

Reaffirming personal responsibility in healthcare in China: Theoretical reflections and practical implications*

* This chapter is based on a published paper. Alternations have been made for the sake of integrality.

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ABSTRACT

Aim: This chapter aims to answer the question: *To what extent should personal responsibility be addressed in advancing the reform of the Chinese healthcare system?*

Background: Great achievements have been made by China's healthcare system since it started its first round of reform in 1978. However, a number of problems such as 'to see a doctor is difficult, to see a doctor is expensive' are remaining, which indicates that reform efforts are still insufficient and future steps may need to be taken in an innovative way.

Methods: Theoretical analysis is employed to clarify certain conceptions and to explore the reasoning behind certain reform measures. Historical analysis is also adopted to track the development of China's healthcare system and thereby form the contextual basis for future innovative healthcare reform.

Findings: Addressing state accountability in health and healthcare is widely accepted and discussed in literature while personal responsibility receives relatively less attention. A back-and-forth feature of reform has been identified after a historical analysis of China's healthcare system development. Given that new challenges occur along with the ageing population and the increasing burden of non-communicable diseases, it is unlikely to succeed if reform efforts continued to merely focus on addressing the responsibility of the state. Reform attention needs to be switched to encourage people to be responsible for their own health, namely to play an active role in taking care of their own health. All in all, addressing personal responsibility in health and healthcare should be an integral part of China's healthcare system.

Keywords: China's healthcare system, reform, state accountability, personal responsibility

2.1 INTRODUCTION

In literature, discussions mainly focus on addressing state accountability in protecting and promoting the right to health (Chapman, 1994, 2010; Chapman et al., 2015; Toebes, 1999a, 1999b, 2006, 2015; Daniels, 2001, 2008, 2011; Fisher et al., 2010; Schrecker et al., 2010). Yet, under the influence of inefficient utilisation and the free-rider problem²⁸, protecting and promoting the right to health through emphasising the state accountability corresponds poorly with reality. Situations are likely to be even worse after healthcare systems encounter new problems caused by the ageing population and the increasing burden of non-communicable diseases. Thus, it is time to bring other stakeholders into account. Given that individuals are believed to have a great control over their own health whereas the active role that individuals can play in healthcare system reforms has long been simply overlooked, this chapter aims at addressing this gap and then provides recommendations on how and where personal responsibility should be addressed in health policies in China. Furthermore, considering the diversified conditions of healthcare systems, this chapter mainly embeds discussions in the context of the Chinese healthcare system. Although recommendations for policy options are largely context-based, other nations can still draw meaningful lessons from this study.

2.2 A CASE STUDY OF THE CHINESE HEALTHCARE SYSTEM

2.2.1 Basic structure

From a macro perspective, the Chinese healthcare system has a multilevel structure, including a public health service system, a medical care system and a medical security system. It is also a hybrid of public and private elements, allocating healthcare resources via state intervention and market transactions (Ho, 2014). Specifically, the public health service system with a nationwide function accounts for ‘disease prevention and control, health education, maternity and child care, mental health, health emergency response, blood collection and supply, health supervision, and family planning as well.’²⁹ Unlike the public health service system, the medical care system is constructed differently in rural and urban China. In rural areas, medical care is mainly delivered by three institutions: the county hospitals, the township hospitals and the village clinics. In urban China, however, medical care is delivered by the general hospitals and the specialised hospitals. Besides the above regular medical institutions, several community clinics have emerged to take care of the preliminary diagnosis and treatment of

28 The free-rider problem often occurs when people benefit from certain kinds of goods but do not pay for them, which brings about an underprovision of these goods or public services. For detailed discussion, please refer to William (1965).

29 Information Office of the State Council. (2012). White Paper on Medical and Health Services in China. Please refer to http://xinhuanet.com/politics/2012-12/27/c_124156559.htm (last accessed 24 March 2019).

certain ordinary illnesses, such as colds and fever. With regard to the medical security system, it is a multilevel insurance scheme that comprises three basic health insurance schemes: the urban resident basic medical insurance scheme (URBMI), the urban employee basic medical insurance scheme (UEBMI) and the new rural cooperative medical system (NRCMS). In 2012, nearly 95% of Chinese people were under the protection of these three basic health insurance schemes. Despite the high rate of health insurance coverage, the Chinese healthcare system still faces with great challenges posed by both old problems, such as ‘to see a doctor is difficult, to see a doctor is expensive’ (看病难, 看病贵), and new problems such as the ageing population and the increasing burden of non-communicable diseases.³⁰

From a micro perspective, the Chinese healthcare system is special in terms of its financial support and administrative structure, as well as legal regulations. These special aspects in turn aggravate the existing formidable problems over time. First, the financial budget is mainly guaranteed by local governments rather than by central government. As a consequence, health policies launched by central government are carried out unevenly from province to province, which results in an increasing geographical disparity in healthcare delivery and becomes a crucial impediment to equal access to healthcare. Second, the Chinese healthcare system is administrated uniquely. Nearly all of the general hospitals in China are state-owned institutions (公共事业单位), which refers to organisations that are established by the government with state-owned facilities. Furthermore, the employees of these organisations enjoy the same welfare conditions as civil servants (Ho, 2014). Third, the legislative and judicial supports for the Chinese healthcare system are far from adequate. The Chinese healthcare system performs poorly when it relates to judicial remedy because China’s judicial system has often been criticised for lacking independence from the government (Liu, 2015, p. 440). According to an authoritative statistic, most health-related cases are solved without resorting to judicial process but through petition (上访). Compared to going through the judicial process, the petition (上访) is believed to be a more accessible and friendly alternative. It depends on an administrative system called ‘letters and visits’ (信访) which allows citizens to solve their conflicts by means of writing a letter of complaint or visiting certain departments of the government directly for redress (Ho, 2014, p. 273). Yet, patients often feel reluctant to use the petition (上访) as well, due to the fact that the government actually plays not only as an executant but also as a supervisor of the Chinese healthcare system. As a consequence, conflicts between doctors and patients cannot be released properly, which eventually results in threats or violence against doctors and other medical staff (Hesketh, 2012). All these tough issues mentioned above are de facto incentives triggering the progressive reforms of the Chinese healthcare system.

30 The World Bank Group, World Health Organization, China’s Ministry of Finance, National Health and Family Planning Commission, and Ministry of Human Resources and Social Security. Healthy China: deepening health reform in China, at xv–xvi. Please refer to <http://www.wpro.who.int/china/publications/2016-health-reform-in-china/en/> (last accessed 24 March 2019).

2.2.2 Progressive reforms and the back-and-forth feature

The principle of solidarity has a long history of being valued by Chinese society. Influenced by this principle, it is the government that plays a leading role in nearly all kinds of social services in China (Yip & Hsiao, 2015). Almost every aspect of social life is controlled by state-owned enterprises, which are de facto established, managed and monitored by the government. In healthcare, the financial budget was adequate because priority was given to a nationwide coverage rather than the quality of service. The annual reports show a great decrease in mortality and a steady increase in life expectancy.³¹ Apparently, the healthcare system functioned well at the very beginning without any noticeable problems concerning availability and affordability (financial accessibility). However, developments are accompanied by some hidden troubles. The first trouble relates to the ‘barefoot doctor’ (赤脚医生). It represents a group of people who have not received formal education but are in charge of providing healthcare for people living in the rural areas of China. Along with the establishment of a cooperative healthcare scheme (合作医疗) and a three-tier preventive healthcare net (三层保障), the mechanism of healthcare in rural China was recommended by the WHO as a model at that time. Yet, as time goes on, the legitimacy of the barefoot doctors’ medical practices has become questionable, which has turned out to be an impediment threatening the whole healthcare system of rural China. The second trouble relates to the financial budget. The national coverage of healthcare was achieved on a rather low level. Every small increase in the quality of healthcare demands a large additional financial support. These increasing demands might put the realisation of other social goods on hold. The third trouble relates to inefficient utilisation. Inefficient utilisation is not a special issue that merely happens in the sphere of healthcare, but the entire Chinese society suffers from it in different ways. The lack of competition threw the state-run centrally planned strategy into a tight corner, which unexpectedly simulates free market thinking.

The first round of healthcare system reform was initiated in 1978. At that time, the Chinese government liberalised its economic system from a central-planning economy to a socialistic market economy, with a premise that the free market should be more productive by virtue of efficient distributive mechanisms. It is certainly an innovative strategy, trying to find a third way to balance the government’s central planning and the free market mechanism in the context of China. Furthermore, the Chinese government became increasingly active in the international arena at that time, signing a series of international documents³² and mak-

31 According to the analysis conducted by Yip & Hsiao (2015) pp. 54–55, infant mortality has decreased ‘from 200 to 57 per 1,000 while the life expectancy has extended from 45 to 68 years.’ Data is available online, please refer to <http://esa.un.org/wpp/> (last accessed 24 March 2019).

32 Those international documents are issued from diverse perspectives. The following list of documents with signifying/ratifying time in brackets is only concerning the field of healthcare. The International Convention on the Elimination of All Forms of Racial Discrimination (only ratifying in 1981); The International Covenant on Civil and Political Rights (only signifying in 1998); International Covenant on Economic, Social and Cultural

ing great efforts to cooperate with the international community. With such a background, the first round of healthcare system reform was launched. Consistent efforts were devoted to various aspects, including slowing down the increasing financial budget and modifying the salary structure of physicians. During that time, public hospitals were changed from 'public good-oriented' institutions into 'for-profit' entities. Undeniably, achievements were made. For instance, the life expectancy grew to 71.8 years in 2001, higher than the average of the whole world (65 years) (Wang, 2004). Nevertheless, deficiencies were obvious. First of all, efficiency might be improved at the expense of fairness in distributing healthcare. Although the market mechanism in China had a due consideration to fairness, it still gave priority to efficiency.³³ Addressing the market mechanism intensifies the tendency to treat healthcare as a kind of exchangeable commodity, which implied that the ability to pay decides the allocation of healthcare resources. Yet, healthcare is special. Humane caring cannot be abandoned when distributing healthcare. As a response, a mechanism of price control was put forward by central government with the aim of protecting vulnerable groups from the potential side effects of the market mechanism. However, the price controlling mechanism unexpectedly contributed to the practice of compensating for low health services charges with high drug prices (以药补医). Compensating for low health services charges with high drug prices (以药补医) allowed the public hospitals to make extra profits through prescriptions, which unexpectedly strengthened the interest in relations between physicians, hospitals and pharmaceutical companies. It deviated public hospitals from their original goals (i.e. curing and caring) and drove them crazy to make as much money as possible. The increased medical expenses, which often could not be reimbursed by the three basic insurance schemes, became the financial burden that was ultimately placed on the patients.³⁴ If a family member unfortunately suffers from an incurable disease, such as cancer, it would be equal to bankrupting their family due to the catastrophically expensive healthcare. Even worse, due to a lack of effective regulations, the market mechanism opened the door to corruption in healthcare, such as the so-called red envelope (红包) custom. The red envelope (红包) custom created an extra financial burden for patients and their families. The potential heavy financial burden made people, especially the worse off, hesitant to access healthcare. Furthermore, it caused healthcare disparities to be more pronounced, not only geographically but also in terms of

Rights (1997/2001); Convention on the Elimination of All Forms of Discrimination against Women (1980/1980); Convention on the Rights of the Child (1990/1992); Convention on the Rights of Persons with Disabilities (2007/2008).

33 'Give priority to efficiency with due consideration to fairness' was first put forwarded by the 14th National Congress of the Communist Party of China as a solitary principle and then reaffirmed by the 15th National Congress of the Communist Party of China. For detailed explanation, please refer to Zhang & Chang, (2016) p. 47.

34 According to the National Bureau of Statistics of China, patients paid 20% of total health expenditure out-of-pocket in 1978 while they shouldered 60% in 2001. For more information, please refer to National Bureau of Statistics of China. (2011).

wealthy and poverty. These problems were aggravated after the epidemic of SARS in 2003. Some scholars argued that it was the market-oriented reform that deteriorated the situation (Liu, 2004; Wang, 2004; Li et al., 2012). Seemingly, this round of reform led the Chinese healthcare system to the other extreme where too much emphasis was given to marketability and therefore inevitably resulted in overriding the right to health of patients.

To deal with these parameters that emerged in the first round of reform, the Chinese government planned to reshape the whole healthcare system with an aim to provide safe, efficient and affordable basic healthcare for all Chinese residents by 2020. It was a starting point of the second round of reform, launched in 2009. Besides the regular budget, an extra amount of 850 billion Chinese yuan has been committed to support the coming round of reform (Meng & Tang, 2013, p. 331). Going over all the efforts, the second round of reform moved backwards to emphasise the state accountability in distributing healthcare. Influenced by the *Primary Health Care*³⁵ project of the World Health Organization, the fundamental goal of the Chinese healthcare system was readjusted to guarantee a decent minimum of care. To achieve this goal, the Chinese government reaffirmed its obligation and increased its financial budget for healthcare. According to authority reports, the total amount of healthcare expenses in China was on the rise, occupying 5.57% of GDP in 2013. Among these healthcare expenses, the expenditure of the Chinese government accounted for 30.1%, which is 2.6% higher than in 2009 (Fang, 2015, p. 38). Guaranteed by virtue of the government, nearly all of the Chinese people could get access to the basic healthcare. Nevertheless, the quality of healthcare still needs to be improved according to the AAAQ standards. One possible reason is that 'a decent minimum' has a drawback that it might limit the scope and the content of the state-supported healthcare. The majority of costly diseases are actually not on the list of diseases that can be reimbursed. As a consequence, many patients still suffer from catastrophically expensive medical services. In addition, there are two contradictions. One is that the majority of healthcare demands are converged to large hospitals where medical facilities are believed to be the most advanced, while very few medical functions are used by hospitals and clinics in the countryside. The other contradiction is that the number of physicians is decreasing while the number of patients is increasing. As mentioned before, the 'barefoot doctors' (赤脚医生) used to be the major force in providing healthcare for people living in rural China. However, they are no longer allowed by law to practice healthcare these days, which results in a lack of health personnel in rural China. Meanwhile, urban China also confronts the same problem but for different reasons. It is partially because of the decreasing number of medical graduates; the high risk but unstable income makes people reluctant to choose the medical profession as a lifelong career.

Reacting to this, the Chinese government planned to take extra steps to deepen the healthcare system reform in 2014. Among newly issued reform measures, major steps in-

35 Please refer to <http://www.who.int/whr/2008/en/> (last accessed 24 March 2019)

clude formulating a system of tiered diagnosis and treatment (分级诊疗), reorganising the institutional structure of public hospitals, and abolishing the practice of compensating for low health service charges with high drug prices (以药补医). Yet, none of them is easy to achieve. Taking the practice of compensating for low health service charges with high drug prices (以药补医) as a simple illustration, it is tough to abolish a system as such. This is not only because of the existing solid interest in relations but also due to the fact that the practice of compensating for low health services charges with high drug prices' (以药补医) accounts for one part of physician's income. Unfortunately, there is no alternative way except increasing the financial budget to make up that part. However, healthcare is not the only good that needs financial support from the government. The increased financial budget on healthcare might negatively influence the realisation of other social goods. This is the problem that the Chinese healthcare system had met before the first round of reform.

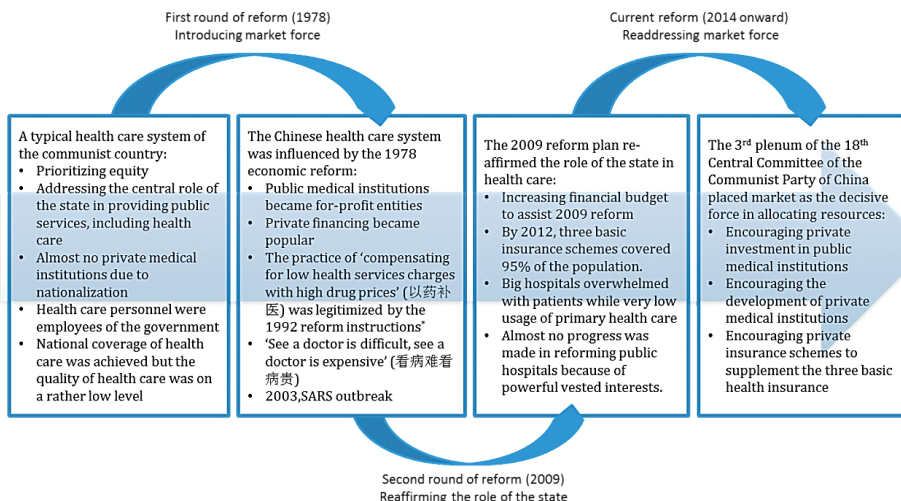


Figure 2.1 Progressive Chinese healthcare system reforms

* In 1992, the State Council launched *Opinions on further reforming healthcare systems*. This government document stimulated the profit-seeking behaviours of public medical institutions. For more information, please refer to <http://www.reformdata.org/content/19920923/25367.html> (in Chinese, last accessed 24 March 2019)

Source: Yip & Hsiao (2015).

Drawing from the progressive Chinese healthcare system reforms, it is easy to observe that reforms hitherto present a back-and-forth feature (Figure 2.1): from addressing the role of the state (1949–1978) to introducing market forces (1978), then to reaffirming the role of the state (2009), then to readdressing the decisive role of market in allocating resources (2014).

The rationale behind the back-and-forth feature is essentially a trade-off between two driving forces – the state and the market – for Chinese healthcare system reforms. Owing to

such a trade-off relationship, big achievements have been made over the past few decades. Yet, old problems, such as ‘to see a doctor is difficult, to see doctor is expensive’ (看病难, 看病贵), remain largely unsolved and, therefore, raise a question for consideration: besides the state and the market, are there any powerful forces that actually play an essential role in Chinese healthcare system reforms but have long been overlooked?

2.3 ADDRESSING PERSONAL RESPONSIBILITY IN HEALTHCARE

Scholarly literature has proved that there exists a causal relationship between disfavoured habits (e.g. excessive smoking, eating disorders and alcoholism) and certain kinds of chronic diseases (e.g. lung cancer, cardiovascular diseases and obesity).³⁶ In this regard, it is safe to claim that people do have a great control over their health status. Yet, the active role that individuals can play in healthcare system reforms has long been simply overlooked because addressing the responsibility of the state (often known as ‘state accountability’) to protect and promote the healthcare interests of individuals is regarded as the mainstream. Thus, discussions in this section mainly focus on addressing personal responsibility in healthcare with special attention given to both theoretical and applied aspects.

In a general sense, addressing personal responsibility in healthcare means to hold individuals accountable for their own health. However, this general definition leaves some ambiguity, such as when it is just to address personal responsibility in healthcare and how to address personal responsibility in ways that are just. Before embarking on the applied aspect (i.e. developing policy recommendations), it is important to have some theoretical reflections on what the personal responsibility is in the sphere of healthcare and the necessity of addressing personal responsibility in promoting healthcare delivery.

2.3.1 Theoretical reflections on personal responsibility in healthcare

In theory, how to place personal responsibility fairly in health policies and practices has long been the key question for many prominent philosophical traditions, including liberal egalitarianism (Cappelen & Norheim, 2005, 2006), luck egalitarianism (Dworkin, 2000; Cohen, 2008; Roemer, 1993; Arneson, 1989; Knight, 2009; Knight & Stemplowska, 2011; Segall, 2007, 2009) and communitarianism (Callahan, 2003).

36 For detailed discussion, please refer to Watson & Conte, (1954); Rehm et al., (2009); Brownell & Walsh, (2017).

Liberal egalitarianism

Liberal egalitarianism is a theoretical approach that mainly focuses on assessing the direct relationship between health disadvantages and individual choices. According to liberal egalitarianism, people should be responsible for their health-related choices, but not necessarily for the consequences of these choices (Cappelen & Norheim 2005, p. 478). To a larger extent, society should concentrate on eliminating the inequalities in health that arise from individual choices but not from factors that are out of individual control, namely, circumstances (Cappelen & Norheim 2006, p. 313). By taking this standpoint, liberal egalitarianism sets itself apart from typical liberal arguments and thereby largely escapes the critique that risky behaviours are hardly recognised as the direct and sole factor to negative health outcomes. With regard to how to place personal responsibility fairly in related policies and practices, Cappelen & Norheim (2005, p. 479) who are active proponents of liberal egalitarianism, are in favour of using a tax mechanism to hold people accountable for their health-related choices. That is, it is legitimate for the government to tax people's unhealthy choices beforehand while guaranteeing equal access to treatment for all people.

Nevertheless, criticisms such as 'bottomless pit' (Buyx, 2008, p. 872), 'coherence, non-monetary shortage and ignoring social determinants' (Albertsen, 2016, pp. 563–565), increasingly appear in scholarly literature which suggest the need for further perfection.

Luck egalitarianism

Luck egalitarianism is a theoretical framework that assigns personal responsibility a central role to play in assuring the distributive justice of healthcare. Despite a variety of ideals,³⁷ luck egalitarians have reached a consensus on one basic claim: it is morally unacceptable that people suffer from inequalities in care caused by factors that are beyond their control (Segall, 2009). Being sensitive to individual choices can be traced back to a special distinction between 'brute luck' and 'option luck' developed by Ronald Dworkin.³⁸ According to Dworkin, a just society should be sensitive to people's voluntary choices ('option luck') while remaining insensitive to their 'brute luck' when distributing resources.³⁹ Taking tobacco use as an example, according to the data collected by the WHO more than 1.1 billion people smoked tobacco worldwide in 2015 and up to half of tobacco users died from smoking.⁴⁰ If an individual chooses to smoke

37 There are diverse views of luck egalitarianism. They are different from one another primarily on the way of advocating equality. For instance, Ronald Dworkin's *equality of resources*; Richard Arneson's *equality of welfare*; G. A. Cohen's *equality of access to advantages*; Eric Rakowski's *equality of fortune*; John Roemer's *equality of opportunity*.

38 According to Dworkin, 'option luck is a matter of how deliberate and calculated gambles turn out ... Brute luck is a matter of how risks turn out which are not in that sense deliberate gambles.' Please refer to Dworkin (2000), p. 73.

39 Dworkin, (2000). *Sovereign virtue*, p. 334. Cambridge, MA: Harvard University Press.

40 For more information about the prevalence of tobacco and tobacco control, please refer to <http://www.who.int/gho/tobacco/use/en/> (last accessed 24 March 2019) and <http://www.who.int/mediacentre/factsheets/fs339/en/> (last accessed 24 March 2019).

tobacco with full awareness of possible health disadvantages, then this option is like taking a gamble on their health. If they lose the gamble (i.e. health problems happen), that person should be held accountable for the loss, not the healthcare system or even the community.

Yet, this argument generates some difficulties. One major difficulty relates to the causal relationship between individual choices and health problems because health problems are often caused by complex factors. Factors other than individual choices (e.g. gene structure) may be the key driving force for diseases. Furthermore, criticised by Buyx (2008, p. 872), merely relying on the criterion of 'free choice' not only makes luck egalitarianism a one-sided theory, but also would make it easily fall into a situation where one can either 'choose freely' or 'not choose at all'. Another strong critique is raised by Elizabeth Anderson. She argues against luck egalitarianism by expressing her special concern for 'negligent victims' and the Good Samaritan (Anderson, 1999). According to her analysis, using the principle of free choice to distribute healthcare would increase the risk of abandoning people who freely choose to sacrifice themselves for the sake of other people's interests (or rights).

Communitarianism

Communitarianism addresses the social characteristics of individual human beings and the importance of fostering shared values in designing policies and practices (Etzioni, 2010; Callahan, 2003, p. 496). Since health is endorsed as one such shared value, the state, in the eyes of communitarians, is justified to require individual human beings to make their best contribution to fostering health – namely, to be responsible for their health-related behaviours and choices (Buyx, 2008, p. 871). In this regard, personal responsibility features in the communitarianism's view of health policies and practices.

However, criticisms are strongly persuaded, which are mainly against some built-in problems such as 'the inability of communitarianism to deal with the diversity of healthcare needs and preferences' (Houtepen & Ter Meulen, 2000, p. 360) and the problem of 'being a paternalistic approach' (Buyx, 2008, p. 872).

Overall, despite all limitations discussed above, these three philosophical traditions do have distinct meaningful policy implications for the government regarding how to improve healthcare delivery through the lens of addressing personal responsibility (Table 2.1).

2.3.2 Practical advice on addressing personal responsibility in healthcare in China

Policy implications from the above philosophical traditions are of equally great value to healthcare systems with different models of governance. In this section, discussions mainly focus on assessing these policy implications in the context of the Chinese healthcare system with a specific aim of developing practical advice for policymakers in China on how to address personal responsibility properly when designing and implementing health policies.

Table 2.1 Three philosophical traditions on addressing personal responsibility

Three Philosophical Traditions on Addressing Personal Responsibility in Health Care		
Liberal Egalitarianism	Basic Arguments	Two supreme principles: responsibility and equalization Focus on assessing health disadvantages that reflect individual choices Holding people accountable for their health-related choices but not for the consequences of these choices
	Policy Implication	Tax people's unhealthy choices beforehand while guarantee equal access to treatment for all people
Luck Egalitarianism	Basic Arguments	It is morally unacceptable that people suffer from inequalities in health care caused by factors that are beyond their control. A just society should be sensitive to people's free choices ('option luck') while remains insensitive to people's 'brute luck' when distributing health care resources.
	Policy Implication	A hypothetical insurance market for health care (Dworkin, 2000) Health incentive schemes (Schmidt, 2009) From an <i>ex-ante</i> perspective, empowering patients (e.g. cultivating health literacy, strengthening self-management skills, encouraging shared decision-making, etc.)
Communitarianism	Basic Arguments	Common good overweighs individual preference Individuals should contribute to the common good by choosing responsible health behaviors
	Policy Implication	Health policies should be designed and implemented with the goal of fostering the shared values of the community.

Addressing personal responsibility by taxing unhealthy choices beforehand

The central argument of liberal egalitarianism is to tax unhealthy choices with the goal of providing equal access to treatment for all people, even for those who choose unhealthy behaviours. To put it simply, liberal egalitarianism holds people accountable for their health-related choices by taxing unhealthy choices beforehand.

Many choices can be classified as being unhealthy, among which smoking tobacco and consuming unhealthy food and drinks are the two leading risk factors accounting for a large proportion of avoidable illness in China. According to the World Health Organization (2015), the tax rate on tobacco in China (approximately 44.43% of retail prices in 2015) needs to be raised up to 75% of retail prices.⁴¹ This suggestion addresses the significant role that the tax mechanism plays in averting illness and deaths that would otherwise be caused by smoking tobacco. With regard to controlling unhealthy food and drinks, several countries have already started to tax unhealthy food and drinks, such as 'fat tax' in Denmark⁴² and

41 World Health Organization. (2015). WHO report on the global tobacco epidemic: raising taxes on tobacco. Please refer to http://apps.who.int/iris/bitstream/10665/178574/1/9789240694606_eng.pdf?ua=1&ua=1 (last accessed 24 March 2019)

42 In 2012, the Danish Parliament repealed the 'fat tax' due to the threat of job losses. This kind of taxation lasted only one year in Denmark. For detailed analysis, please refer to Stafford (2012).

'junk food tax' in Hungary⁴³ and Mexico⁴⁴. In China, however, improving health by taxing unhealthy food and drinks is merely a recent interest among researchers and policymakers. Given that the Chinese healthcare system is currently faced with a great challenge posed by the increasing burden of non-communicable diseases (NCDs), using a tax mechanism may serve as a good strategy for not only protecting people from the harm of NCDs but also helping to sustain the Chinese healthcare system. Yet, due to lack of general guidelines, introducing a tax mechanism may also bring about negative effects on society. For instance, taxing unhealthy food and drinks is likely to put an extra burden on low-income families, which may ultimately widen the existing disparities between the rich and the poor in China. Thus, empirical evidence needs to be collected and analysed critically before introducing a tax mechanism.

Addressing personal responsibility from an ex ante perspective: developing health incentive schemes and empowering people in their own health

Addressing personal responsibility from either an ex ante perspective or an ex post perspective makes a difference, especially in terms of understanding the policy implications of luck egalitarianism. The ex ante aspect concerns prevention while the ex post aspect is often related to the attribution of blame, and punishment. Addressing personal responsibility in healthcare from an ex post perspective brings counterintuitive feelings because it is most likely to use personal responsibility as an excuse to punish people for avoidable losses. Conversely, addressing personal responsibility in healthcare from an ex ante perspective cultivates an attitude of risk prevention because it provides people with opportunities to prevent or, at least alleviate, the negative influence of avoidable suffering.

A typical example of addressing personal responsibility in healthcare from an ex ante perspective is the health incentive schemes of the German healthcare system. According to Schmidt's (2007) study, Germany's statutory sickness fund has been offering diverse kinds of bonuses for people who actively participate in preventive care, since 2004. Among all kinds of bonuses, awarding healthy behaviours with reward points is a normal measure. People can gain reward points for their healthy behaviours and thereby use these points to redeem against sports equipment, health books, iPods, and gift cards for music download (Schmidt, 2007, p. 243). In this regard, policymakers in China should learn from Germany's experience to develop context-based incentive schemes to encourage people to be active in taking care of their own health.

43 The 'junk food tax' is put on a wide range of prepackaged foods which contain high salt and sugar. For detailed analysis, please refer to Holt (2011).

44 In 2014, the Mexico government introduced an 8% tax on unhealthy food and drinks. According to the policy, the 'unhealthy food and drinks' refers to 'non-essential foods with energy density ≥ 275 kcal/100g and sugar-sweetened beverages (SSBs).' For more analysis on the effects of this tax, please refer to Batis et al. (2016).

Another example relates to engaging people in their own health and healthcare. It mainly refers to encouraging people to play a more active role in taking care of their own health, such as leading a healthy lifestyle, strengthening self-management skills and improving shared decision-making.⁴⁵ Some countries have already enacted special laws to improve people's engagement in their own health and healthcare. Referring to a study by Schmidt (2007, pp. 242–243), the citizens of Germany are required by law (i.e. Article 1 of Book V of Germany's Social Security Code) to take a kind of 'co-responsibility' for their health, which essentially means that the citizens of Germany should 'lead a health-conscious lifestyle, take part in appropriately timed preventive measures and play an active role in treatment and rehabilitation, avoid sickness and disability, and overcome the respective consequences.' However, China has not yet enacted a similar law addressing the importance of engaging in their own health, which may point out a meaningful direction for future lawmaking efforts in China.

Addressing personal responsibility with a special concern to foster the shared values of the Chinese community

Drawing from the policy implication of communitarianism, designing and implementing health policies should aim at fostering the shared values of the community. In China, the majority of the shared values lie in the Confucian ethical tradition. Confucian ethical tradition attaches great importance to the virtue of *ren* (benevolence) and *xiao* (filial piety).⁴⁶ From a Confucian viewpoint, the individual human being is incomplete without belonging to a family (Chen & Fan, 2010, p. 577). Confucian societies (e.g. Singapore and China) therefore value close family ties and attach great importance to the role of the family when drafting social policies (Wong et al., 2009, p. 53). To a large extent, this viewpoint decides the family-based character of the healthcare system in China, such as emphasising the role of the family in healthcare decision-making. Thus, personal responsibility in healthcare should be addressed so it is compatible with the aim of fostering the shared value of the Chinese community, such as its long tradition of valuing family ties.

⁴⁵ These measures are recommended by the World Health Organization for the sake of achieving integrated, people-centered care. Chapter 3 of this thesis provides a more detailed analysis on how to implement these measures in the Chinese context. Here, for more information about the policy options for this framework, please refer to <http://www.who.int/servicedeliverysafety/areas/people-centred-care/strategicapproach.pdf?ua=1> (last accessed on 24 March 2019)

⁴⁶ The English translation of those basic virtues of Confucianism, Please refer to Runes (1983), p. 338.

2.4 CONCLUDING REMARKS

Given that the reforms of the Chinese healthcare system hitherto have a back-and-forth characteristic and the system encounters an increasingly heavy burden posed by the ageing population and non-communicable diseases, it is time to bring other stakeholders into consideration for the sake of the success of future reforms. Thus, this paper focuses on addressing personal responsibility in healthcare by stating that every individual needs to play a more active role in taking care of their own health. In order to develop practical advice for policymakers in China, supportive evidence from three typical theoretical frameworks and their policy implications are collected and analysed. Practical advice is largely context-specific recommendations, yet other nations can still derive meaningful lessons from the above analysis when similar problems occur.

Although the main focus of this paper is to raise the concern of how and where personal responsibility should be addressed in healthcare, it by no means denies the primary role of the state in protecting and promoting people's health, but rather to remind policymakers the importance of including every stakeholder and drawing a clear boundary between their responsibilities.

2.5 REFERENCES

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