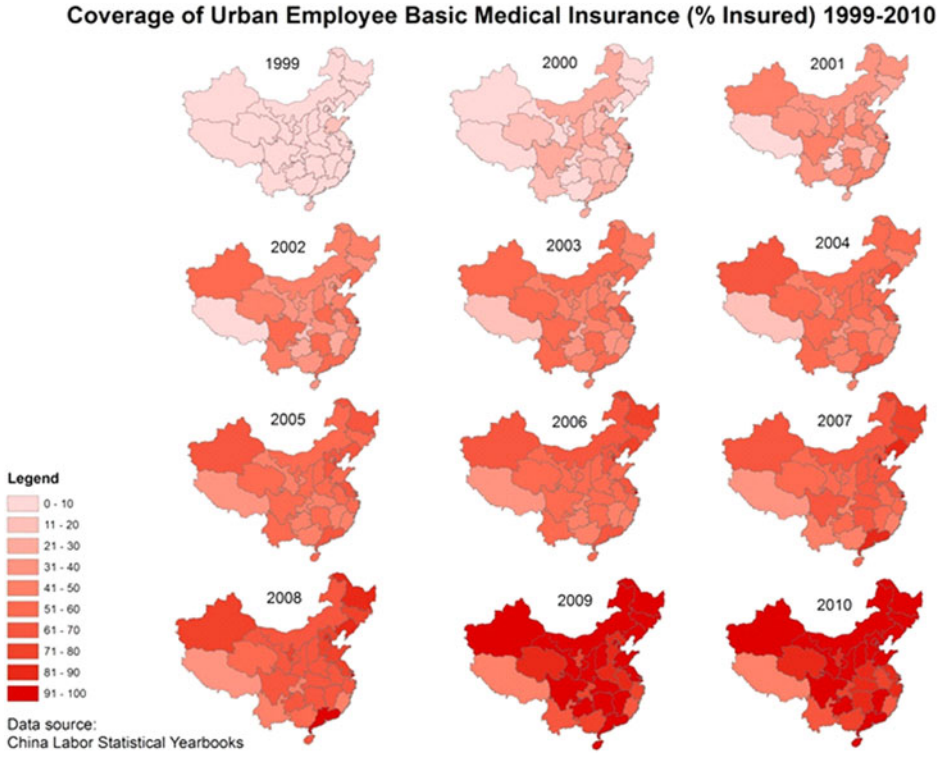


Graph 2. Coverage of Urban Resident Basic Medical Insurance (% insured), 2007–2010.

In summary, the evolution of China's healthcare entitlements during the past decades follows an 'expansion–shrink–expansion' cycle, suggesting that Chinese leaders have not viewed healthcare as a basic social right.[20] Instead, the changing scope and generosity of healthcare benefits have reflected the strategies adopted by the Chinese central leadership of different generations, with distinct political and economic priorities in minds. During the economic transition from command economy to market economy from 1978 to 1998, political leaders' priority over increasing economic efficiency induced the abolishment of free healthcare and induced state retreat from social welfare. During the subsequent state-sector restructuring and reforms from the late 1990s into the early 2000s, increasing concern over social instability led to the socialization of risk pools and social protection through a rapid build-up of the social health insurance system for urban employees. In 2003, accompanying the rise of the new Hu–Wen leadership and their visions of sustainable development with a 'harmonious society' and economic openness, social health insurance coverage began expanding and became inclusive.[21] However, social welfare expansion without significant political reforms in China has stimulated much

20. For the issue of lack of social rights and its impact in China, see Zhaohui Hong, 'The poverty of social rights and dilemmas of urban poverty in China', *Journal of Contemporary China* 14(45), (2005), pp. 721–739.

21. Some scholars argue that economic openness, especially after 2001, when China was accepted into the WTO, is a powerful driving force behind China's social welfare expansion. See Yongnian Zheng, 'Society must be defended: reform, openness, and social policy in China', *Journal of Contemporary China* 19(67), (2010), pp. 799–818.

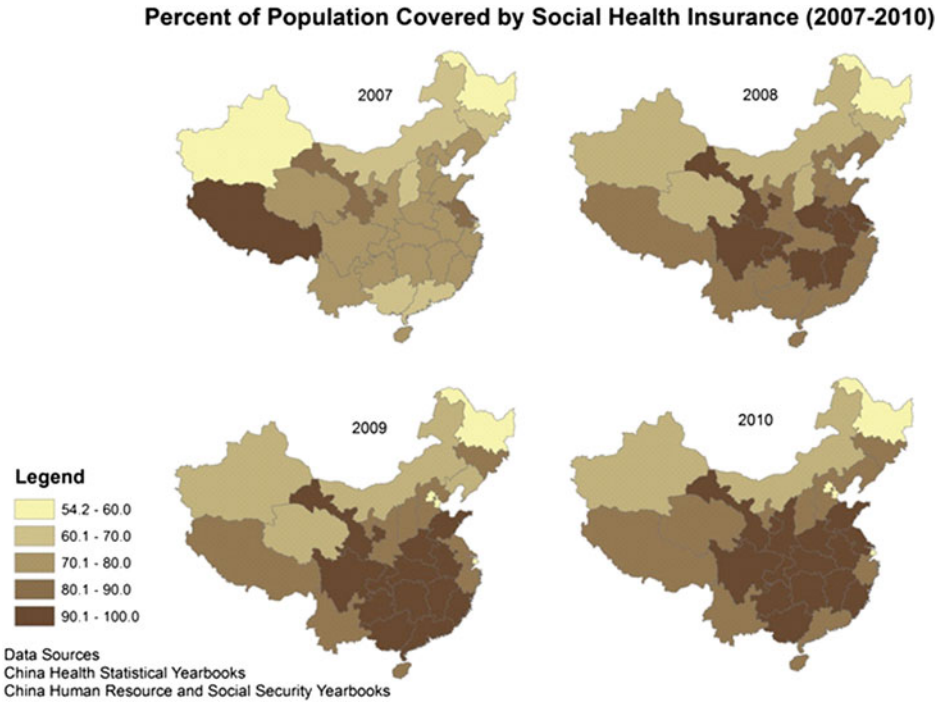


Graph 3. Coverage of Urban Employee Basic Medical Insurance (% insured), 1999–2010.

curiosity among scholars regarding its distributive consequences and implications. Given the absence of enfranchisement in China, can everyone benefit the same from the expansion of social welfare? Who will benefit more from the expansion of social welfare and who will lose or pay the cost? The next section will examine the distribution of the expanded social health insurance benefits in Chinese society.

IV. Distribution of the expanded social health insurance benefits in China

The impact of social welfare reform has been no less dramatic than that of economic reform in China. Social welfare reform has produced new inequalities, regional disparities and an abandonment of the 'iron rice bowl' for the urban industrial working class. This section will first illustrate with descriptive data who are the beneficiaries of the social health insurance expansion and how much health insurance benefit they obtain from the expansion. Special attention will be given to the distributive implications of the expansion, which will highlight the highly stratifying nature of the social health insurance expansion. The section then relies on two individual-level survey datasets to test the stratification hypothesis in two ways: (1) on coverage of the generous employment-based social health insurance; and (2) on the distribution of various health insurance programs among social groups.



Graph 4. Percent of population covered by social health insurance (2007–2010).

It contends that the social health insurance expansion not only strengthens and deepens existing social cleavages, but also creates new divides in Chinese society.

IV.1. Inequality of social health insurance benefit

Both individual-level survey data and provincial-level statistics demonstrate that China's social health insurance coverage has dramatically expanded in the past decade. According to the China Health & Nutrition Panel Survey (CHNS) data,[22] the coverage of social health insurance (including UEBMI, URBMI and NRCMI programs) in nine Chinese provinces increased from 37.39% in 2000 to 89.5% in 2009 on average (see Figure 1). In terms of the number of beneficiaries, provincial-level statistics show that peasants and their dependents were the largest beneficiary group of Chinese social health insurance throughout 2007–2010 (Graph 5). From 2007 onwards, urban residents (the urban unemployed, self-employed, elderly and students) increasingly get insured by the newly established URBMI program, becoming the second largest group of beneficiaries of social health insurance in

22. China Health & Nutrition Panel Survey (CHNS) is an international collaborative, multi-waved panel survey project. It covers nine Chinese provinces that vary substantially in geography, economic development, public resources and health indicators. The first wave of the CHNS data was collected in 1989 and more data were collected (almost every three years) in the following decades. For more information about CHNS, see http://www.cpc.unc.edu/projects/china.

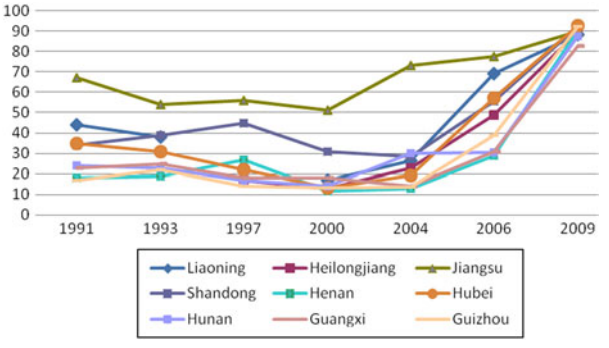
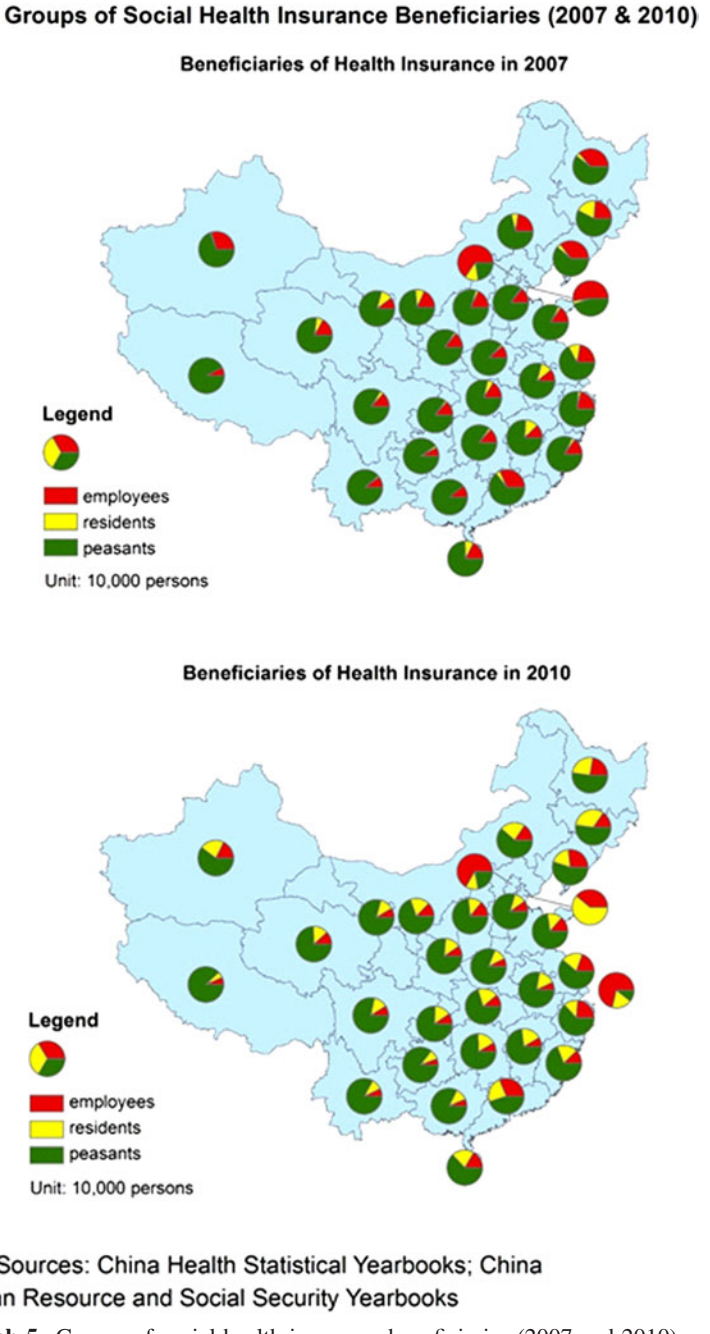


Figure 1. Health insurance coverage in nine provinces (1991–2009) (unit: % insured). *Source*: China Health and Nutrition Survey.

most provinces by 2010 (also seen in Graph 5). By contrast, the percentage of employees among total beneficiaries of social health insurance declined from 2007 to 2010 by 4%. Only in the coastal metropolises (Beijing, Shanghai and Tianjin) are more than half of social health insurance beneficiaries employees. However, it would be wrong to conclude that urban employees, who are the primary beneficiaries of the UEBMI program, have lost out in the social health insurance expansion. On the contrary, a comparison of the *per capita* expenditures of UEBMI, URBMI and NRCMI programs in 2007 and 2010, respectively, indicates that the generosity to urban employees was remarkably higher than the generosity to urban non-employees and rural populations in both years (Graph 6). In 2010, the expenditure of the UEBMI program was 13 times the summed expenditures of the URBMI and NRCMI programs. This implies that the smallest group of social health insurance beneficiaries—urban employees—enjoys the vast majority of social health insurance benefits. Therefore, Chinese social health insurance after expansion can be considered not only fragmented, but also highly stratifying in terms of generosity.

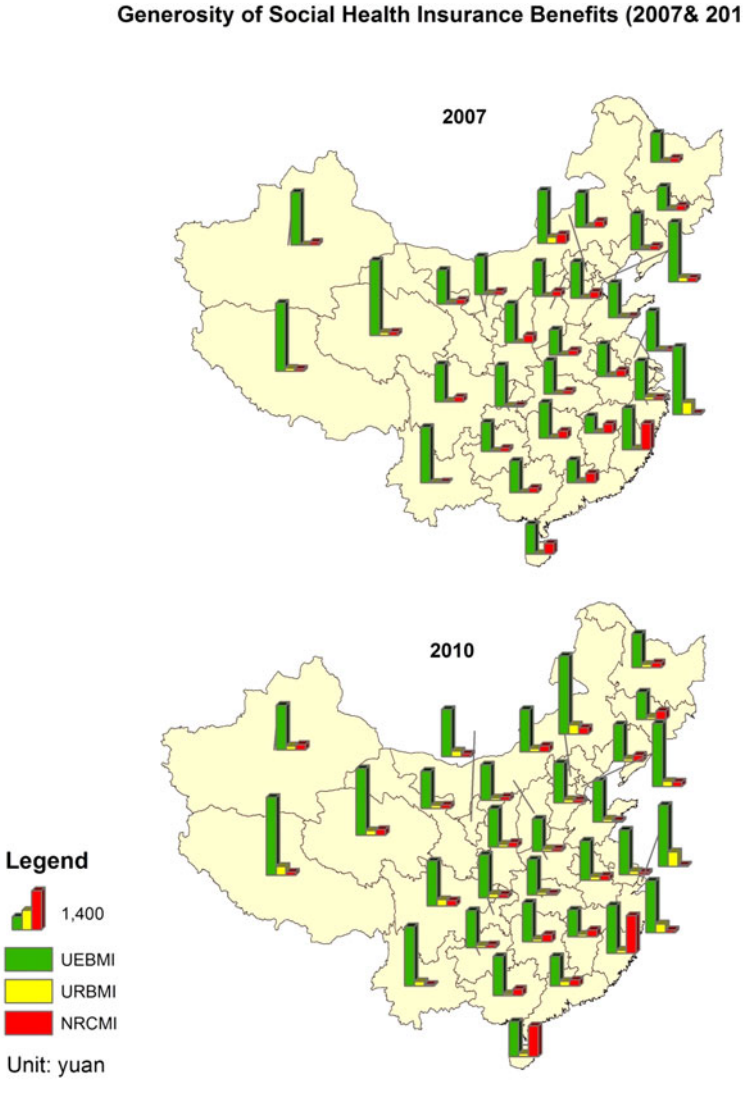
The tremendous disparity between the size of beneficiary groups and the size of their respective benefits urges us to look carefully into the types and levels of benefits offered by different social health insurance programs. Based on eligibilities, Chinese social health insurance programs[23] can be categorized into two types: employment-based programs (e.g. GIS, UEBMI) and residency-based programs (e.g. URBMI, NRCMI). Employment-based social health insurance is financed by defined contributions from employers and employees, while residency-based social health insurance programs are financed mostly by general taxes in addition to individuals' premium payments. Government subsidization accounts for up to 70% of financing responsibilities for residency-based social health insurance in some provinces. In this

23. Social health insurance is the dominant type of health insurance in China. Chinese social health insurance is organized and managed by the government; it is also enforced by the government through economic, administrative and legal means. Other types of health insurance in China include commercial health insurance for individuals and company supplementary health insurance.



Graph 5. Groups of social health insurance beneficiaries (2007 and 2010).

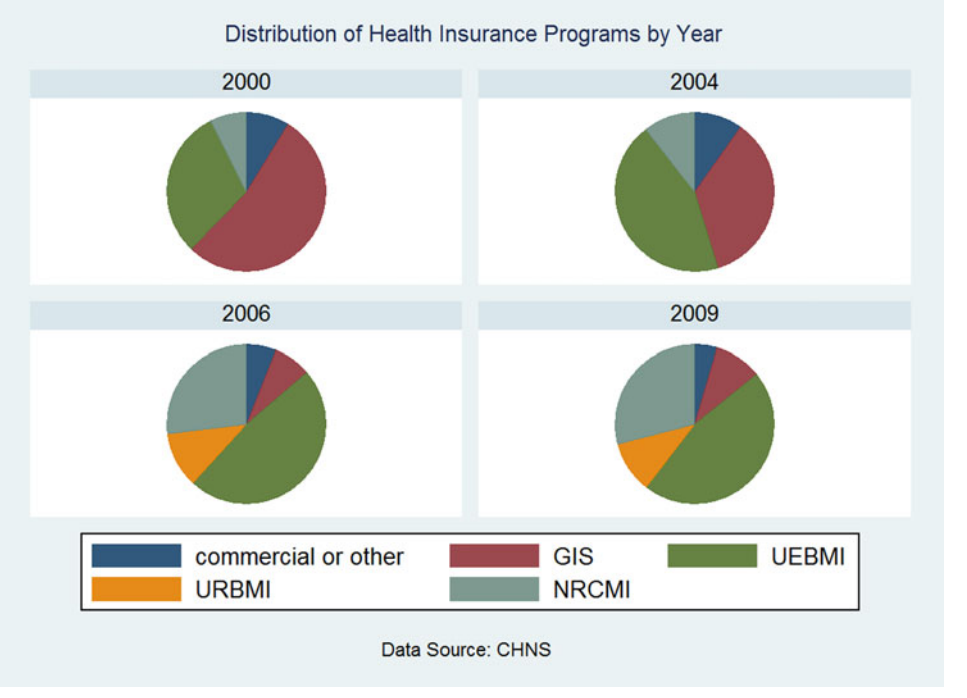
sense, the residency-based social health insurance in China is conceptually closer to the social transfers financed from general taxes that are commonly seen in



Graph 6. Generosity of social health insurance benefits (2007 and 2010).

Scandinavian welfare states, rather than the conventional social insurance models employed in European continental welfare states.

According to the CHNS data, the landscape of Chinese social health insurance has dramatically changed from 2000 to 2009 (Graph 7). In 2000, before social health insurance expansion, employment-based health insurance programs such as GIS and UEBMI were the dominant social health insurance programs in China, enrolling and supporting approximately 80% of overall social health insurance



Graph 7. Distribution of health insurance programs by year.

beneficiaries. By contrast, in 2009, after social health insurance expansion, as much as 40% of social health insurance beneficiaries were covered by residency-based health insurance programs such as URBMI and NRCMI. It is noteworthy, furthermore, that the government's free medical care (GIS), which had previously covered government officials and civil servants, shrank to one of the smallest health insurance programs in 2009, as it became a supplementary scheme under UEBMI in many provinces. Shares of commercial and other health insurance programs remained residual and decreasing in China from 2000 to 2009, especially after the social health insurance expansion that has significantly squeezed the space for private insurance.

In terms of the generosity of health insurance, a report by the Ministry of Human Resources and Social Insurance in 2010 demonstrates that the UEBMI's in-patient reimbursement rate is notably higher than the URBMI's, except in three metropolises (Beijing, Shanghai and Tianjin) (see Figure 2). The provincial average of in-patient reimbursement rates is 67.68% for UEBMI beneficiaries (mainly urban state-sector employees), down to 55.32% for URBMI beneficiaries (mainly urban non-working people including the elderly, children and students). A similar pattern can be found for out-patient reimbursement, with a few exceptions (see Figure 3). The provincial average of out-patient reimbursement for UEBMI beneficiaries is 98.23 Yuan per patient, 1/3 higher than for URBMI beneficiaries. Despite the lack of comparable data for the NRCMI program, both my research and secondary literature indicate that the

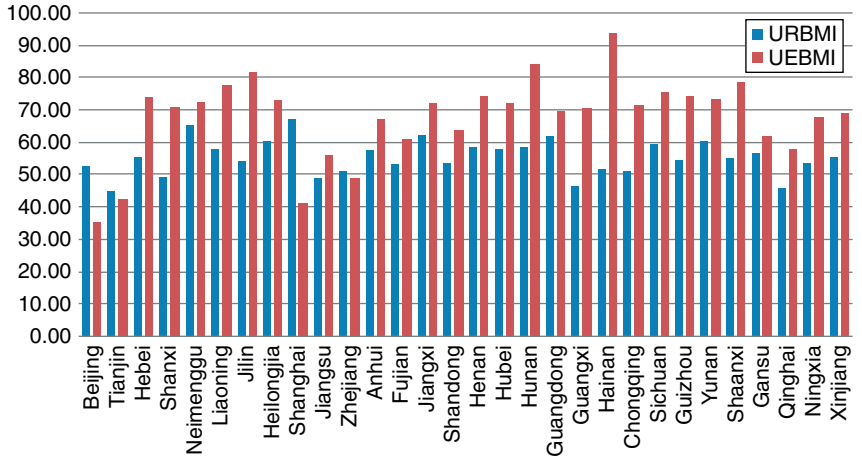


Figure 2. In-patient reimbursement rates of UEBMI and URBMI by province in 2010 (unit: % in total expenses). *Source*: Statistics from Ministry of Human Resource and Social Security, PRC.

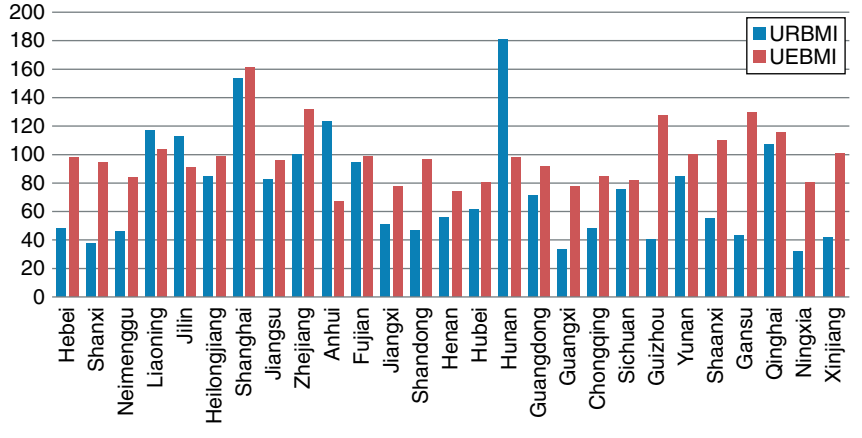


Figure 3. Out-patient reimbursement amount of UEBMI and URBMI by province in 2010 (unit: yuan per patient). *Source*: Statistics from Ministry of Human Resource and Social Security, PRC.

NRCMI's reimbursement rates are lower further than the URBMI's.[24] Hence, it can be said that the employment-based social health insurance programs provide the most generous yet exclusive benefits to urban formal employees, while the residency-based social health insurance programs supply inclusive yet limited benefits to other groups.

24. Meng Qingyue and Tang Shenglan, 'Universal coverage of health care in China: challenges and opportunities', in *World Health Report 2010* (New York: World Health Organization, 2010).

IV.2. Stratification of social health insurance: employment-based health insurance coverage

The above section has delineated a nuanced picture of Chinese social health insurance expansion. On the one hand, social groups such as peasants or urban residents who are unemployed, self-employed or informally employed, and who were previously excluded from the urban employment-based social health insurance programs, have gradually been insured through the residency-based health insurance programs (mainly URBMI and NRCMI). On the other hand, the benefits these newly insured groups have received are quite limited and rely heavily on government subsidization for financing (half from the central government and half from the local government in the western and inland provinces). Such a policy design generates certain consequences with intrinsic distributive implications. First, the residency-based social health insurance benefits are vulnerable to fiscal cutbacks, especially when local governments—one of the major sponsors of social health insurance, are unable to make ends meet. Second, the employment and non-employment divide artificially created in the social health insurance programs identifies beneficiaries with labor market participation and thus continues to marginalize labor market 'outsiders'. Third, the urban–rural disparity is reflected and embedded into the social health insurance system as well. Hence, the expansion of Chinese social health insurance reinforces and strengthens social inequalities. The stratification of social health insurance throughout the expansion period is evident on two aspects: selective coverage of the generous employment-based social health insurance; and different types of health insurance programs available to different groups. It is hypothesized that both the coverage of employment-based social health insurance and the distribution of social health insurance programs among social groups are highly correlated with people's socioeconomic and employment status. This section will present empirical evidence regarding the coverage of employment-based health insurance and the next section will focus on the distribution of various health insurance programs among social groups.

The analysis of employment-based social health insurance coverage is based on a publicly available dataset, the China General Social Survey (CGSS),[25] which was collected at the individual level in multiple rounds from 2003 to 2008. For inter-temporal comparison, this analysis relies on CGSS data collected in 2003, 2006 and 2008. The dependent variable (*medinsu*) is binary, constructed from respondents' answer to the question: 'does your work unit/company provide any kind of medical insurance?' on the CGSS questionnaire. The independent variables are all at the individual level and concentrate on individual respondents' socioeconomic and employment status. The socioeconomic factors included are respondent's education level (*educ*), annual income (*log_indiv_income*), household registration status (*urban hukou*),[26] membership in the Chinese Communist Party (*CCP*) and migration status

25. The China General Social Survey (CGSS) is an annual or biannual questionnaire survey of China's urban and rural households aiming to systematically monitor the changing relationship between social structure and quality of life in urban and rural China. For more information, see http://www.chinagss.org/.

26. A *hukou* is a record in the system of household registration required by law in China. The household registration system was officially promulgated by the Chinese Communist Party in 1958 to control the movement of people between urban and rural areas. Individuals were broadly categorized as a 'rural' or 'urban' person.

(*migrant*). The employment factors included are respondents' employment status (*unemployed*), employment type—whether they have signed a legal labor contract with an employer (*formal*), employment sector (*employment sector*)[27] and employer size (*employer size*). Control variables are respondents' demographic factors such as age (*age*) and gender (*female*). A descriptive summary of the data is provided in Table 1. A logistic regression model is employed in this analysis.

The logistic regression results, presented in Table 2, strongly support the stratification hypothesis. Employment-based health insurance coverage continues to privilege those advantaged in socioeconomic status—the high-income and high-educated group. Moreover, CCP members were more likely to be covered by employment-based health insurance in 2003 and 2006, but the positive effect of party membership disappears in 2008. Using the 'divide by four' rule for interpreting logit coefficients,[28] holding other conditions constant, urban *hukou* increased one's probability of being covered by employment-based health insurance by about 29% in 2003, but the magnitude of this effect decreases over the time period studied. Migrants had a lower probability of being covered by employment-based health insurance until 2008, when migration's negative effect on social health insurance coverage is becoming trivial and statistically insignificant.

While we can conclude from the above results that the impacts of socioeconomic status on employment-based social health insurance coverage are declining in terms of significance and magnitude from 2003 to 2008, the effects of employment situations on insurance coverage increases over the same period. Again, using the 'divide by four' rule for convenience, holding other conditions constant, unemployment decreased one's probability of being covered by the employment-based social health insurance by 1% in 2003, however, this effect increased significantly to 19% in 2008, meaning that unemployed people were increasingly cut off from the employment-based social health insurance programs from 2003 to 2008. By contrast, formal employees (those who have a legal labor contract with their employer) have increasingly benefitted from employment-based social health insurance. In effect, formal employment (*formal*) turns out to be the most salient and significant factor in determining one's probability of being covered by employment-based social health insurance in all model specifications. As for employment sectors, the state sector is consistently and significantly associated with higher probabilities of being covered by employment-based health insurance. On the contrary, working in the private sector decreases one's probability of being covered by employment-based social health insurance, though this effect is not consistent and significant if we look at a specific year's sample. A large-sized employer is also more likely to provide

27. These categories of employment sectors are state-owned enterprise or *SOE*, collective-owned enterprise or *COE*, private enterprise or *POE*, foreign-owned enterprise or *FOE*, and *other*.

28. Andrew Gelman and Jennifer Hill, *Data Analysis Using Regression and Multilevel/Hierarchical Models* (Cambridge: Cambridge University Press, 2006), p. 82. The main idea of the 'divide by four' rule is that one can take logistic regression coefficients and divide them by four to get an upper bound of the predictive difference corresponding to a unit difference in *x*. This upper bound is a reasonable approximation near the midpoint of the logistic curve, where probabilities are close to 0.5. At this point the slope of the logistic curve or the derivative of the logistic function is maximized.

Table 1. Descriptive summary of data for logistic regression model

	Mean	Median	Min	Max	N
Medinsu*	.62	1	0	1	9940
Age	45.11	44	16	90	9991
Female*	.52	1	0	1	9991
Edu	4.74	5 (high school)	0 (no formal education)	11 (graduate school or above)	9983
Log_indiv_income	9.29	9.29	3.00	13.85	8475
CCP*	.16	0	0	1	9914
Urbanhukou*	.90	1	0	1	9991
Migrant*	.10	0	0	1	9991
Unemployed*	.14	0	0	1	9991
Formal*	.52	1	0	1	8306
Employer size	3.61	4 (100–499 employees)	1 (1–10 employees)	8 (10000 + employees)	9252
SOE*	.52	1	0	1	9991
COE*	.13	0	0	1	9991
POE*	.13	0	0	1	9991
FOE*	.02	0	0	1	9991
Other*	.02	0	0	1	9991

*means the variable is binary with 1 referring to "yes" and 0 referring to "no".

employment-based health insurance, although this effect was strongest in 2003 and gradually decreased thereafter.

To summarize the results from the logistic regression analysis, an individual's chance of being covered by employment-based social health insurance is determined by both her socioeconomic status (such as urban or rural household registration, indigene or migrant) and employment situations such as employment status (employed or unemployed), employment type (formal or informal), employment sector (state sector or non-state sectors) and employer's size. The urban–rural divide has existed in Chinese society for decades due to the rigid household registration system stemming from the command economy prior to 1976. The divides between the state and non-state sectors and between formal and informal employees in the coverage of employment-based social health insurance, as shown in the CGSS data, reflect new kinds of social inequalities associated with China's burgeoning market economy. Therefore, it is fair to conclude that the expansion of the employment-based social health insurance hardly corrects socioeconomic inequalities; instead, it reflects and reinforces labor market cleavages. The Chinese state that has been remarkably successful in supervising the transition from a command economy to a market economy, failed to correct the existing and emerging social inequalities.

IV.3. Stratification of social health insurance: distribution of various health insurance programs in society

Section IV.1 has demonstrated that the employment-based social health insurance provides much more generous benefits to a relatively small-sized group of

Table 2. Logistic regression results about employment-based health insurance coverage

	2003	2006	2008	Total
Female	.01	− .01	.08	.05
	(.15)	(.10)	(.12)	(.06)
Age	.02**	.04***	.03***	.03***
	(.01)	(.00)	(.01)	(.00)
Edu	.17***	.15***	.18***	.15***
	(.04)	(.03)	(.03)	(.02)
Log (lndiv_income)	.69***	.78***	.36***	.55***
	(.11)	(.07)	(.09)	(.04)
CCP	.40*	.53**	− .27	.15
	(.21)	(.16)	(.18)	(.10)
Urban hukou	1.14**	.99***	.37*	.78***
	(.39)	(.18)	(.21)	(.12)
Migration	− .55*	− .55**	− .02	− .42***
	(.24)	(.19)	(.19)	(.12)
Unemployed	− .04**	− .57***	− .75**	− .39**
	(.15)	(.16)	(.27)	(.12)
Formal employment	1.31***	1.47***	2.25***	1.22***
	(.23)	(.11)	(.13)	(.07)
Employer size	.60***	.22***	.13***	.25***
	(.05)	(.03)	(.04)	(.02)
Employment sector:	.88***	1.61***	.90**	1.04***
SOE	(.25)	(.12)	(.42)	(.10)
Employment sector:	− .34	.67***	.30	.26**
COE	(.30)	(.14)	(.44)	(.11)
Employment sector:	1.75**	.50	.24	.60**
FOE	(.71)	(.40)	(.55)	(.24)
Employment sector:	− .49	.06	− .44	− .44***
POE	(.33)	(.19)	(.42)	(.11)
Employment sector:	− .30	1.18*	− .34	− .13
Other	(.50)	(.64)	(.54)	(.25)
Constant	− 11.99***	− 11.68***	− 7.38***	− 9.08***
	(1.13)	(.72)	(.95)	(.45)
N	1486	3601	2029	7116
Pseudo R^2	.37	.35	.34	.30

***$p < 0.01$, **$p < 0.05$, * $p < 0.1$.

beneficiaries—urban formal employees. The social health insurance expansion that preserves the vested interests of urban employees while incorporating other societal groups by creating separate health insurance programs further stratifies society by reinforcing existing social cleavages and generating new divides within social groups. Section IV.2 provided empirical evidence for the stratification in terms of employment-based social health insurance coverage among social groups. This section uses another individual-level dataset, the China Health and Nutrition Survey (CHNS), collected in nine Chinese provinces in multiple waves between 2000 and 2009, to demonstrate how people with different socioeconomic and employment status are 'selected' into different health insurance programs with distinct levels of benefit. In order to better compare the stratification of social health insurance before

and after the social health insurance expansion, I use data collected in urban areas in the years of 2004 and 2009, respectively.

The dependent variable, health insurance program (*prog*),[29] consists of five categories: 'commercial or other health insurance', 'GIS', 'UEBMI', 'URBMI' and 'NRCMI'. The rank of generosities of these Chinese social health insurance programs is: GIS > UEBMI > URBMI > NRCMI. Other than social health insurance, some people (9.87% and 2.97% of urban adult respondents in the 2004 and 2009 samples, respectively) join the non-social health insurance programs such as commercial or other health insurance programs, but the non-social health insurance continues to be trivial in terms of coverage and generosity in China. The focus of the analysis lies on social health insurance programs. Since the dependent variable is multinomial, a multinomial logistic regression model is applied to this analysis. I use 'commercial or other health insurance' as the baseline category in the multinomial logistic regression. The independent variables cover two dimensions of individuals' attributes: socioeconomic status and employment situation. The socioeconomic factors included are household registration status (*urban hukou*)[30] and education level (*edu*).[31] The factors pertaining to a respondent's employment situation include employment status (*employsta*),[32] employment sector (*employown*)[33] and employer size (*employsz*).[34]

A summary of the descriptive data shows that the distribution of various health insurance programs among individuals dramatically differs with people's socioeconomic and employment situations both before and after the expansion (Graphs 8–11). In addition, several discernible trends stand out from cross-time comparison of the descriptive data. First, social health insurance programs became more diverse, especially for the urban population in 2009. Second, the share of non-social health insurance, such as commercial and private health insurance, has been significantly shrinking from 2004 to 2009. Third, the share of government free medical care (GIS) became much smaller in 2009 compared to 2004. This does not mean that the privileges of civil servants and government officials in healthcare have disappeared; rather, GIS has been integrated into the UEBMI program as a subcategory or supplementary insurance program for the privileged groups in two-thirds of Chinese provinces.[35]

29. The variable 'prog' is multinomial, with '1' being 'commercial or other health insurance scheme'; '2' being GIS or 'government scheme'; '3' being UEBMI or 'urban employee scheme'; '4' being URBMI or 'urban resident scheme'; and '5' being NRCMI or 'rural corporative scheme'. Because the urban resident health insurance, URBMI, was initiated in 2007, there is no case under this category in the 2004 CHNS sample.

30. The variable 'urban *hukou*' is binary, with '1' representing urban *hukou* and '0' meaning having no urban *hukou*.

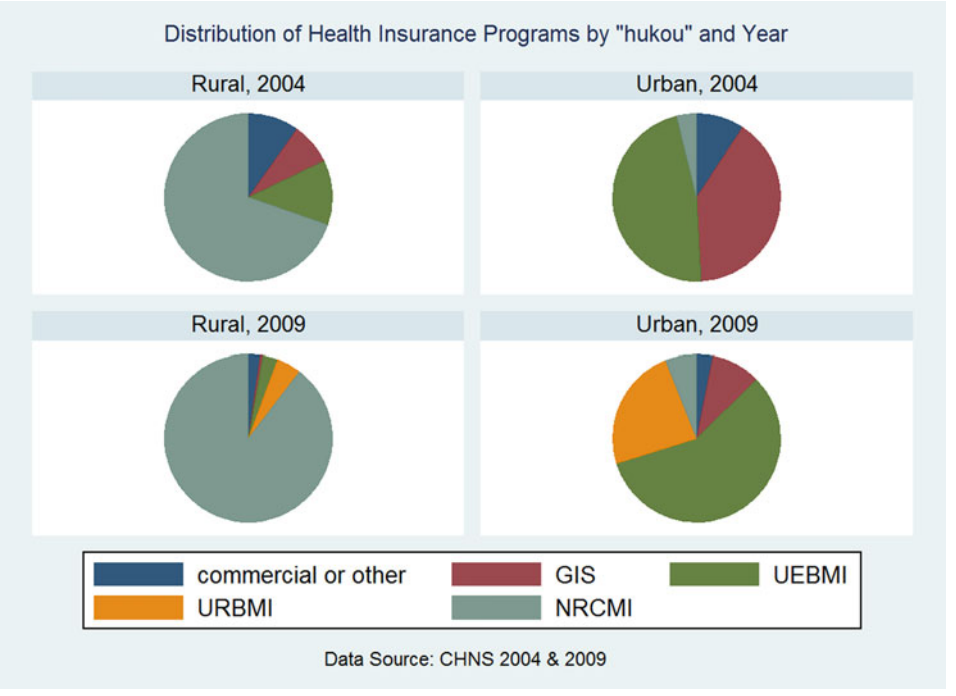
31. The variable 'edu' is ordinary, with '0' = no regular education; '1' = primary school; '2' = middle school; '3' = high school; '4' = technical or occupational school; '5' = college; '6' = graduate school and above.

32. The variable 'employsta' is categorical, with '1' = employed; '2' = unemployed or student; '3' = housekeeping; '4' = retired; '5' = other.

33. The variable 'employown' is categorical with '1' = government or public institute; '2' = state-owned enterprise; '3' = collective-owned enterprise; '4' = private firms; '5' = foreign firm; '6' = other.

34. The variable 'employsz' is ordinary with '1' = ' < 20 employees'; '2' = '20–100 employees'; '3' = ' > 100 employees'.

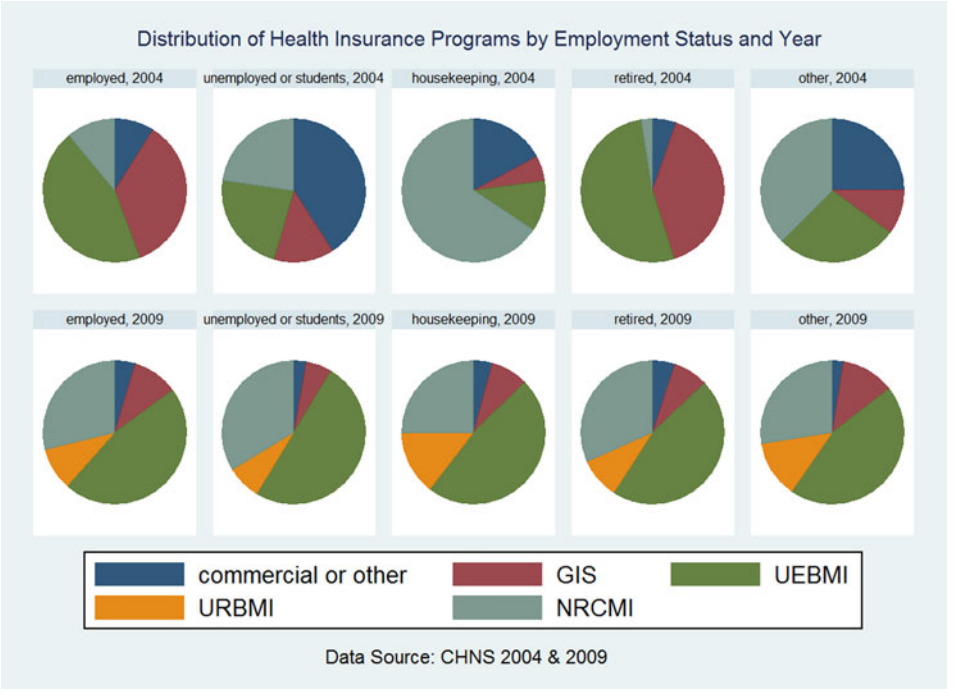
35. '80% of Chinese provinces abolished government free medical care', *Xinhua News Agency*, available at: http://news.xinhuanet.com/local/2012-12/14/c_114025198.htm (accessed 15 December 2012).



Graph 8. Distribution of health insurance programs by 'hukou' and year.

The regression results for the 2004 sample are presented in Table 3, and results for the 2009 sample are summarized in Table 4. As expected, highly educated people were more likely to become the beneficiaries of urban employment-based social health insurance programs (GIS and UEBMI) than commercial or other health insurance in 2004. However, this effect decreases in terms of magnitude and significance in 2009. By contrast, urban household registration (*hukou*)'s effect substantially increases in both magnitude and significance from 2004 to 2009. Specifically, urban *hukou* significantly increases the odds of individuals having urban employment-based social health insurance (i.e. GIS or UEBMIC) relative to having commercial health insurance in 2009, while it did not have such an impact in 2004. This indicates that urban household registration (*hukou*) rather than individuals' income level (assuming education to be a proxy of income) has become an increasingly important condition for obtaining urban healthcare benefits (including GIS, UEBMI and URBMI) since 2004. This implies that the distribution of social health insurance benefits is more skewed to urbanites than to high-income groups.

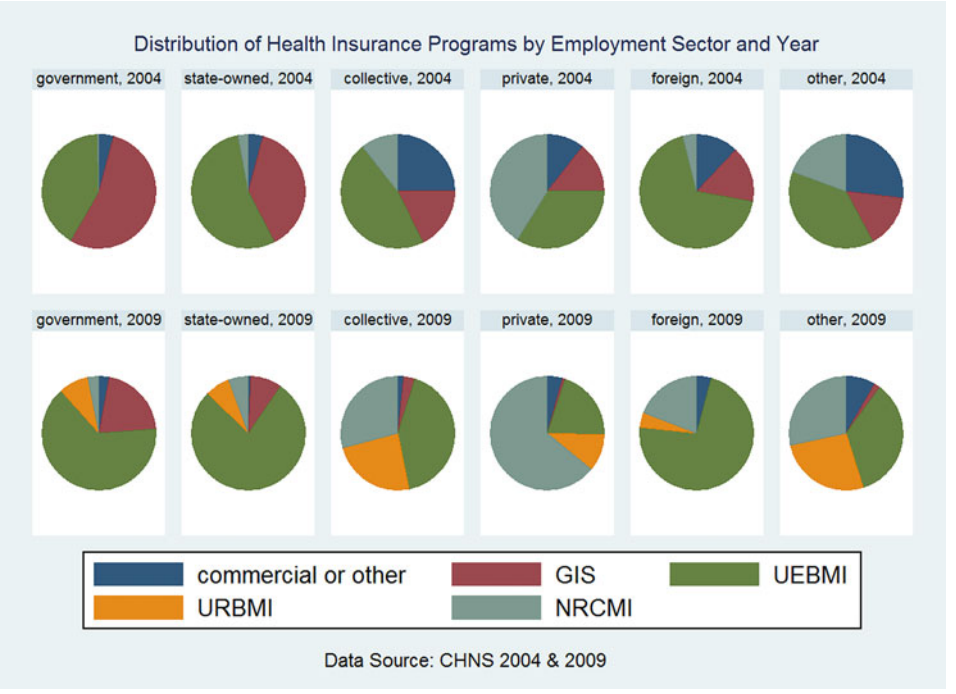
The quantitative results on employment status also lend support to the stratification hypothesis of social health insurance expansion. Specifically, the odds of an individual participating in employment-based health insurance (i.e. GIS or UEBMIC) relative to participating in commercial health insurance significantly decrease if his/her employment status changes from employed to unemployed. On the contrary, the odds of an individual joining urban social health insurance (i.e. GIS, UEBMI or



Graph 9. Distribution of health insurance programs by employment status and year.

URBMIC) relative to joining commercial health insurance significantly increase if his/her employment status changes from employed to retired. These results can be interpreted to mean that as compared to employees, unemployed people (including students and housekeepers) are generally excluded from generous social health insurance programs such as the GIS and UEBMI, while retirees have increasingly benefited from various urban social health insurance programs, from employment-based social health insurance (i.e. GIS, UEBMI) to residency-based social health insurance (i.e. URBMI) throughout 2004–2009.

As for the effects of employment sector, there was no significant difference in terms of odds of one joining social health insurance relative to joining commercial and other health insurance if one's employment sector changed from government institutes to SOEs in 2004 or 2009. This implies that no significant gap in terms of social welfare benefits existed between government employees and SOE employees in those years. However, the odds of individuals joining employment-based health insurance relative to joining commercial and other health insurance significantly decreased if their employment sector moves from government institutions to private sectors in 2004 and 2009. This suggests that, compared to government and state-sector employees, private-sector employees are less likely to benefit from employment-based social health insurance than from commercial or other forms of health insurance. It is also noteworthy that private-sector employees' disadvantage in obtaining employment-based social health insurance benefits became more

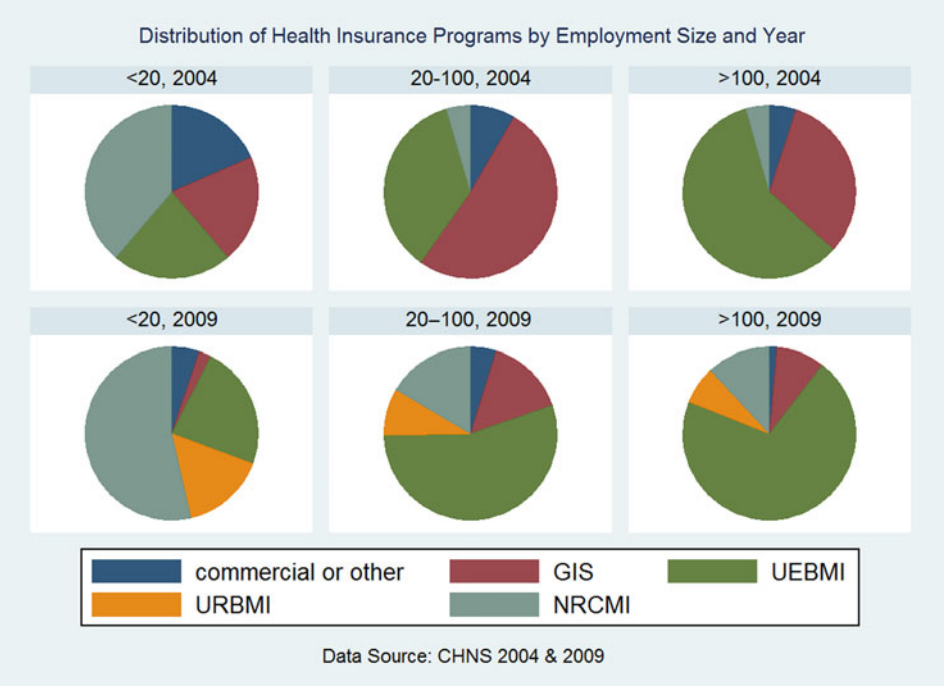


Graph 10. Distribution of health insurance programs by employment sector and year.

substantial in 2009 than in 2004. In addition, the odds of individuals having employment-based health insurance relative to having commercial or other health insurance significantly decreased if their employment sector moved from government institutions to collective or foreign-owned firms in 2004, though such an effect disappeared in 2009, implying an expansion of employment-based social health insurance coverage among collective and foreign-owned firms in 2009.

The effect of employer's size on employment-based social health insurance coverage is positive as expected. Working for a large-sized employer significantly increased the odds of one having UEBMI relative to having commercial or other health insurance in both 2004 and 2009, which means that large-sized firms or work units in China continued to insure employees through UEBMI rather than commercial or other health insurance programs.

To summarize the multinomial logistical regression results, people with different socioeconomic status and employment situations are enrolled into different health insurance programs. Other factors being equal, people with urban *hukou* are covered by the social health insurance programs with generally higher levels of benefit. Moreover, people of different employment status are covered by different social health insurance programs. Retirees and incumbent employees are covered by the generous GIS or UEBMI programs, while unemployed people (including students and housekeepers) are either uninsured or insured by the programs with much meager and more vulnerable benefits, such as URBMI and NRCMI. Furthermore, employees



Graph 11. Distribution of health insurance programs by employment size and year.

in private sectors or in small-sized firms tend to be enrolled into the social health insurance programs with the lowest generosity, such as NRCMI. Hence, social health insurance after expansion stratifies Chinese society along three cleavage lines: (1) urban versus rural; (2) labor market insiders versus outsiders;[36] and (3) state versus non-state sectors. These social cleavage lines are not exclusive to one other. On the contrary, they are interwoven in such a way as to fragment the society and privilege some groups over others without breaking society into a single and deep class line. How does one explain the political rationale behind the social welfare expansion? What can the inequality and fragmentation of social health insurance tell us about China's authoritarianism? The next section discusses these questions.

V. The paradox: welfare expansion and social stratification

Examination of the distribution of China's expanding social health insurance brings in a paradox here: the impressive expansion of social health insurance enrollment and the increased number of social health insurance programs have not reduced, but rather have reproduced, socioeconomic inequalities. Instead of leveling the social playing field, the changes in social health insurance continue to link social benefits to

36. 'Labor market insiders' refers to employees who have formal and stable employment relations or contracts with employers. On the contrary, 'labor market outsiders' are people who have no formal or stable labor relations or contracts, such as temporary, part-time or student workers.

Table 3. Multinomial logistic regression results about health insurance program choice in 2004

	(1)			(2)		
	GIS	UEBMI	NRCMI	GIS	UEBMI	NRCMI
Edu	.34***	.27**	− .57***	.14	.12	− .48**
	(.09)	(.09)	(.14)	(.15)	(.15)	(.21)
Urban hukou	.80	.62	− 2.67***	− .26	− .49	− 3.01***
	(.51)	(.47)	(.43)	(.89)	(.86)	(.83)
Employment status: employed	Baseline case					
Employment status: unemployed or students	− 2.35***	− .2.53***	− 1.12			
	(.71)	(.71)	(.78)			
Employment status: housekeeping	− 2.65**	− 1.83**	− .21			
	(1.11)	(.74)	(.62)			
Employment status: retired	1.04***	1.04***	− 1.03**			
	(.31)	(.31)	(.52)			
Employment status: others	− 1.71***	− .98**	− .63			
	(.64)	(.49)	(.58)			
Employment sector: government or public				Baseline		
Employment sector: state				− .76	− .47	.84
				(.66)	(.66)	(1.33)
Employment sector collective				− 3.00***	− 1.75***	.54
				(.62)	(.58)	(1.25)
Employment sector: private				− 2.22***	− 1.07*	1.73
				(.61)	(.60)	(1.20)
Employment sector: foreign				− 2.87***	− 1.44*	.26
				(.89)	(.78)	(1.65)
Employment sector: others				− 3.30***	− 1.50**	1.06
				(.85)	(.73)	(1.33)
Employer size				.41	1.06***	.36
				(.27)	(.26)	(.35)
Constant	− .46	.12	3.27***	1.76	.21***	1.68
	(.56)	(.52)	(.51)	(1.17)	(1.14)	(1.56)
Pseudo R^2		.18			.24	
N		1014			529	

***$p < 0.01$, **$p < 0.05$, * $p < 0.1$.

Table 4. Multinomial logistic regression results about health insurance program choice in 2009

	(1)				(2)			
	GIS	UEBMI	URBMI	NRCMI	GIS	UEBMI	URBMI	NRCMI
Edu	.24**	.05	−.28***	−.65***	.09	.08	−.12	−.52***
	(.12)	(.10)	(.10)	(.11)	(.18)	(.15)	(.16)	(.17)
Urban hukou	2.03***	2.41***	1.01***	−2.89***	2.06**	2.12***	.79	−3.29***
	(.60)	(.39)	(.35)	(.33)	(.87)	(.54)	(.52)	(.48)
Employment status: employed	Baseline case							
Employment status: unemployed or students	−2.53**	−1.80***	.45	−.08				
	(1.10)	(.54)	(.49)	(.53)				
Employment status: housekeeping	−15.14	−2.00***	.94**	.49				
	(592.04)	(.53)	(.46)	(.47)				
Employment status: retired	2.04***	1.96***	1.61***	−.49				
	(.57)	(.55)	(.56)	(.64)				
Employment status: other	−1.69**	−1.78***	.01	.05				
	(.71)	(.46)	(.43)	(.44)				
Employment sector: public institutes					Baseline case			
Employment sector: state					14.08	14.82	14.61	15.13
					(1030.56)	(1030.56)	(1030.56)	(1030.56)
Employment sector: collective					13.76	14.91	16.42	16.86
					(1672.52)	(1672.52)	(1672.52)	(1672.52)
Employment sector: private					−3.34***	−1.19**	−.08	.86
					(.71)	(.49)	(.55)	(.66)
Employment sector: foreign or others					−17.50	−.94	−1.93	.99
					(1289.78)	(.86)	(1.32)	(1.11)
Employment sector: others					−2.63**	−1.09	.02	−.19
					(1.26)	(.80)	(.85)	(1.03)
Employer size					.72**	.83***	.24	.01
					(.33)	(.28)	(.30)	(.32)
Constant	−1.81***	.20	1.24***	4.91***	−1.61	−.79	.28	3.67***
	(.66)	(.46)	(.43)	(.41)	(1.26)	(.94)	(.98)	(1.03)
Pseudo R^2			.39			.40		
N			2272			893		

*** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

citizens' socioeconomic status and residency. As proved in Section IV, the expansion has significantly reinforced rather than mitigated social cleavages by institutionalizing those existing and emerging social divides into the social health insurance system. As a result, social welfare expansion strengthens rather than attenuates social stratification in China. This reflects authoritarian regimes' 'divide and rule' tactic in social welfare provision.[37] It serves the authoritarian leaders' interests in maintaining regime stability by consolidating divisions among social groups to prevent alliances that could challenge the regime while tying social groups' loyalties directly to the central state authority. Under such a fragmented social welfare system, horizontal mobilization among societal groups—including cross-regional, cross-class or cross-sectoral coalitions—becomes even more difficult as people's preferences and interests are divided in a complicated way that their capabilities of aggregating and articulating appeals to the state are weakened.[38] Although the 'divide and rule' strategy in social welfare provision can contribute to preventing social groups from horizontally mobilizing across sectors, regions or classes, it inevitably impairs labor market mobility and social solidarity. The institutional fragmentation of social security and welfare system has been commonly deemed by media, press and public policy scholars as one of the largest obstacles to China's urbanization.[39] It is thus speculated that in the long run such a strategy is detrimental rather than beneficial for China's authoritarian regime, whose legitimacy has been heavily relying on economic performance.

VI. Conclusion

This article starts from a theoretical inquiry—how are social welfare benefits stratified in countries outside of the OECD? Empirically, it explores who gets what, when and how from China's recent social welfare expansion. Despite a large number of studies assessing the welfare state in advanced industrial democracies as well as single social health insurance programs in China such as UEBMI, NRCMI and UEBMI, little research has explored the overall landscape of China's social health insurance, which has changed dramatically since expansion in 2003. This article attempts to fill these gaps by providing a nuanced understanding of the distribution pattern of social health insurance benefits in China. Based on in-depth data analysis and fieldwork, this article finds that China's social health insurance expansion from

37. For more examples on the fragmented social insurance model promoted by the authoritarian welfare state such as Germany under Bismarck, Austria under von Taaffe and France under Napoleon III, see Esping-Andersen, *The Three Worlds of Welfare Capitalism*; Hermann Beck, *The Origins of the Authoritarian Welfare State in Prussia: Conservatives, Bureaucracy, and the Social Question, 1815–70: Social History, Popular Culture, and Politics in Germany* (Ann Arbor, MI: University of Michigan Press, 1997); and Gaston V. Rimlinger, *Welfare Policy and Industrialization in Europe, America, and Russia* (New York: Wiley, 1971).

38. For an in-depth analysis of segmentation of the Chinese employee class, see Zhining Ma, 'Chinese employee class: an analysis using a three-dichotomy segmentation approach', *Journal of Contemporary China* 19(67), (2010), pp. 935–948.

39. 'Further integrating social security system for urbanization' ['Cheng zhen hua jin cheng zhong jia kuai tui jin she hui bao zhang zhi du xie jie yu zeng he'], *Xinhua News*, available at: http://news.xinhuanet.com/politics/2013-05/15/c_124715276.htm (accessed 31 October 2013); 'Urbanization requires eliminating several institutional obstacles' ['Cheng zhen hua gai ge xu jia kuai po chu xiang guan zhi du zang ai'], *Xinhua News*, available at: http://news.xinhuanet.com/2013-05/25/c_124763476.htm (accessed 31 October 2013).

2003 to 2009 did significantly expand people's access to social health insurance. Peasants and urban non-working people who were previously excluded from the urban employee health insurance are now covered by separate social health insurance programs. However, the social health insurance coverage and benefits after expansion are not only fragmented but also highly stratified across three cleavage lines: (1) rural versus urban; (2) labor market insiders versus labor market outsiders; and (3) state versus private sectors. The social health insurance expansion from 2003 to 2009 reflects and reinforces social inequalities based on individuals' labor market participation and socioeconomic status.

The findings and arguments of this article highlight the coexistence and complexity of multiple social cleavages embedded in China's social health insurance system, which, it is worth noting, also characterize the distribution of other social welfare benefits in China, such as pensions. The distribution pattern of social welfare in China starkly differs from the model of the conventional welfare state in advanced industrial democracies: it is neither solely a market-state division as in the liberal welfare state nor an occupational cleavage as in the conservative welfare state. The multiplicity and complexity of social cleavages in the Chinese social welfare system reveal the authoritarian leaders' 'divide and rule' strategy for maintaining order. The fragmented social welfare provision enables multiple social cleavages to cross-cut without following a single and deep class line. Of special importance for the Chinese authoritarian regime to survive is the maintenance of particularly favorable welfare provisions for the urban and state-sector employees while establishing and preserving an essentially modest social provision for other social groups.

As more and more Chinese people are covered by social health insurance, their dissatisfaction with the system has gradually shifted from a lack of health insurance coverage to inequity of health insurance benefits. Integration of social health insurance was first placed on the agenda in 2009 when the central government announced a comprehensive health reform with the primary goal of making healthcare accessible and affordable to all people. However, integrating the fragmented social health insurance programs with distinct eligibilities, generosities and financing mechanisms has proven to be a difficult task for the government, more complex than the incremental expansion of social health insurance coverage that it has accomplished over the past decade. Since 2012, the Chinese top leadership has come to rely on urbanization to fuel China's economic growth and the leaders plan to move 250 million rural residents into newly constructed towns and cities over the next dozen years. This makes integration of the fragmented social insurance an imperative for the government. Will the resource reallocation and redistribution as a result of social insurance integration empower previously marginalized social groups in the upcoming decade? How will the leadership integrate the fragmented social insurance to facilitate the largest wave of urbanization in human history without sacrificing their political controls over social order and mobilization? Will it be possible for different social groups to ally in order to articulate their policy preferences and thus influence the configuration of social health insurance integration? If yes, what are their tools and how will they mobilize themselves across sectors, regions or classes? These are interesting questions to address in future research.