Public attitudes toward health care provision in China: Is there demand for equality?

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Abstract

Research on China's health system since the 1980s has documented its commercialization and the emergence of substantial inequalities across the population in state-provided health insurance cover and access to services. Scholars and Chinese policy makers have suggested that these inequalities might cause dissatisfaction – perhaps enough to jeopardize "social stability". But do Chinese people perceive, and tolerate, differential access to health services? Studies of public attitudes to income inequalities in China in the early 2000s indicated that its citizens were surprisingly – given the backdrop of the egalitarian 1970s – tolerant. Our paper reports the findings of a nationally-representative survey conducted in late 2012 and early 2013. We find first that a majority of people do think there are inequalities – between rich and poor, urban and rural residents, civil servants and others, but only a minority think there are inequalities between men and women, migrants and non-migrants. Second, more educated people and the "losers" in all these dyads are the most likely to think there is inequality. But who is most dissatisfied with the inequalities? We find that around a third of the population think that inequalities are not "normal", and that urban residents and the best educated are more likely than rural residents and the less well educated to think that inequalities are "abnormal". But the most disgruntled are those whose family's economic situation has worsened over the last five years.

Introduction

It is widely agreed that from the early 1980s, China commercialized its state planning era public sector health care system and by the late 1990s had begun to partly privatize provision. It is also generally accepted that during the 1980s, rural health risk protection – in the form of rural cooperative medical schemes – collapsed, while during the 1990s the proportion of the urban population with some form of health insurance fell. As a result, growing numbers of people had to pay for their health care directly out of their own pockets at a time when

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income inequalities were growing.[1] Research has found that as a result people on low incomes – often rural dwellers – found it increasingly difficult to pay for rapidly rising health care costs.[2] At the same time, inequalities in access to health care grew on other dimensions, for example as clinics in poor rural areas closed down while in the cities specialist hospitals proliferated.[3]

These scholarly findings have been accepted by health analysts and policy makers in China. As a commentator in one Chinese newspaper argued as recently as 2011:

> While wealthier Chinese people have benefited from advanced medical technologies, many poor people do not have adequate access to even the most essential medical services. About 80 percent of China's healthcare and medical services are concentrated in cities, and timely medical care is not available to more than 100 million people in rural areas.[4]

Although the most often-discussed health care gaps are between rich and poor citizens and between rural and urban areas, others exist. Ling Xu and colleagues also found that in the cities, women were less likely to have "mainstream" health insurance than men.[5] Government officials are also more likely to have better insurance than ordinary rural and urban citizens.[6] Finally, scholars have paid a great deal of attention to the plight of rural migrants to the city, who – because they are not formally registered as permanent residents in their place of work

[1] Blumenthal, D., & Hsiao, W. C. (2005). Privatization and Its Discontents: The Evolving Chinese Health Care System. [Health Policy Report]. *New England Journal of Medicine, 353*(11), 1165-1169. Duckett, J. (2011). *The Chinese State's Retreat from Health: Policy and the Politics of Retrenchment*. London and New York, Routledge. Bloom, G. and J. Fang (2003). China's rural health system in changing institutional context. *IDS Working Paper 194*. Institute of Development Studies, Brighton. Eggleston, K., L. Ling, et al. (2008). "Health service delivery in China: A literature review." *Health Economics* 17(2): 149-165. World Health Organization (2000). *World Health Report 2000*. Geneva, World Health Organization. Dang, B., K. Nguyen, et al. (2007). "Rural health care in Vietnam and China: Conflict between market reforms and social need." *International Journal of Health Services* 37(3): 555-572. Urban state-backed health insurance by the late 1990s included remnant provision through planning era labour and government insurance as well as a new programme for the urban employed and called 'urban employee basic medical insurance' [add refs].

[2] Jackson, S., A. C. Sleigh, et al. (2005). "Health Finance in Rural Henan: Low Premium Insurance Compared to the Out-of-Pocket System." *The China Quarterly* 181(March): 137-157. Lindelow, M. and A. Wagstaff (2005). "Health Shocks in China: Are the Poor and Uninsured less Protected?" *World Bank Policy Research Working Paper* (3740): 1-25.

[3] Akin, J., Dow, W., Lance, P., & Loh, C. (2005). Changes in access to health care in China, 1989-1997. *Health Policy and Planning, 20*(2), 80-89. Gao, J., Tang, S., Tollhurst, R., & Rao, K. (2001). Changing access to health services in urban China: implications for equity. *Health Policy and Planning, 16*(3), 302-312.

[4] Chelala, Cesar (2011), "China: Proper healthcare for one and all", *China Daily*, 25 March.

[5] Xu, L., Wang, Y., Collins, C., & Tang, S. (2007). Urban Health Insurance Reform and Coverage in China Using Data from the National Health Services Survey in 1998 and 2003. *BMC Health Services Research, 7*(37).

[6] Duckett, J. (2004). State, Collectivism and Worker Privilege: A Study of Urban Health Insurance. *The China Quarterly*(177), 155-173. They also have access to better hospitals or VIP wards.

– are usually ineligible for local health insurance schemes as well as likely to have low incomes.[7]

The Chinese government from the late 1990s and especially into the early 21st century acknowledged and began to tackle some of these inequalities. It extended "Urban Employee Basic Medical Insurance" (UEBMI) nationwide from the late 1990s. And although UEBMI was widely criticized for leaving workers' dependants (who had been provided for under planning era "labour insurance") unprotected, it did bring civil servants into the same programme s other urban employees.[8] Then in 2002, it announced a push to re-establish rural health risk protection with "New Cooperative Medical Schemes" (NCMS), which were rolled out across the country over the next few years.[9] Then from 2005, Urban Residents Health Insurance (URHI) extended insurance to the non-working population, and some localities experimented with including migrants in their schemes. While these policies demonstrated efforts to reduce inequalities,[10] funding for both URHI and NCMS – even though contributions to the latter have been increased several times since 2002 – was still less much less generous than UEBMI.[11] Despite all these initiatives unequal access to health care remained a serious problem.[12]

But health care reforms did receive a further, major, boost from 2009, when a new reform programme was announced. This followed several years of review and consultation over the future of China's health system. In January 2005, the Vice-minister of Health, Gao Qiang, admitted that 50 per cent of people could not afford to see a doctor if they fell ill.[13] And soon after, an influential government think-tank published a report that was highly critical of the last two decades of commercializing, marketizing health system reforms and the inequalities

[7] [Add refs.] See also Duckett, J. (2007). Local governance, health finance, and changing patterns of inequality in access to health services. In V. Shue & C. P. Wong (Eds.), *Paying for Progress in China: Public Finance, Human Welfare, and Changing Patterns of Inequality* (pp. 46-68). London & New York: Routledge Curzon.
[8] Officials (not called 'civil servants' until well into the reform era) had been provided with 'public employee' insurance that had been often more generous than labour insurance. Under UEBMI they did sometimes retain privileges, however, such as access to VIP wards or top hospitals.
[9] [Add ref and figure for participation.]
[10] Meng, Q., Xu, L., Zhang, Y., Qian, J., Cai, M., Xin, Y., et al. (2012). "Trends in access to health services and financial protection in China between 2003 and 2011: a cross-sectional study." *The Lancet, 379*(9818), 805--814.
[11] [Add refs, figures.]
[12] World Health Organization (2008), "Making Health Care Affordable in China", *Bulletin of the WHO*, Vol. 86 (11), November. Available at http://www.who.int/bulletin/volumes/86/11/08-011108/en/index.html, accessed 6 March 2013.
[13] "Senior official explains challenges in building health", *People's Daily Online*, 11 January 2005. Available at http://english.peopledaily.com.cn/200501/11eng20050111_170224.html. Accessed 15 June 2006.

they had created.[14] The government then in 2006 initiated a review of the health system and stated its intention to pursue more thoroughgoing reform. After both expert and popular consultation,[15] and much media attention,[16] the government in Spring 2009 announced a new health reform programme that promised to provide access to "basic health care" for all the population.[17] Since then, health policy changes have become oriented toward broadening access further by extending state-backed insurance and increasing state funding while retaining some commitment to developing private sector investment and provision.[18]

Thus, in the decade of Hu Jintao's leadership (2002-12),[19] the Chinese government began to tackle inequalities in access to health services. And in doing so it was reportedly motivated by perceived popular dissatisfaction with these inequalities and the social and political instability it might cause.[20] Scholars, too, have speculated on the socio-political ramifications. David Blumenthal and William Hsiao have suggested, for example, that rural-urban health gaps are "an important reason for growing anger in some rural districts toward the Chinese government, the Chinese Communist Party, and China's new, wealthy elite and are contributing to increasingly frequent local riots and disturbances".[21]

But how do the Chinese public view the situation? Do Chinese people think that their health care system delivers unequally to rich and poor, urban and rural dwellers, civil servants and ordinary people, men and women, migrants and local people? Do they think such inequalities are acceptable? And who across the population is most aware and most concerned about inequality?

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[14] Development Research Centre (Ed.). (2005). *Zhongguo fazhan pinglun, zeng kan (China Development Review, supplement)* (Vol. 7). Beijing.

[15] Kornreich, Vertinsky and Potter (2012). "Consultation and Deliberation in China: The Making of China's Health-Care Reform".

[16] Duckett and Langer (Forthcoming), "Populism versus Neo-liberalism".

[17] Party Central Committee and State Council (2009). Guanyu shenhua yiyao weisheng tizhi gaige de yijian (Opinions on deepening Medical and Health System Reform), issued 6 April.

[18] Xinhua News Agency (2010) "China to encourage private investment in health care sector." *Xinhuanet* 26 September. At: http://news.xinhuanet.com/english2010/china/2010-09/26/c_13530601.htm, accessed 13 June 2011.

[19] Heike Holbig argues (p. 28) that Hu's predecessor, Jiang Zemin, justified inequalities and even thought they should be widened. See Holbig, H. (2009), "Ideological reform and political legitimacy in China: Challenges in the post-Jiang era", in T. Heberer and G. Schubert (eds), *Regime Legitimacy in Contemporary China: Institutional change and stability* (London: Routledge), pp. 13—4.

[20] Liu, Y. (2004). "China's Public Health Care System: Facing the Challenges." *Bulletin of the World Health Organization* 82(7): 532-538. Zhang, L., H. Wang, et al. (2006). "Social capital and farmer's willingness-to-join a newly established community-based health insurance in rural China." *Health Policy* 76(2): 233-242.[check exactly what they say].

[21] Blumenthal and Hsiao (2005). "Privatization and Its Discontents", p. 1168.

Despite the media constraints in China, reporting on health system reforms since around 2005 has been relatively relaxed, and the 2006-09 policy review was widely debated in the press.[22] Moreover the government itself has expressed concerns about problems in the health system in stating its aim of making basic care accessible to all. We can therefore expect that across the population people will be aware of health sector issues, including inequality, and will not feel inhibited about discussing them.

There have, however, been few studies of popular attitudes toward health care inequalities, and no recent ones. Chack-kie Wong and colleagues studied urban popular attitudes, but their survey was conducted in 2003, before the recent round of reforms began, and with a non-random sample of around 300 urban employees in only one locality.[23] They asked one question about inequality, reporting that among their sample of urban employees, a small majority of 57 per cent disagreed with the statement that it is reasonable for urban and rural residents to be treated differently in terms of their health care benefits, while almost a quarter agreed.[24] Martin Whyte, in his 2004 survey of popular attitudes to inequality in China found that 47 per cent of people in his nationally representative sample thought that it was fair "for the rich to get better care", with only 28 per cent disapproving, but they did not focus their survey on health care and examine further these or other attitudes to health inequalities.[25]

Our paper, based on a national survey of the Chinese population conducted in late 2012 and early 2013, examines people's views on these issues almost four years after the government

[22] Kornreich, Y., Vertinsky, I., & Potter, P. B. (2012). Consultation and Deliberation in China: The Making of China's Health-Care Reform. *The China Journal, 68* (July), 176--203. See also Duckett, J., & Langer, A. (Forthcoming). Populism versus Neo-liberalism: Diversity and Ideology in the Chinese Media's Reporting of Health System Reform. *Modern China*.

[23] Wong, C.-k., V. I. Lo and K-l. Tang (2006). *China's Urban Health Care Reform: From State Protection to Individual Responsibility*. Lanham, MD, Lexington. They also surveyed separately around 300 patients. They asked "Do you agree that it is reasonable for an individual to bear part of his or her medical expenses?" and a series of questions about responsibility in health care: (1) whether the government should help those who can't afford to pay medical fees, (2) whether the government has responsibility to provide basic care for all, (3) whether it is reasonable to treat urban and rural dwellers differently in terms of health care benefits, and (4) whether people should be entitled to health are protection if they don't pay for medical insurance. They also asked whether medical expenses are the primary responsibility of individuals, employment units or the government. See pp. 160-1. See also Wong, C.-k., & Lee, P. N.-s. (2001). Economic Reform and Social Welfare: the Chinese perspective portrayed through a social survey in Shanghai. *Journal of Contemporary China, 10*(28), 517-532.

[24] Wong, Lo and Tang, *China's Urban Health Care Reform*, p. 97.

[25] Whyte, *The Myth of the Social Volcano*.

announced its new health reforms in 2009. In it, we test hypotheses derived from the literature discussed above about perceptions of inequalities in the health system.

Methodology

The survey

This study is based on analysis of data from a survey commissioned by the authors for a project to examine popular attitudes, trust and the utilization of health care in China.[26] Fieldwork was carried out nationwide from 1 November 2012 to 17 January 2013 by the Research Centre for Contemporary China at Peking University. The target population was mainland Chinese citizens aged 18 to 70 residing for more than 30 days in family dwellings in all 31 provinces. The survey used the GPS "assisted area sampling method" to project a grid onto 2855 counties, county-level cities or urban districts of the same status.[27] Stratification took place in stages. At the first stage, the country was divided into three official macro-regions, Eastern, Central and Western; each macro-region was divided into urban and rural administrative areas, giving six layers in total; 60 primary sampling units (PSUs) corresponding to county-level administrative divisions were selected at random across the six layers with probability proportionate to population. Within each PSU, three half-square minutes (HSMs) of latitude and longitude were chosen with probability proportionate to population density, within each of these, again proportionate to population density, a number of spatial square seconds (SSS) corresponding to 90m x 90m squares was selected at random. Within each SSS, all dwellings were enumerated, and 27 were selected in each HSM by systematic sampling. Within each dwelling respondents were identified by the Kish method. The completed questionnaires were collected, checked, and signed by the field supervisors on location and verified for validity during database creation. To minimize deviation from national 2010 census characteristics, weighting and post stratification was done by age and gender. The result was a sample of 5,424 dwellings in which 3,684 valid interviews were completed, giving a response rate of 67.9 per cent.

[26] Performance Evaluations, Trust and Utilization of Health Care in China Survey, 2012-13. Funded by the United Kingdom's Economic and Social Research Council, Grant No. ES/J011487/1. For more information, see: http://www.gla.ac.uk/petu.

[27] Landry, P. F., & Shen, M. (2005). Reaching Migrants in Survey Research: The Use of the Global Positioning System to Reduce Coverage Bias in China. *Political Analysis*, 13(1), 1-22.

Hypotheses

With so few studies of attitudes to inequalities in health care in China, we established our research hypotheses about whether people see their health system as unequal using academic studies and the expectations expressed in major Chinese government statements about the health care system and key health care policy documents.

In his 2004 survey, Whyte found that a majority of people (71 per cent) were aware of large national income inequalities, and since at least the mid-2000s the government has acknowledged inequalities in access to health care and the media have reported health system reform problems. We therefore expected that across the population a majority of ordinary people would see the health system as unequal on the dimensions established in scholarly research – though with the government more attentive to the plight of the poor and rural dwellers, we expected awareness of rich/poor and urban/rural differences to be higher than others. Specifically, our first hypothesis (*H#1*) was that *a majority of people see the health care system as providing unequally for especially for rich and poor, urban and rural residents, but also for civil servants and ordinary residents, men and women, migrants and non-migrants.*

But who is more likely to see the health care system as unequal? We hypothesized (H#2) that *the "losers" in each of these dyads (the poor, rural residents, "ordinary people", women and migrants) are more likely to see inequality* on "their" dimension of inequality.[28] But we also expected that some people's knowledge, experience or particular difficulties might make them more sensitive to inequalities. Specifically, we hypothesized (H#3) that *better educated people are more likely to be aware of inequalities, as are those with poor health and those who experience difficulties paying their medical costs. Older people with experience of the pre-reform era when there was more equality in terms of incomes and health care provision (at least within countryside and cities if not between them), were also hypothesized to be more likely to see inequalities*.

But are people unhappy, or at least concerned, about inequalities in access to health care? Chinese government statements are usually expressed only in general terms, but as indicated

[28] Drawing on Whyte, *The Myth of the Social Volcano*, p. 100. Research on inequalities in other societies has found that winners tend to think that their position has been fairly achieved, and that losers may be more discontented [add refs].

above, they reveal the government's concern that inequalities in health care across the population are destabilizing: in official parlance, extending basic health care provision to all is said to be necessary in order to maintain "social stability".[29] Whyte has argued, however, on the basis of his 2004 public attitudes survey that in fact Chinese people are surprisingly tolerant of inequalities. We therefore established our hypotheses about people's tolerance of inequalities and what influences their tolerance based on Whyte's earlier study. Whyte found that that overall, most people were not very disgruntled by income inequalities because they tended to think income inequalities were the result of talent or hard work.[30] We therefore hypothesized (H#4) that only "*a minority of the population will feel strongly that inequalities in access to health care between rich and poor are 'not right'".*

Overall levels of dissatisfaction with inequalities, however, cannot tell us who among the population are dissatisfied. Yet knowing who is dissatisfied is important for understanding potential sources of instability. Whyte found that urban residents, migrants and those with higher education were more critical of *income* inequalities than rural residents, non-migrants and the less well-educated.[31] Among subjective indicators, he found that those who reported that their family living standard had improved over the last few years were less critical of inequalities, as were those with high self-reported status.[32] Age, geographical region, and CCP membership had no influence. Based on these findings, we hypothesized (H#5) that "*the most dissatisfied with inequalities will be urban residents, migrants and those with higher education, as well as those who reported little improvement in family circumstances as well as those with lower self-assessed status".*

Findings

In what follows we present our preliminary analysis, testing our hypotheses using simple cross-tabulations and the Chi Square Test to assess the strength of the hypothesized association between variables. We will use these findings to develop models for the next

[29] [Add ref.] The definition of "basic" is never given.
[30] Say what his measure/evidence is. Whyte, M. K. (2010). *The Myth of the Social Volcano: Perceptions of Inequality and Distributive Justice in Contemporary China*. Stanford, CA: Stanford University Press. See also Whyte, M. K. (2010). Do Chinese citizens want the government to do more to promote equality? In P. H. Gries & S. Rosen (Eds.), *Chinese Politics: State, Society and the Market*. Oxford: Routledge. Han, C., & Whyte, M. K. (2009). The Social Contours of Distributive Injustice Feelings in Contemporary China. In D. Davis & F. Wang (Eds.), *Creating Wealth and Poverty in Postsocialist China* (pp. 193-212). Stanford: Stanford University Press.
[31] Whyte, *The Myth of the Social Volcano*, p. 114.
[32] Note that Whyte also found that those with high self-reported status were less critical.

stage of multivariate analysis where we will probe more deeply the strength of these associations.

Perceptions of inequalities in health care provision

To test our first hypothesis we analyzed a series of questions on the extent of inequality in access to health care. We had asked our respondents: "Comparing the situations of different groups of people in getting health care services, would you say that it is very unequal, somewhat unequal, fairly equal or very equal?" We then asked them to compare: "rich and poor people"; "urban and rural residents"; "civil servants and ordinary people"; "men and women", and "people from other provinces and local people". We found that a majority of people thought access was either very unequal or somewhat unequal across three out of the five dimensions, with 73 per cent seeing inequalities between rich and poor, 64 per cent seeing them between urban and rural dwellers, and 66 per cent seeing them between civil servants and ordinary people (see Table 1). A slightly smaller share of our sample, but a large minority (38 per cent), thought that there were differences between in-migrants and local residents. Only a minority (14 per cent) thought that there were inequalities between men and women.

To test our second hypothesis, we analyzed the responses on each dimension of inequality to assess whether the poor are more likely to feel there are rich/poor inequalities, rural residents are more likely to see urban/rural inequalities, ordinary people are more likely to see inequalities between themselves and civil servants, women are more likely to see gender inequalities, and in-migrants are more likely to see inequalities between migrants and locals. Here we report only our cross-tabulations of perceptions of (each dimension of) inequality with our hypothesized independent variables.

To assess the differences in the perceptions of "rich and poor" on the issue of rich/poor inequalities, we looked at the mean income of people who thought there was equality and compared it with the mean income of people who thought there was inequality on this dimension. We found that there was not a clear association, but that average household incomes were slightly lower for those who thought access was *very* equal and those who said they "did not know" (Table 2). We used household registration status – whether people were registered as "agricultural" or "non-agricultural" – to compare the views of rural and urban dwellers. We found that those with agricultural household registration (*nongye hukou*) were

significantly more likely than those with non-agricultural registration (*fei nongye hukou*) to think that access to health care was unequal (indeed *very* unequal) between urban and rural dwellers (see Table 3).[33]

To get at variance in perceptions of our third dimension of inequality we compared the views of those who worked (or had recently worked) in a "government or party organization" with those who had worked in organizations of other kinds ("other public sector", "private and foreign-invested", "individual and self-employed"). We found that those who had worked in the latter three kinds were more likely to think that there were inequalities in provision between civil servants and others (a majority of 74, 79 and 78 per cent respectively, compared with 63 per cent of those in government and party organizations). Those who worked in party or government organizations were less likely to think that access was *very* unequal between civil servants and ordinary residents, and slightly more likely to think that it was "fairly equal" (Table 4).[34] Women were slightly (but not significantly) more likely than men to think there were gender inequalities (Table 5). To distinguish the views of migrants and non-migrants we compared the views of people with their household registration in another province or city, or another county/city in the province and from the same county/city where the interview took place. We found that those from outside the province or city were more likely than those with local *hukou* to feel there were inequalities in health security between migrants and local people (Table 6). [35]

To test our third hypothesis we cross-tabulated perceptions of inequalities between rich and poor with age cohorts, level of education, with whether or not people had difficulties paying their health bills, and with people's self-assessed health. We found that those with university education were more likely to think there was inequality on this dimension (Table 7), as were those who had difficulties paying their health bills (Table 8), and those with *very* poor self assessed health were more likely to see health care provision between rich and poor as *very* unequal (Table 9). There was an association with age, but it was the opposite of that

[33] Migrants (people with *hukou* in a different county, city or province from where they were living at the time of the interview) were also more likely to think there were urban/rural inequalities.

[34] [Run SPSS macros for significance testing" (copyright Gwilym Price).] CCP members were significantly less likely to think that there were inequalities civil servants and others.

[35] We classified as 'migrants' those with *hukou* in 'another county or city in this province' or 'in another province or city' (QA5). We classified as 'locals' people with *hukou* in the same county or city, including those who said their *hukou* was in 'this village or urban district', 'another village or urban district in this town/city', 'another town/urban district in this county/city'.

hypothesized: rather than older cohorts, those born in the 1940s and 1950s and so with experience of the more egalitarian Maoist era, seeing greater inequalities, it was the younger cohorts, those born in the 1980s and 1990s who were more likely to view access to health care as unequal – and especially as *very* unequal (Table 10).

Attitudes toward health care inequalities

To test our fourth hypothesis that a minority of the population will feel strongly that health care inequalities are "not normal" across each of our dimensions, we asked our respondents "In a developing country such as ours, would you say that it is completely normal, mostly normal, somewhat abnormal, completely abnormal that rich people can receive better health care than other people?[36] We found that overall 36 per cent of our sample thought that inequalities in access to health care between rich and poor people were "normal", while 34 per cent thought that they were "abnormal" (Table 11).

To test our fifth hypothesis that urban residents, migrants and those with higher education, as well as those who reported little improvement in family circumstances and low status, would be more likely to think that inequalities are "normal", we cross-tabulated views on inequalities with type and location of *hukou*, highest level of education, self-reported family circumstances over the last five years and self-reported status. We found that urban residents (with non-agricultural *hukou*) were more likely to think that inequalities were not "normal", though those with agricultural *hukou* are not significantly more critical – they are just more likely to answer "don't know" (Table 12). They were also more likely than their urban counterparts to answer "don't know" on questions about inequalities between urban and rural areas (Table 13). Migrants, however, were not more critical or rich/poor inequalities in access to health care (though they *were* significantly more critical of differences between migrants and locals) (Table 14). Level of education did make a difference, but it both increased the likelihood that people would see inequality as normal *and* (to a lesser extent) that they would see it as abnormal – this is because those with lower education were more likely to respond "don't know" (Table 15). Finally, we looked at subjective indicators. We found that there was no significant association overall between those who reported their household economic circumstances had improved over the last five years and those who thought that it had got

[36] In Chinese, we used the word '正常', which translates into English as 'normal' in the sense of 'proper' or 'right'.

worse (Table 16).[37] But the picture among people reporting different assessments of their social status was complex. Those reporting lower status were overall slightly more likely to see inequalities between rich and poor as "normal" than abnormal, and those reporting higher status were more likely to see them as "abnormal", and it was those who saw their status as in the middle who were more likely to see the inequalities as "normal" compared to the average (Table 17).[38]

Discussion and conclusions

Almost four years after the central government announced a new round of health reforms aimed at extending access we find that a large majority of the population still views access as unequal between rich and poor and between urban and rural residents. It seems, however, that there is not just awareness of the more publicised issues of unaffordable care for those on low incomes and the systemic differences between the cities and countryside. People also see inequalities between civil servants and the rest of the population – and are more aware of these than of inequalities between migrants and locals, men and women. This may indicate a general cynicism about official privilege at a time when corruption is high profile, but it also indicates blindness to the disadvantaged situation faced by migrants and women.

As hypothesized, we found, however, that the "losers" on our inequality dyads are not so blind, and tended to be more likely than the winners to see inequalities. Those seeing the inequalities between rich and poor as "very unequal" had lower average incomes, while those with agricultural household registration, "ordinary people" and women and migrants tended to feel the health system provided less well for them. In addition, reform "losers" more generally, were more likely to see health system inequalities, as well as those who said they were unable to afford their medical bills and those with poor self-assessed health. But some "winners" – those with higher education – were also more likely to think there were inequalities. In the next stage of our analysis we will test the robustness of these associations.

While it is significant that a majority of the population today see the health system as unequal on several dimensions, it is important to know who is disgruntled with such inequalities. Our

[37] Note though that those who thought their circumstances were "much worse" now, were more likely to think inequality was not normal as well as more likely to say '"don't know".

[38] Using a finer-grained seven-point scale it seems that those at the top of the scale were likely to see inequalities as abnormal, but who put themselves on point 6 were more likely to think access was equal and abnormal. However, the counts for these categories were small. We need to further analyze these data.

analysis in this paper has focussed primarily on the rich/poor dimension (though we do intend in due course to investigate the others), and on that we found a slightly higher proportion of the population to be dissatisfied than did Whyte in his study of income inequalities, with more than a third feeling that the inequality was not '"normal" or "right". We found also that although urban residents were slightly more likely than their rural counterparts to see the inequalities as "abnormal", they were also more likely than their rural counterparts to see the inequalities as "normal". This is in part because rural residents were more likely to say that they "did not know". Urban dwellers were, moreover, more likely to see urban and rural access to health care as "equal but abnormal", further undermining the conventional picture of them as more critical of inequalities. But we found that rather than differences between urban and rural registration being the most important influence on dissatisfaction, it was the recent trend in household economic circumstances that seemed to matter most. Those whose families were worse off now than five years ago were more likely to be dissatisfied with inequalities between rich and poor – so that trajectory rather than self-assessed status (or current level of income) seems to be important. We will probe this factor and tolerance of the other dimensions of inequality further in the next stage of our analysis.

Appendix 1

Table 1 Perceptions of the extent of inequality between rich/poor, urban/rural, civil servants/ordinary people, men/women, migrants/locals

% of all responses within each dimension of inequality

	Rich/poor	Urban/ rural	Civil servants/ ordinary	Men/ women	Migrants/ non-migrants
Very unequal	24	12	19	2	5
Somewhat unequal	49	52	47	12	33
Fairly equal	18	25	18	61	37
Very equal	2	2	2	17	5
Don't know/ Refused	7	9	14	9	20
Total	**100**	**100**	**100**	**100**	**100**

Note: figures are rounded and so may not add up to 100%.

Table 2: Average household income different perceptions of inequality between rich and poor

Extent of inequality in access to health care: rich and poor	Mean income (thousand yuan)	N
Very unequal	53	860
Somewhat unequal	58	1792
Fairly equal	51	658
Very equal	48	73
Don’t know	43	255
Refuse to answer	57	41
Average/Total	54	3679

Note: figures are rounded and so may not add up to 100%.

Table 3 Non-agricultural and agricultural hukou * Extent of inequality in access to health care between urban and rural residents

% within hukou type

	Extent of inequality in access to health care: urban and rural residents				
	Very unequal	**Somewhat unequal**	**Fairly equal**	**Very equal**	**Total**
Agricultural	15	58	25	2	100
Non-agricultural	10	56	30	3	100
Average across whole sample	*14*	*57*	*27*	*2*	*100*

$X^2 = 26.45$ ($p = .000$)

Note: figures are rounded and so may not add up to 100%.

Table 4 Workplace type * Extent of inequality in access to health care between civil servants and ordinary people

% within in workplace type

	Extent of inequality in access to health care: civil servants and ordinary people				
	Very unequal	**Somewhat unequal**	**Fairly equal**	**Very equal**	**Total**
Party of government organ	12	51	35	2	100
Other public sector	23	51	24	3	100
Private, foreign-invested	22	57	18	2	100
Individual, self-employed	22	56	21	2	100
Average across whole sample	*22*	*55*	*21*	*2*	*100*

$X^2 = 16.58$ ($p = .056$)

Note: figures are rounded and so may not add up to 100%.

Table 5 Gender * Extent of inequality in access to health care between men and women

% within in gender

	Extent of inequality in access to health care: men and women				
	Very unequal	**Somewhat unequal**	**Fairly equal**	**Very equal**	**Total**
Female	3	15	64	18	100
Male	1	12	68	18	100
Average across whole sample	*3*	*13*	*66*	*18*	*100*

$X^2 = 10.71$ ($p = .013$)

Note: figures are rounded and so may not add up to 100%.

Table 6 Location of *hukou* * Extent of inequality in access to health care between migrants and local people

% within *hukou* location

	Extent of inequality in access to health care: people from other provinces and local people				
	Very unequal	**Somewhat unequal**	**Fairly equal**	**Very equal**	**Total**
This town/city	6	40	47	7	100
Another county/city in this province	8	49	37	6	100
Another province/city	12	53	32	2	100
Average across whole sample	*6*	*42*	*46*	*7*	*100*

$X^2 = 42.95$ ($p = .000$)

Note: figures are rounded and so may not add up to 100%.

Table 7 Highest education achieved * Extent of inequality in access to health care between rich and poor

% within highest level of education achieved

	Extent of inequality in access to health care: rich and poor				
	Very unequal	**Somewhat unequal**	**Fairly equal**	**Very equal**	**Total**
Primary or less	25	52	21	2	100
Junior high	25	54	19	3	100
Senior high, technical	28	51	20	1	100
University	30	57	13	1	100
Average across whole sample	*26*	*53*	*19*	*2*	*100*

$X^2 = 25.51$ ($p = .002$)

Note: figures are rounded and so may not add up to 100%.

Table 8 Ability to pay health bills * Extent of inequality in access to health care between rich and poor

% within ability to pay health bills

	Extent of inequality in access to health care: rich and poor				
	Very unequal	**Somewhat unequal**	**Fairly equal**	**Very equal**	**Total**
We can afford our family medical bills easily	20	54	24	2	100
We can afford our family medical bills, but with difficulty	27	54	17	2	100
We struggle to find ways to pay our family medical bills	33	50	15	3	100
We cannot afford our family medical bills	58	33	8	2	100
Average across whole sample	*26*	*53*	*19*	*2*	*100*

$X^2 = 84.097$ ($p = .000$)

Note: figures are rounded and so may not add up to 100%.

Table 9 Self-assessed health over last year * Extent of inequality in access to health care between rich and poor

% within self-assessed health category

		Extent of inequality in access to health care: rich and poor				
		Very unequal	**Somewhat unequal**	**Fairly equal**	**Very equal**	**Total**
Health	Very good	31	48	17	3	100
	Good	23	55	21	2	100
	Average	27	55	16	2	100
	Poor	31	47	19	3	100
	Very Poor	47	30	17	7	100
Average across whole sample		*26*	*53*	*19*	*2*	*100*

$X^2 = 49.19$ ($p = .000$)

Note: figures are rounded and so may not add up to 100%.

Table 10 Age cohort * Extent of inequality in access to health care between rich and poor

% within age cohort

		Extent of inequality in access to health care: rich and poor				
		Very unequal	**Somewhat unequal**	**Fairly equal**	**Very equal**	**Total**
Age cohort	Born 40s, 50s	22	56	20	2	100
	Born 60s, 70s	26	51	21	2	100
	Born 80s, 90s	29	53	16	2	100
Average across whole sample		*26*	*53*	*19*	*2*	*100*

$X^2 = 17.84$ ($p = .007$)

Note: figures are rounded and so may not add up to 100%.

Table 11 Inequality between rich and poor: extent*acceptability

% across sample

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Unequal but normal	1304	36	36	36
	Equal and normal	293	8	8	44
	Unequal and abnormal	1233	34	34	78
	Equal but abnormal	363	10	10	88
	DK/na on both	430	12	12	100
	Total	*3624*	*100*	*100*	

Note: figures are rounded and so may not add up to 100%.

Table 12 Agricultural or non-agricultural hukou * Inequality between rich and poor: extent * acceptability Crosstabulation

% within hukou type

		Inequality between rich and poor: extent*acceptability					
		Unequal but normal	Equal and normal	Unequal and abnormal	Equal but abnormal	DK/na on both	Total
Hukou type	Agricultural	34	9	33	10	14	100
	Non-agricultural	40	7	36	9	8	100
Total		*36*	*8*	*34*	*10*	*12*	*100*

Note: figures are rounded and so may not add up to 100%.

Table 13 Agricultural or non-agricultural *hukou* * Inequality between urban and rural: extent*acceptability Crosstabulation

% within agricultural or non-agric *hukou*

		Inequality between urban and rural: extent*acceptability					
		Unequal but normal	Equal and normal	Unequal and abnormal	Equal but abnormal	DK/na on both	Total
Agricultural or non-agricultural *hukou*	Agricultural	26	8	37	14	15	100
	Non-agricultural	23	10	37	20	9	100
Total		*25*	*9*	*37*	*16*	*13*	*100*

Table 14 Hukou location * Inequality between rich and poor: extent*acceptability Crosstabulation

% within location of hukou

		Inequality between rich and poor: extent*acceptability					
		Unequal but normal	Equal and normal	Unequal and abnormal	Equal but abnormal	DK/na on both	Total
Hukou location	This town/city	35	8	34	10	12	100
	Another county/city	43	6	35	9	8	100
	Another province/city	45	6	31	10	9	100
Total		*36*	*8*	*34*	*10*	*12*	*100*

Note: figures are rounded and so may not add up to 100%.

Table 15 Highest level of education * Inequality between rich and poor: extent*acceptability Crosstabulation

% within level of education

		Inequality between rich and poor: extent*acceptability					
		Unequal but normal	Equal and normal	Unequal and abnormal	Equal but abnormal	DK/na on both	Total
Education collapsed	Primary or less	31	9	31	10	19	100
	Junior high	38	8	33	11	10	100
	Senior high, technical	36	8	37	11	8	100
	University	44	7	37	5	7	100
Total		*36*	*8*	*34*	*10*	*12*	*100*

Note: figures are rounded and so may not add up to 100%.

Table 16 Family compared five years ago * Inequality between rich and poor: extent*acceptability Crosstabulation

% within family compared five years ago

		Inequality between rich and poor: extent*acceptability					
		Unequal but normal	Equal and normal	Unequal and abnormal	Equal but abnormal	DK/na on both	Total
Family compared five years ago	Better now	36	9	34	10	11	100
	Same	36	8	33	9	14	100
	Worse now	32	5	41	9	1 3	100
Total		*36*	*8*	*34*	*10*	*12*	*100*

Note: figures are rounded and so may not add up to 100%.

Table 17: Self-assessed status * Inequality between rich and poor: extent*acceptability Crosstabulation

% within Self-assessed status

		Inequality between rich and poor: extent*acceptability					
		Unequal but normal	Equal and normal	Unequal and abnormal	Equal but abnormal	DK/na on both	Total
Self-assessed status collapsed	Lower status	36	8	33	10	13	100
	Middle	38	9	35	10	7	100
	Higher status	32	9	37	12	10	100
Total		*36*	*8*	*34*	*11*	*11*	*100*

Note: figures are rounded and so may not add up to 100%.