PUBLIC ADMINISTRATION AND POLICY

An Asia-Pacific Journal
Volume 22 Number 2 2019

HKPAA 香港公共行政學會
Hong Kong Public Administration Association

The Hong Kong Polytechnic University
香港理工大學

School of Professional Education and Executive Development
專業進修學院
SPEED

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The Public Administration and Policy – An Asia-Pacific Journal (*PAP*) is a semi-annual refereed journal jointly sponsored by the Hong Kong Public Administration Association and SPEED, The Hong Kong Polytechnic University.
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ISSN 1727-2645

Public Administration and Policy

Volume 22 Number 2 2019

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Editorial

Introduction – What happened in Hong Kong in 2019?

Hong Kong experienced a very serious social and political unrest in 2019. The introduction of the amendment of the Fugitive Offenders Ordinance (FOO) by the HKSAR Government triggered off widespread public protests in June 2019. The bill tried to deal with the case of a Hong Kong resident, Chan Tong-kai, who murdered his girlfriend in Taiwan and escaped back to Hong Kong and to plug the existing loopholes due to the absence of legislation in coping with mainland and Taiwan criminal suspects. The Chief Executive Carrie Lam formally withdrew it on 4 September 2019. Hong Kong faced the most severe social turbulence, severe rift between the pro-establishment and pro-democracy political camps, economic slowdown, high level of street violence, lawlessness, destruction of public and private properties and unprecedented governance crisis in 60 years.

Usually, after many peaceful demonstrations, a small group of radical protesters who were well funded and equipped with professional gears such as expensive knee pads, helmets, goggles, gloves and gas masks resorted to use violent means to create disorders in the scene. They hurled petrol bombs and bricks at police stations and government buildings; occupied the airport terminal, humiliating and beating up some passengers and a mainland Chinese reporter; damaged many public facilities and Mass Transit Railway stations; blocked traffics in roads, tunnels and bridges; forced the shutdown of many business shops and restaurants; committed arson and damaged public facilities; forced into the Legislative Council (parliament) building, ransacked everything inside, including the HKSAR and national flags and emblems. They used all kinds of weapons such as iron sticks and umbrella with knife heads to attack and caused injuries to police officers and ordinary citizens. During the first 100 days of the social unrest from 6 June to 16 September 2019, the police arrested 1,453 protesters (including 400 students) and prosecuted over 200 protesters for various crimes including riots, assaulting police, illegal possession of firearms and arson, etc. (SCMP, 2019). More than 250 police officers were injured in carrying out their duties during the protests. Fortunately, there was no death during the first 100 days of the demonstrations as the Hong Kong police restrained from using more damaging firearms.

According to some academics (Lee, 2019; Cheung, 2019) and media analysts, there are many causes leading to the unrest. They include the growing gap between the rich and poor. The Gini coefficient for Hong Kong is over 0.5, one of the most unequal societies in the developed world. By comparison, according to the OECD, the Gini coefficient for the USA is 0.39 (Lee, 2019). The skyrocketing housing prices and rents are unaffordable for many young professionals as the income for university graduates remained stagnant over the past 20 years. The younger generations are very dissatisfied with their chance of upward mobility in the society. The civic, national and cultural education in secondary schools were not successful as a large number of students lack patriotism, civic responsibilities and respect for law and order. They damaged public and community facilities, social order and seek independence from China. They blame the mainlanders for

Public Administration and Policy
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Emerald Publishing Limited
1727-2645
DOI 10.1108/PAP-12-2019-024

taking the resources from local low-income groups and pushing up the housing prices and rents, as well as replacing neighbourhood stores with luxury brand shops. The relationships between the local people and mainlanders are very poor. The lack of political leadership in the HKSAR Government also contributes to the problem. When Carrie Lam took up her Chief Executive post, she abolished the Central Policy Unit and vacated the Information Coordinator post which are very important in public policy making and publicity. As a result, Lam did not have sufficient good advice on the amendment bill's political risks and the consequences of pushing the bill through without adequate public engagements and supports.

Some of the analysts further pointed out that the protesters who are well funded and equipped with abundant supplies of protest gears such as anti-tear gas masks, knife headed umbrellas and fire bombs probably received support from organisations outside Hong Kong. There are countries such as the USA and some other western countries may not be happy to face the rise of China and want to slowdown the Chinese progress by destabilising Hong Kong and detaching it from China. When will the current political and social unrest in Hong Kong finally end? Can "One Country, Two Systems" continue? The Hong Kong people and the HKSAR and the Central governments will have to find some acceptable solutions to these questions.

This journal plans to publish some special issues next year. A special issue on Corruption Scandals in Asian Countries has been scheduled for publishing in early 2020.

We wish to thank all the paper contributors in this issue and the reviewers for their constructive comments and suggestions in helping authors to improve their papers. Finally, I thank our editorial team and international advisors for their efforts in making the journal publication possible.

Summary of articles

This issue starts with two viewpoints on the recent social and political unrest in Hong Kong. It is followed by six research papers on various topics. The following are brief highlights of all the articles:

(1) The first article is What has gone wrong in Hong Kong? by Anthony B.L. Cheung. This article identifies the underlying problems of the recent unrest caused by the introduction of the amendments of Extradition Law in Hong Kong. The perspectives of politics and governance are used to analyse the situation. As a result, three underlying problems are identified, including the existential crisis under "One Country, Two Systems", the politics of "fear of losing", and the institutional weakness to reform and change under the current system of "Hong Kong people governing Hong Kong". In conclusion, the author suggests that the Hong Kong Special Administrative Region Government should take initiatives to address the above problems.

(2) The second article is Sober minds are needed to understand what is going on in Hong Kong by Yok-sing Tsang. This article explores some sober minds of better reordering of the relationships among the Central People's Government of China (CPG), Hong Kong SAR Government (HKSARG) and the people of Hong Kong. It attempts to analyse and explain the varying challenges faced by all stakeholders in the recent social and political unrest in Hong Kong. As a result of HKSARG's failure to amend the FOO, the feelings of resentment at both social inequality and political stagnation in Hong Kong turn into hostility towards the HKSARG, CPG and the Mainland people. Performance and procedural legitimacy are equally critical to help HKSARG overcome its governance crisis. This viewpoint hopes to put "One Country, Two Systems" back on the right track.

(3) The third article is Crisis responses in public hospitals: case studies in Hong Kong by Tai-ming Wut. This research paper investigates the medical incident responses from two public hospitals in Hong Kong, namely, Kowloon Hospital and Caritas Medical Centre, in order to improve the strategic preparation for crisis management in hospitals. It analyses two medical incidents using Situational Crisis Communication Theory by Coombs (2007). The two case studies demonstrate the importance of consistency in terms of crisis responses. For the first case, the crisis responses from different parties after the incident, including Hospital Authority, the doctor and the nurses from Kowloon Hospital, are contradicting to each other. First, Hospital Authority confirmed that the incident is solely an accident which is a denial response. Second, the doctor passed the responsibility to the nurses which is a scapegoating response. Third, the nurses tend to reduce the responsibility for the death of patient by excusing strategy. As a whole, their responses are inconsistent to each other. For the second case, Caritas had initially denied the responsibilities but finally had given partial apology under public pressure. That makes people think that Caritas does not really regret. Rebuilding posture should be used instead of denial and diminishment posture. However, public organisation and civil servants are reluctant to use a full apology due to possible legal consequences. The apology ordinance would ease the pressure to express regret and sympathy.

(4) The fourth article is Innovation to improve patient care in Australian Primary Health Network (PHN): an insider's perspective by David Stewart Briggs *et al.* Its purpose is to review the establishment of PHN in Australia and its utility in commissioning Primary Health Care (PHC) services. This study is an analysis of the management practice of the establishment and development of a PHN as a case study over the three-year period of establishment and development. The PHN is the Hunter New England and Central Coast PHN (HNECCPHN). It is based on "insiders perspectives" drawing from documentation, reports and evaluations undertaken. HNECCPHN demonstrates a unique inclusive organisation across a substantial diverse geographic area. It has taken an innovative and evidence-based approach to its creation, governance and operation. HNECCPHN addresses the health challenges of a substantial Aboriginal and/or Torres Strait Islander population. It can be described as a "virtual" organisation, using a distributed network of practice approach to engage clinicians, communities and providers. The authors describe progress and learnings in the context of theories of complex organisations, innovation, networks of practice, knowledge translation and social innovation. This is the first study of the results of the implementation of an important change in the funding and delivery of PHC in Australia. It describes the implementation and progress in terms of relevant international practice and theoretical concepts and demonstrates significant innovative practice in the short term.

(5) The fifth article is Impacts of social welfare system on the employment status of low-income groups in urban China by Shen-cheng Wang *et al.* Aiding employment is an important poverty reduction strategy in many countries' social welfare systems, as this strategy can help empower the recipients with a better living standard, development and social inclusion. The purpose of this study is to identify the most significant individual and systematic variables for the employment status of low-income groups in urban China. The data of this study are drawn from "Social Policy Support System for Poverty-stricken Families in Urban and Rural China 2015" report. The Ministry of Civil Affairs of the People's Republic of China appointed and funded the Institute of Social Science Survey at Peking University to deliver the

related project and organise a research team to write the report. Multiple binary logistic regression analysis is adopted to identify both individual and systematic factors that affect the employment status among low-income groups in urban China. According to the results of the binary logistic regression model, individual factors, including: gender; householder status; education; and self-rated health status, play a significant role in determining the employment status of low-income groups in urban China. Clearly, the impacts of individual factors are more influential to marginal families than to families entitled to receive Basic Living Allowance. In contrast, compared with marginal families, systematic factors are more influential to families entitled to receive Basic Living Allowance. This study highlights the importance of precise poverty reduction strategy and the issue of "welfare dependence" among low-income groups in urban China. Policy recommendations derived from the findings are given, including: the promotion of family-friendly policies, the introduction of a smart healthcare system, the establishment of a Basic Living Allowance adjustment mechanism; and the provision of related social services.

(6) The sixth article is Costs of hospitalisation for chronic kidney disease in Guangzhou, China, by Hui Zhang *et al.* Chronic kidney disease (CKD) was a worldwide public health problem which imposed a significant financial burden not only on patients but also on the health care systems, especially under the pressure of the rapid growth of the elderly population in China. This study aimed to examine the hospitalisation costs of patients with CKD between two urban health insurance schemes and investigate the factors that were associated with their inpatient costs in Guangzhou. This was a prevalence-based, observational study using data derived from two insurance claims databases during the period from January 2010 through December 2012. The authors identified 5,803 hospitalisations under two urban health insurance schemes. An extension of generalised linear model – the extended estimating equations approach was performed to identify the main drivers of total inpatient costs. Among 5,803 inpatients with CKD, the mean age was 60.6. The average length of stay (LOS) was 14.4 days. The average hospitalisation costs per inpatient were Chinese Yuan (CNY) 15,517.7. The mean inpatient costs for patients with Urban Employee-based Basic Medical Insurance (UEBMI) scheme (CNY15,582.0) were higher than those under Urban Resident-based Basic Medical Insurance (URBMI) scheme (CNY14,917.0). However, the percentage of out-of-pocket expenses for the UEBMI patients (19.8 per cent) was only half of that for the URBMI patients (44.5 per cent). Insurance type, age, comorbidities, dialysis therapies, severity of disease, LOS and hospital levels were significantly associated with hospitalisation costs. The costs of hospitalisation for CKD were high and differed by types of insurance schemes. This was the first study to compare the differences in hospitalisation costs of patients with CKD under two different urban insurance schemes in China. The findings of this study could provide economic evidence for understanding the burden of CKD and evaluating different treatment of CKD (dialysis therapy) in China. The information could also be used by policy makers in health insurance programme evaluation and health resources allocation.

(7) The seventh article is Jamaica's development of women entrepreneurship: challenges and opportunities by Raymond Saner and Lichia Yiu. This study assesses how far Jamaica has come regarding women economic empowerment, female entrepreneurship and its development policies in favour of women entrepreneurship development. This exploratory study employs a mixed-method

approach to achieve its research objectives, consisting of literature review and corroboration with database and indices. Key insights of research on female entrepreneurship are used to reflect on published data to assess progress of female entrepreneurship development in Jamaica. The 2017 edition of the Global Entrepreneurship Monitor (GEM) and Gender Entrepreneurship and Development Index were used to gain a better understanding of how the Jamaican business environment has changed over time and how the economic development and business environment impact female participation in Jamaica's labour force and entrepreneurial initiatives. The economic conditions in Jamaica and the role of females as domestic caregiver have made it difficult for women to enter the workforce even though Jamaican women are comparatively speaking better educated than men. Women remain at a disadvantage in the labour force. Jamaica's legislation and budget allocations in favour of female entrepreneurship are analysed to identify where and how Jamaica is investing its efforts to improve women's participation in the labour force. The authors conclude with suggestions on how the Jamaican government could facilitate further women entrepreneurship development to reach a more gender-balanced inclusive socio-economic development. While global policy has been promoting women empowerment through entrepreneurial development, little is known on the actual outcome of such human capital investment and the critical vectors that contribute to such outcome. This scarcity of knowledge is also applicable to Jamaica. This study attempts to contribute to women entrepreneurship research by reaching beyond the output-oriented perspective of various skill development programmes and attempts to link policy choice with overall macro results of entrepreneurship development in general and women entrepreneurship development in specific. It thus provides a rare glimpse of the entrepreneurship ecosystem in Jamaica.

(8) The final article is An international review of arts inclusion policies: lessons for Hong Kong by Alvin Cheung *et al.* It reviews and compares the implementation of "arts inclusion" policies (AIPs) in 14 different public administrative systems around the world. It aims to provide a consolidated source which informs continued studies in this field and to develop a framework to compare AIPs at an international level. Using "arts inclusion policy" as the search term, academic journals from a wide spectrum of fields were reviewed. A data set was extracted from the Compendium of Cultural Policies and Trends' online database which provided real-time information of national cultural policies. Another data set is from the United Nations' Inequality-adjusted Human Development Index, as the geographic scope of the review – largely focusing on UK, USA, Australian, Scandinavian and Asian contexts. Using existing policy-making literature as benchmark, the authors designed and applied a comparative framework dedicated to AIPs which focussed on "policy-making structures" as the main ground of comparison. An important finding is that the policy development and implementation of AIPs often underscore inter-sectoral involvement. With policy leadership and financial incentives pivotal to effective AIPs, central governments should take a more concerted leadership role to include AIPs in national inter-sectoral policies, encourage evidence-based research, expand funding and advocate the recognition of the impacts of arts inclusion. It concluded that AIPs in western countries remain more developed in targeted scopes and programme diversity compared to those of Asian countries and regions, and continued studies in this field is encouraged. This study is the first of its kind to include a number of Asian and western countries within its research scope, allowing it to offer a more

holistic outlook on the development and implementation of AIPs in different countries and regions. A common critique with all relevant existing literature was usually their lack of concrete comparative grounds, and the present study's all-encompassing review of literature from across different levels and sectors of respective public administrative systems contribute to a unique and comprehensive perspective in the arts and health discourse.

Peter K.W. Fong
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President, Hong Kong Public Administration Association

References

Cheung, A.B.L. (2019), "What has gone wrong in Hong Kong?", *Ming Pao*, 4 September, p. A18 (in Chinese).

Lee, D.S. (2019), "Understanding Hong Kong's turbulent summer", *Harvard Business Review*, 23 September.

SCMP (2019), "The first 100 days of protests", *South China Morning Post*, 21 September, p. A6.

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What has gone wrong in Hong Kong?

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Received 6 September 2019
Revised 21 September 2019
Accepted 26 September 2019

Abstract

Purpose – The purpose of this paper is to identify the underlying problems of the recent socio-political disturbance originated from the amendments of extradition law in Hong Kong.
Design/methodology/approach – The perspectives of politics and governance are adopted to analyze the current situation.
Findings – Three underlying problems are identified, including the existential crisis under "One Country, Two Systems", the politics of "fear of losing" and the institutional weakness to reform and change under the current system of "Hong Kong people governing Hong Kong".
Originality/value – The Hong Kong Special Administrative Region Government should take initiatives to address the above problems.

Keywords Hong Kong, Governance, One country two systems, Existential crisis

Paper type Viewpoint

Whether the current political crisis in Hong Kong finally ends with reconciliation or by force, the Hong Kong people and China's central government (hereinafter "central government") will have to confront the same question: can "One Country, Two Systems" persist, and how?

At present, the "opposition" against the Government comes not only from a small group of "radical trouble makers" but also from a relatively large majority of the general public. The central government and the Hong Kong Special Administrative Region (SAR) Government should be well aware of this. Among those opposing government are people who object to the amendments of the extradition law, who are dissatisfied with the government's administration, who criticize the unfairness of the system, who are skeptical about "One Country, Two Systems" and who are disappointed about or even feel despair of the political status quo. As anger, hatred, trauma and sorrow abound, it is necessary to untie big and small knots in order to help resolve the crisis. It takes time to heal and the government must take the initiative. Theoretically, there is a four-step approach: the "4R" – Response, Reconciliation, Review and Reform. However, it is difficult to proceed if the unrest is still on.

The radical protesters might think that they could force the SAR Government and central government to cave in by using extreme means riding on popular sentiments and international pressure. They are taking things too much for granted. No government authority would soften its stance against those who disrupt public order. There is always a "law and order majority" in any society. Once the bottom line of the ordinary people is crossed, their sentiments will change. In 1967, the leftist anti-British riots were eventually suppressed by the colonial government in Hong Kong through heavy-handed military and

This paper is translated from Cheung, A.B.L. (2019), "What has gone wrong in Hong Kong?", (香港出了什麼問題？), *Ming Pao*, September 4, p. A18 (in Chinese) by Walter H.H. Shum and edited by Alice Y.C. Te.

Public Administration and Policy
Vol. 22 No. 2, 2019
pp. 93-96
Emerald Publishing Limited
1727-2645
DOI 10.1108/PAP-09-2019-0021

police actions. At that time, more of the general population were willing to stand on the side of the government in restoring public order. Also, international public opinion will not be sympathetic toward the escalation of violence (see, for example, Hartcher, 2019). If the current incidences turn into violent revolutionary uprisings, the central government will definitely intervene using military force.

However, government cannot rely solely on a "stop violence and control disturbances" strategy to regain the hearts and minds of the general public. Making reference to French President Emmanuel Macron's experience in handling the "yellow vest" movement, while he took a hardline approach to deal with the riots, his focus as the leader was to submit himself to humble engagement with local communities, to regain mainstream support through policy and administrative reforms with a much softer touch. Ultimately the manifestation of public power must hinge on the support from the people.

What major problems have emerged since the reunification of Hong Kong with China in 1997? Let's put economic and livelihood issues aside for the time being. It is not because they are unimportant, but the main contradiction presently lies with politics and governance. This can be seen in three aspects.

The existential crisis under "One Country, Two Systems"

First, the "uneasiness" under "One Country, Two Systems" has led to an existential crisis. It is only natural that tensions exist between the "two systems". Therefore, it is necessary to maintain a balance between the high degree of autonomy of the Hong Kong SAR and the authority of the central government. The critical factors are respect, compatibility and mutual benefits. Without special features and splendor, Hong Kong will not be beneficial to China. Yet, a SAR that only emphasizes itself but ignores its connection with the rest of the country will not make the Mainland authorities and people feel that it "adds values" to the nation. Since reunification, the contradictions and tensions between the "Two Systems" have been increasing, and the balance between "divergence" and "convergence" has not been dealt with properly. Due to historical and institutional factors, the different ways of "existence" between the Mainland and Hong Kong have created gaps and cognitive differences. As a result, both sides are easily prone to feelings of "being threatened".

Successive Chief Executives have been politically trapped or defeated over issues concerning the Mainland and central authorities. The first Chief Executive, Tung Chee-hwa was defeated in trying to enact national security legislation under Article 23 of the Basic Law. His successor, Donald Tsang's first political reform was defeated and, in 2010, his second political reform was almost derailed. The third Chief Executive, Leung Chun-ying was frustrated by the anti-national education movement and "Occupy Central" protests. The current Chief Executive, Carrie Lam was defeated over extradition law amendments. In addition, major infrastructure projects and economic cooperation involving the "Mainland" have been negated as "red" projects by the opposition parties (who referred to them as "being planned" by the central authorities) because they know that many local people are still wary of the Mainland system and that criticizing the Mainland has political appeal.

Therefore, if people's hearts are not soothed and the focus is only on the reaffirmation of constitutional order and the central government's "comprehensive jurisdiction" over the SAR, this would not achieve positive effect. The practice of "One Country, Two Systems" and the related question about the future of Hong Kong have to be rethought.

The politics of "fear of losing"

Second, the ambiguity of Hong Kong's identity has caused the perplexity of Hong Kong people. Since reunification, there has been a problem of identity orientation which first appeared in the fields of culture and values as seen, for example, in the early controversies of mother-tongue medium of instruction in schools (perceived by some locals as no longer

emphasizing English) and using Putonghua in teaching Chinese (perceived as sidelining Cantonese). Some cultural activists and the intellectual community have advocated the heritage of Hong Kong, historical preservation and the safeguarding of core values, because they are afraid of "losing" the original Hong Kong system and way of life. In 2003, half a million people took to the street to oppose Article 23 legislation, marking how the deep-seated "fear of losing" (freedom) first entered mass politics. The recent large-scale anti-extradition protests represent a continuation of the politics of "fear of losing".

In the early 1980s, central government officials responsible for the reunification of Hong Kong were very clear about the mentality of Hong Kong people. They made the promise of "horse racing will continue, the dancing parties will go on, and everything will remain the same." Deng Xiaoping even considered that supporting the Communist Party was not a criterion in defining patriots. The Basic Law contains multiple articulations in favor of continuing the pre-existing system, policies and way of life. Therefore, there is no doubt that the central government respects the reality of Hong Kong and has, from the outset, striven to win the hearts of Hong Kong people. The Basic Law has prescribed "Hong Kong permanent residents" as the identity of the locals thus delineating the related legal rights and the right of citizenship. It clearly differentiates Hong Kong from the Mainland and provides for a unique system of SAR governance.

The Hong Kong identity and national identity do not have to be mutually exclusive. The key is how to balance the two identities. Hong Kong people can love Hong Kong and be patriotic at the same time. According to The University of Hong Kong's public opinion polls, in 1997 the proportion of those who considered themselves as "Hongkonger" and "Hongkonger in China" was 36 percent and nearly 24 percent, respectively, making a total of some 60 percent. This should not come as a surprise. Over the past 20 years, the former proportion had fluctuated between 30 and 40 percent, reaching the highest at 45 percent in 2012. However, due to the anti-extradition saga, it rose sharply to 53 percent by mid-2019, while the latter was 23.3 percent, adding up to more than three-quarters. It is expected to go further upwards as stimulated by endless protests.

The rise of "localism" can be seen everywhere. However, when localism evolves into separatism that negates the Mainland and even seeks to cut off from the Mainland, it would certainly lead to the anxiety of the central government and its strong reactions. If the confrontations and violence escalate, it would also attract more extreme interpretations by the central government. In this way, the original sense of mutual accommodation that should have accompanied reunification would inevitably become distorted. What kind of "Hong Kong" should be maintained in order to reflect its significance of this time?

The system of "Hong Kong people governing Hong Kong" lacks the momentum of seeking reform and changes

Third, the current "Hong Kong people governing Hong Kong" system has been unable to bring the society into cohesion and also lacks the momentum for reform and changes. When formulating the Basic Law in the 1980s, in order to achieve a smooth transition, the drafters were inclined to extend the original governance system and logic, under-estimating the unavoidable changes of people's sentiments and the socio-political environment. The Basic Law has entrenched the structure of administrative government and bureaucratic policy thinking inherited from the British colonial regime, and at the same time institutionalized the distribution of powers and benefits of existing capitalists and elites. Mainstream political parties (whether pro-establishment or pan-democrat) based on direct elections in the districts are given no role to play in government, let alone to cultivate political talent in Hong Kong.

As a result, there are multiple structural disparities: using a traditional administrative regime to govern a society with pluralist politics and interests; appointing a Chief Executive and ruling team without baptism by popular mandate to exercise "executive-led"

authority over legislative politics that are backed by district public opinion and functional constituencies' interests; and adapting an administrative mindset that take continuity and risk aversion as priorities to cope with the rapidly changing socio-economic environment. The government is inherently weak. It is dragged by executive-legislative gridlock amidst a politics of diminishing order and ethos, frequently resulting in lengthy deliberations and debates but limited decisions and actions. Crippled by vested and short-term interests on the one hand, the government is unable to command the majority support of parties on the other. Hence, policies often lag behind the needs of the times thus giving people an impression of not being proactive. As such, it makes some people to reminisce about the good old days of reforms under the former colonial government.

After more than 20 years of reunification, Hong Kong has been haunted by democratic deficit and political reform disputes. Although the central government has the "8.31" bottom line for political reform [Note 1], if it does not face up to the institutional shortcomings of the existing system of "Hong Kong people governing Hong Kong" but blindly believes that competent bureaucrats will make capable leaders to govern Hong Kong ("If the British colonial government can, why can't we?"), it has obviously under-estimated the complexity of Hong Kong's local politics. If the system is not reformed, it will be difficult for the Hong Kong SAR government to get out from the dead ends of governance. Internal frictions will persist, depleting energies on all sides and wasting an advanced metropolis which used to be daring and innovative. The loss of Hong Kong is also the loss of the nation.

Note

1. A decision of the National People's Congress Standing Committee (NPCSC) on August 31, 2015, dubbed as the "8.31 Decision", requires the Chief Executive to be a person "who loves the country and loves Hong Kong" and the method for selecting the Chief Executive by universal suffrage "to provide corresponding institutional safeguards for this purpose". A nominating committee similar to the present Election Committee composition would nominate 2-3 candidates, each supported by more than half of the members of the nominating committee. The process of forming the 2016 Legislative Council would remain unchanged. See: NPCSC (2014) Decision of the Standing Committee of the National People's Congress on Issues Relating to the Selection of the Chief Executive of the Hong Kong Special Administrative Region by Universal Suffrage and on the Method for Forming the Legislative Council of the Hong Kong Special Administrative Region in the Year 2016, August 31, Beijing.

Reference

Hartcher, P. (2019), "A message to Hong Kong's protesters: there's only one way you can win", *The Sydney Morning Herald*, September 3, available at: www.smh.com.au/national/a-message-to-hong-kong-s-protesters-there-s-only-one-way-you-can-win-20190902-p52n3x.html

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Sober minds are needed to understand what is going on in Hong Kong

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Received 7 September 2019
Revised 23 September 2019
Accepted 27 September 2019

Abstract

Purpose – The purpose of this paper is to explore some sober minds of better reordering of the relationships among the Central People's Government of China (CPG), Hong Kong SAR Government (HKSARG) and the people of Hong Kong.

Design/methodology/approach – It attempts to analyse and explain varying challenges faced by all stakeholders in the recent social and political unrest in Hong Kong.

Findings – As a result of HKSARG's failure to amend the Fugitive Offenders Ordinance, the feelings of resentment at both social inequality and political stagnation in Hong Kong turn into hostility towards the HKSARG, CPG and the Mainland people.

Originality/value – Performance and procedural legitimacy are equally critical to help HKSARG overcome its governance crisis. This viewpoint hopes to put "One Country, Two Systems" back on the right track.

Keywords Hong Kong, Governance, Democracy, Social inequality, "One Country, Two Systems", Fugitive Offenders Ordinance (FOO)

Paper type Viewpoint

The political storm that has ravaged the Hong Kong society for more than three months and is still going on, the worst governance crisis the Hong Kong SAR has experienced since its establishment was triggered by the Government's attempt to amend the Fugitive Offenders Ordinance (FOO) to enable transfer of fugitive criminals between Hong Kong and other parts of China. Chief Executive Mrs Carrie Lam has admitted that the legislative exercise, despite having the best of intentions, was an unwise move, arousing in Hong Kong people a huge degree of fear and anxiety which the government had failed to reckon with. Many have criticised the government for its lack of sensitiveness in responding to protesters' demands, which has kept the crisis escalating.

But the political storm would not have exploded to such an enormous scale if there had not been a vast amount of pent-up resentment towards both the local government and the sovereign power. The piece of legislation at issue is only about fugitives, and it caught the attention of only very few until public fear was aroused by exaggerating allegations from the opposition. Many people have chosen to believe in these allegations regardless of the validity of their grounds, because they have little trust in the government in defending their rights and interests. The public consultation period for the bill was too brief, official explanations were inadequate and the government was seen trying to rush the bill through Legislative Council. Nevertheless, the huge number of people who have joined the protests would not have done so if they had not been angry with the government for a long time, for reasons other than the controversial amendment bill.

Public Administration and Policy
Vol. 22 No. 2, 2019
pp. 97-99
Emerald Publishing Limited
1727-2645
DOI 10.1108/PAP-09-2019-0022

People, especially young people, are angry with the worsening social inequality. Hong Kong has been doing reasonably well in its economic growth in the last two decades, but fruits of the growth have not been shared by the majority of the people. Grass-roots families have seen little improvement in their livelihood. As the government takes pride in Hong Kong consistently remaining the "freest economy" in the world, the wealth gap keeps widening, and today Hong Kong's Gini coefficient is the highest among comparable economies, with a per capita GDP over three times the world's average. The cruelty of our social inequality manifests itself most strikingly in the disgraceful housing conditions of many poor families. Many say that young people are rebellious because they cannot buy their own home. This is untrue and unfair. Young people are righteously indignant because they see many people cannot afford a decent home.

Another reason for many Hong Kong people to feel frustrated and angry is the standstill in our constitutional development. The Basic Law says there should be "gradual and orderly progress" in our move towards full democracy, the ultimate aim being the Chief Executive and all legislators shall be elected by universal suffrage. In 2007, the Central Government gave a timetable for our democratisation, by which the Chief Executive could be elected by universal suffrage in 2017. But in 2015 we failed to pass a resolution on how to elect the Chief Executive in 2017. Not only did we lose the chance to have the Chief Executive elected by all people in 2017; we lost the timetable as well. Now no one can tell when we can attain the final goal of democracy, if ever at all.

And many believe that our social inequality problems are largely due to the undemocratic way our government is formed. The Chief Executive is chosen by the Election Committee, which is seen to be dominated by big businesses. Whenever conflicts arise between ordinary people and the big businesses, the Chief Executive will always stand on the side of the latter, for they are her bosses, not the people. The government is colluding with the big businesses, in particular the land developers, to rob the ordinary people. That is why private housing is so expensive and public housing is in short supply.

The feelings of resentment at both social inequality and political stagnation easily turn into hostility towards the Central Government and the Mainland. Beijing is seen by many to be the main factor holding back democratic development in Hong Kong. At the same time, social and economic integration of Hong Kong with the Mainland has led to increasingly frequent conflicts and bred ill feelings between people from the two sides. The staggeringly large number of visitors and immigrants flooding in from the Mainland are blamed for over-stretching Hong Kong's resources and aggravating the SAR's social problems.

This explains why the proposed FOO amendment, once interpreted as an attempt to take away the fire-wall between the Hong Kong and Mainland judiciary systems, would drive so many angry protesters into the streets. It also explains actions taken by the most radical protesters aimed at challenging China's sovereignty over Hong Kong and deliberately provoking the Central Government.

Demands of the protesters have gone far beyond withdrawal of the bill, which the government has done already. They want an independent commission to be appointed to investigate into police abuse of powers, unconditional release of everyone arrested in clashes with the police, and universal suffrage. The government cannot accede to all these demands. Nor can the government negotiate for a compromise, for no one can represent the protesters in negotiation. Moreover, it is quite obvious the government is incapable of handling political crises, let alone a crisis of such enormous scale as the present one. All this adds up to mean that the disturbances will not die down for some time to come. Hong Kong people have to learn to live with haphazard road blocks, sudden

closing-down of MTR stations following wanton vandalism, and violent scenes in streets as shown on TV.

No one can tell when the troubles are going to end. But when troubles do subside, it is hope that there will be enough sober minds in Hong Kong and Beijing who have a clear idea of what went wrong, and are able to put "One Country, Two Systems" back on the right track.

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Received 13 February 2019
Revised 3 June 2019
15 August 2019
Accepted 10 September 2019

Crisis responses in public hospitals: case studies in Hong Kong

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Abstract

Purpose – The purpose of this paper is to investigate the medical incident responses from two public hospitals in Hong Kong, namely, Kowloon Hospital and Caritas Medical Centre, in order to improve the strategic preparation for crisis management in hospitals.

Design/methodology/approach – The paper analyses two medical incidents using Situational Crisis Communication Theory by Coombs (2007). The two case studies presented herein demonstrate the importance of consistency in terms of crisis responses.

Findings – For the first case, the crisis responses from different parties after the incident, including Hospital Authority, the doctor and the nurses from Kowloon Hospital, are contradicting to each other. First, Hospital Authority confirmed that the incident is solely an accident which is a denial response. Second, the doctor passed the responsibility to the nurses which is a scapegoating response. Third, the nurses tend to reduce the responsibility for the death of patient by excusing strategy. As a whole, their responses are inconsistent to each other. For the second case, Caritas had initially denied the responsibilities, but finally had given partial apology under public pressure. That makes people think that Caritas does not really regret.

Originality/value – Rebuilding posture should be used instead of denial and diminishment posture. However, public organization and civil servants are reluctant to use a full apology due to possible legal consequences. The apology ordinance would ease the pressure to express regret and sympathy.

Keywords Organizational learning, Crisis response, Situational Crisis Communication Theory (SCCT)

Paper type Research paper

Introduction

To manage a crisis more effectively and efficiently, public hospitals should have a crisis management policy with clear definition of a crisis. Crisis is "a serious threat that can disrupt organizational operations and has the potential to create negative outcomes such as deaths, injuries, financial loss and reputation loss" (Coombs, 2007, p. 3). Violation of their constituents or stakeholders' expectation is also related to crisis as this may lead to stakeholders' disappointment about the public hospitals in Hong Kong which are managed by Hospital Authority. When making an official announcement about the medical incident, the management of the public hospital might need to seek prior approval from Hospital Authority. It takes time to give a response after a crisis occurs. Media might obtain information or seek for opinions from other unofficial sources when they produce news about the incident. Stakeholders might get false or distorted information and affect their perception about the case.

This paper investigates two public hospital medical incidents in Hong Kong to illustrate how public hospitals can perform or respond better when they manage crises according to the public relation theory – Situational Crisis Communication Theory (SCCT).

Public Administration and Policy
Vol. 22 No. 2, 2019
pp. 100-110
Emerald Publishing Limited
1727-2645
DOI 10.1108/PAP-09-2019-0016

Conceptual framework

The most commonly used crisis communication theories are Benoit's (1995) Image Restoration Theory and Coombs' (2007) SCCT (Dhanesh and Sriramesh, 2018). Benoit (1995) initially points out that an organization must be responsible for its action and need to respond to accusations quickly. Coombs (2007) further proposes a more comprehensive theory on crisis management – SCCT. His theory suggests that the crisis response of an organization could affect how stakeholders perceive the organization in the crisis (Coombs, 2007). That is to say, an organization should be careful in giving a right response. Based on the suggested response strategies by Benoit (1995), Coombs uses attribution theory to account for his theory. When the organization manages the crisis, it is important for them to find out if anyone needs to be responsible for the incident. SCCT tries to address the crisis situation and organization responsibility in order to formulate the appropriate crisis response (Coombs, 2007).

Coombs (2007) explains that there are "three crisis types: victim crisis cluster, accidental crisis cluster and preventable crisis cluster. Examples for victim crisis cluster are natural disasters, rumors, workplace violence and malevolence. Examples for accidental crisis cluster are challenges, technical-error accidents, and technical-error product harm. Examples for preventable crisis cluster are human-error accidents, human-error product harm and organizational misdeeds. Victim crisis cluster has little attribution of crisis responsibility; accidental crisis cluster has moderate attribution of crisis responsibility while preventable crisis cluster has high attribution of crisis responsibility" (p. 142). Crisis in public hospitals might belong to one of these three crisis types. So, the first step is to identify which crisis type the incident belongs to.

The second step is look at the crisis history and prior reputation. If an organization or the public hospitals in this study has a crisis history or negative prior reputation, people might tend to think that the public hospital involved should take greater crisis responsibility. The last step is to select the recommended crisis response strategy. Coombs provides crisis response strategy suggestions based on the information obtained in prior steps. The suggested strategy could be denial posture, diminishment posture, rebuilding posture and bolstering posture depending on the crisis type and crisis history. There are three methods for denial posture: attacking the accuser, denial and scapegoating; and two methods for diminishment posture: excusing and justification. Rebuilding posture could be in the form of compensation and apology. And, bolstering posture takes three different ways in reminding, ingratiation and victimage. Coombs suggests that the affected organization like a public hospital matches its response posture according to the level of responsibility (Coombs, 2007).

Methodology

Case study method examines a few cases. A number of different features of each case are observed (Thomas, 2011). The process of doing case studies is to study the person, projects, policies, institutions or others involved holistically in different ways and the subject case will be an example of a class of phenomena (Thomas, 2011). In another words, case study is aimed at understanding the details so as to find out what is happening. It is useful to answer the research question in the study:

RQ1. To assess whether the public hospitals involved have made appropriate crisis responses?

Case study is a suitable research tool in analysing crises as it provides an in-depth examination in longitudinal way with information gathered through document collection and analysis (Glesne, 2011), and the progress of the crisis is also captured. In contrast, the quantitative approach usually examines a cross-sectional view of the picture which cannot explain the evolution of the crisis.

First case review

Kowloon Hospital in Hong Kong was established in 1920. It is a public hospital and was previously operated by the Hong Kong Government. It now belongs to the Kowloon Central Cluster and is managed by Hospital Authority. Hospital Authority is operated under the Hospital Authority Ordinance and the Authority is to oversee all the services provided by public hospitals in Hong Kong. Kowloon Hospital provides various medical services including geriatrics, psychiatry, rehabilitation and respiratory medicine. The hospital also provides acute and extended-care services like physiotherapy, occupational therapy, prosthetic and orthopaedic clinical care, nutrition guidance service and speech therapy (Kowloon Hospital, 2018).

The first case is about Mr X, a 73 years old cancer patient, who underwent total laryngectomy surgery at Queen Elizabeth Hospital in June 2011. The patient had to breathe through a surgical hole in his neck through the throat after the surgery. However, as Mr X had suffered from stroke, he was then transferred to Kowloon Hospital for rehabilitation. However, during Mr X's stay at Kowloon Hospital, Mr X's throat was covered by gauze with tapes which had affected his breathing (Chan, 2013a).

According to Chan (2013a), Mr X's death was caused by the breathing hole in his throat being blocked by gauze. About one week before the incident, Mr X's family members had reported to the nurses a few times about problem with the gauze but no follow-up action had been taken by the nurses.

The Coroner's Court in Hong Kong concluded that Mr X's death was an accident in January 2013. The accident was not associated with any of the doctor or nurses. The court did not state about any potential professional misconduct of the nurse or doctor leading to the death of the patient in the accident.

After the Coroner's Court delivered the judgement, family members of Mr X made a complaint to the hospital for its negligence to the patient. However, the Medical Council of Hong Kong rejected the complaint in August 2015 based on the coroner's court's judgement delivered in 2013. Nevertheless, the family kept on collecting additional evidence in order to prove the judgement from the Coroner's Court was wrong. The Nursing Council of Hong Kong started disciplinary hearing of the involved nurses in November 2015. All the three nurses were found guilty of professional misconduct in March 2016 and were forbidden from practicing for one month (Tsang, 2016) as penalties. The judgement of the Nursing Council of Hong Kong about the gauze blocked the throat event was in disagreement to the 2013 judgement of the Coroner's Court.

In May 2018, the Medical Council of Hong Kong conducted disciplinary hearing of the doctor involved in the case. In the hearing, the doctor was accused of negligence and violated the Rules of Professional Conduct, including failure to stop the patient's permanent tracheostoma – the opening in the windpipe – being managed or treated as a temporary tracheostomy wound. As the doctor did not warn the nurses or other medical staff that the wound was a permanent tracheostomy and finally found guilty of misconduct in fatal blunder (Cheung, 2018).

Crisis type

There were at least two human mistakes committed in the event; and thus, the case could be classified as under preventable crisis cluster. Preventable crisis refers to the situations when organization placed people at risk, took inappropriate actions or violated a law or regulation. The strong attributions of crisis responsibility will also lead to severe threat on organizational reputation.

The first human mistake is that the doctor involved was found negligence of failing to warn nurses or other medical staff that the wound was a permanent tracheostomy. This might cause death to the patient.

Another human mistake is about the inappropriate treatment to the patient's permanent tracheostoma. The nurses wrongly put the gauze on the patient's breathing hole in his throat. The victim's family had reported to the nurses few times about the problem with the gauze. The nurses should have taken the responsibility to check and fix the issue accordingly.

These two mistakes can be avoided as it was not related to any technical issue but simply communication breakdown.

Crisis history

There are at least three negative prior reputation cases of Kowloon Hospital before Mr X's case. The first event occurred in May 2005. Kowloon Hospital had installed circuit television cameras in the wards without consultation with patients. It made the patients uncomfortable and raised issues of privacy (*Apple Daily*, 2005).

The second case happened in April of 2008. The nurses lost a USB drive stored with the patient's personal and medical records data in the hospital and the incident was discovered one year later. It was a human error since the mistake was made by the nurse (*Apple Daily*, 2008a).

The third case was that Kowloon Hospital has lost 300 student nurse data and affected both their internal staff and the daily operation of the hospital. It also raised the public concern about the information systems security of Kowloon Hospital. Hospital Authority has demanded Kowloon Hospital to arrange immediate review of their information technology system security in the hospital (*Apple Daily*, 2010).

Although the above cases had created a bad image for the hospital, it was lucky that no human injury or death was involved. That is to say, the hospital does not have similar case of suspected medical malpractice or professional misconduct involving doctors and nurses. It is concluded that no similar crisis history relating to fatal blunder being happened in Kowloon Hospital before Mr X's case.

Analysis of actual responses

Crisis managers in the affected organization are advised to manage the crisis quickly. Otherwise, people will turn to other sources to get the case information (Coombs, 2007). There are a number of stakeholders in this case: the doctor and nurses relating to Mr X's death; and Hospital Authority as the one in charge of Kowloon Hospital. Therefore, the response from Hospital Authority represented the standpoint of Kowloon hospital.

After the medical incident, Hospital Authority made a response that it was an accident and no human error was involved. Their statement was based on the judgement from the Coroner's court in 2013. The spokesperson of Hospital Authority stated that there was no crisis (*Sun Daily*, 2013). Denial posture and denial method were used in such response based on the SCCT.

In the response of the doctor involved after the first judgement of Medical Council of Hong Kong, he has pointed out that this was the fault of the nurses since changing gauze for the patient is the nurses' job duty. He was not involved in the process (*Ming Pao*, 2018). The job duty of the doctor is to diagnose, follow up and treat the patient. Scapegoating method under the denial posture was used by the doctor. It seems to the author that nurses were blamed for the case.

The doctor's counsel said, "He was extremely regretful about the loss of a patient. He was also a victim of the breakdown of the system of Hospital Authority" (Cheung, 2018). This was not a formal full apology. Instead, it was a partial apology. It avoids bearing full responsibility and legal consequence of the case. The counsel also used victimage method under bolstering as part of the response. However, it might be in the wrong direction according to SCCT since the case does not belong to the victim cluster.

During the disciplinary hearing of nurses, the nurses involved were trying to minimize their responsibility for the case. The nurses might be responsible because changing gauze is their duty. The nurses did not follow up the complaints from Mr X's family members relating to the problem about the gauze and did not actively seek clarification on the unclear terms (Chan, 2013a). In this case, the nurses argued that they are inexperienced in taking care of the patient after total laryngectomy surgery in Kowloon Hospital; and the hospital has not provided them with any training or instruction for handling such kind of patients (Chan, 2013b). They have followed the normal procedure and the medical notes prepared by the doctor. An incorrect term "tracheostomy" was used in the notes, which made the nurses believe that the medical hole is a temporary tracheostomy only (Tsang, 2016). From this statement, excusing method under diminishment posture was used because the nurses tried to reduce their responsibility for the crisis.

Response according to SCCT

The SCCT theory suggests that organization uses appropriate response strategy according to the levels of responsibility which determined by the crisis type and crisis history.

According to the analysis of the case, Kowloon Hospital does not have any similar crisis before and the case belongs to a preventable crisis cluster. According to SCCT, the hospital should use rebuilding posture for preventable crisis. Under rebuilding posture, Kowloon Hospital should take up the crisis responsibility and ask for forgiveness by using full apology and/or compensation method. Kowloon Hospital may consider holding a press conference for a quick and complete settlement of the above crisis.

Rebuilding posture may combine with diminishment posture according to SCCT (Coombs, 2007). In this case, Kowloon Hospital could consider using excusing method to minimize the organization's responsibility. Since the nurses and doctor have to take care of a lot of patients in the hospital and human resources shortage in the healthcare and medical sector is always an issue, a common example is that a few nurses have to take care of the whole ward. Mistakes may occur easily, although no one wants it to happen.

Last but not least, bolstering posture can be adapted as supplements to the other response postures. Since Kowloon Hospital has a rather long service history, they should tell the stakeholders about its past good work under reminding method. Ingratiation method can also be used since it is common to see heavy workload and stress for those working in public hospitals.

Organizational learning

Organizational learning is vital for crisis prevention as people can learn from mistakes. New measures might need to be adopted in order to prevent the same incident from happening again. Thus, the learning ability of the organization needed to be nurtured. There are different learning outcomes to justify the levels of learning after a crisis; the outcome level can be judged by three criteria, including similar mistake, new policy and areas of improvement (Crandall *et al.*, 2010).

For this case, the level of learning after the crisis is midrange outcomes. Kowloon Hospital has not committed similar mistakes after the case. Since there is no precedent of fatal blunder like gauze blocking the breathing hole and caused death to the patient, Kowloon Central Cluster's spokesman said that the Hospital had implemented some improvement measures after the accident, such as organizing staff training to distinguish a permanent tracheostomy from a temporary one (Chan, 2013c). A comprehensive measure in improving ward communication is expected.

Second case review

Caritas Medical Centre (CMC) is one of medical services provider under Caritas Hong Kong. The centre is established in 1964 located at Sham Shui Po. The centre is now one of the members in Kowloon West Cluster managed by Hospital Authority and serves 360,000 people in the northwestern part of Kowloon. The centre is an acute general hospital with 1,019 beds. The centre provides 24-h accident and emergency (A&E) services, full range of acute, extended care, ambulatory and community medical service (Caritas Hong Kong, 2009).

Since CMC is under Caritas Hong Kong with strong Catholic culture, the centre maintains Caritas motto "Love in the Service of Hope" to provide service. And the centre's mission is "to provide a continuum of the best possible, comprehensive health care for the community in a setting which recognizes and supports the physical, emotional and spiritual needs of patients and their families" (Caritas Hong Kong, 2009).

Medical incidents in Hong Kong hospitals are generally rare; however, different levels of medical incidents have occurred in CMC in the past.

For the period from 7 to 16 November 2006, unsterilized surgical knives were used in 13 cataract operations at CMC (Hospital Authority, 2006).

On 12 August 2011, another incident incurred relating to blood transfusion for a 64 years old female patient (Hospital Authority, 2011).

On 2 May 2014, a 59 years old male patient died in a medical incident. He had a history of diabetes, and serious coronary disease with completed Percutaneous Coronary Intervention in 2000; and received regular follow-up treatment in the Specialist Outpatient Clinic of Medicine (SOPC) and Geriatric Department (M&G) in CMC. However, after examining the patient's medical record, it was found that the SOPC and M&G did not allocate the prescribed drugs to the patient since 11 March 2014 (*Apple Daily*, 2014).

On 20 December 2008, it is suspected that a 56 years old man, Yeung Tak Cheung, suffered from heart attack while delivering goods with his son by truck. His son then drove the truck to CMC, parked outside the entrance of Wai Ming Block of CMC and asked for help at the lobby. However, the Caritas staff asked him to call the emergency number 999 as a proper procedure and refused to help. After receiving the report, the Fire Service Department assigned Mong Kok Fire Station to send an ambulance to the location. Unfortunately, there was traffic jam on the way and another ambulance was sent. That caused a delay of 26 min for sending the patient to the A&E Department and the victim died finally (Hospital Authority, 2008a).

On 21 December 2008, the Executive Director of CMC, Ma Hok Cheung, described this incident as "unfortunate". He admitted that the hospital is lack of clear guideline for their staff to deal with emergencies outside the hospital. However, he insisted that the staff who asked the son to call 999 had already "act according to the guidelines" and had no dereliction of duty. He said that "Our guidelines are just for the accidents inside the hospital. Our hospital has no clear guidelines for our staff if accidents occur outside the hospital". On 22 December 2008, Chow Yat Ngok, Secretary for Food and Health of Hong Kong, condemned that the way that the Hospital Administrator had handled this case was "far from satisfactory". He pointed out that the staff who first arrived the scene has the responsibility to notify emergency department or the person in charge. On the other hand, staff can call 999 for help if they really believe that there is a need to do so. Guidelines should be able to provide direction in dealing with most of the situations, but it is still unable to be applied in all cases. In the hospital, lots of emergencies might happen and the guidelines might not necessarily cover all cases. Chow requested CMC to submit the report of this accident within one week (Hospital Authority, 2008b).

On the same day, the Executive Director of CMC, Ma Hok Cheung; Hospital Authority Chairman, Wu Ting Yuk; and the Chief Executive Officer, Shane Solomon apologized

for the incident. Hospital Authority released the report of the incident on 5 January 2009. The Executive Director of CMC, Ma Hok Cheung, admitted that their employees and his treatment process were inadequate including lack of awareness, unclear expression, lack of compassion, etc. Hospital Authority will set up an *ad hoc* committee to follow up the case. After about six weeks from the report release day, the details of punishment announced. The Executive Director of CMC, Ma Hok Cheung and the A&E Director, Wu Kui, were prohibited from promotion and pay rise for 14 months. The staff who worked at information desk need retraining. However, Wu Kui appealed to Hospital Authority. The allegations and punishment were taken back at last (Hospital Authority, 2009).

On 7 May 2010, the Coroner's Court ruled that the victim's death was due to natural causes and not belonged to other categories. The evidence was insufficient to support the hypothesis of other classification of death. While the man had potentially fatal disease, there was no evidence to suggest that he was died because of other causes (*Headline Daily*, 2010).

Actual response

After this incident, CMC had different responses to the stakeholders at different times. At first, they claimed that no one or any department needed to be responsible for the incident as it was an unfortunate event. On the next day, Ma Hok Cheung, the Executive Director of CMC, modified the previous remark and admitted that the action took was inconsistent to public expectations. Also, apology was given to public after being asked by the reporter. However, he emphasized that the staff involved had followed the guidelines of the hospital and worked hard. He also emphasized that this incident happened at the area outside the hospital which their guidelines had no such coverage for their staff to follow in handling such situation. CMC Chief of Service of A&E Department, Dr Ng Fu claimed that calling 999 was the best solution because transferring patient to the hospital was the responsibility of the Fire Service Department's ambulance (*Apple Daily*, 2008b).

Response according to SCCT

CMC responses show that they seemed to have applied rebuilding strategy as they gave out apology. In theory, their apology is just a partial apology because they expressed their concern and regret only. Apology under rebuilding strategy is a full apology, which the organization should admit to the crisis, accept the responsibility and express their concern and regret. Although they had given out partial apology, it was not made immediately and not at a right timing. Moreover, there is no sign that they had combined other strategies with rebuilding strategies to avoid reputation threat. They also used scapegoating under denial strategy because they claimed that Fire Service Department's ambulance has the responsibility of transferring patient to the hospital. It was unwise to use it as this was not a victim crisis. All these led to reputation threat to CMC.

In this case, crisis is preventable as it is a human-error accident. CMC should use rebuilding strategy. Diminishment strategy and bolstering strategy could also be used. They should use a full apology first, together with excuses that they have limited control to the incident and mainly focus on reminding stakeholders of their past good work.

Organizational learning

For the level of learning, CMC reached a midrange outcome from the learning from this crisis. After this crisis, although CMC might have committed other medical error it never committed the same type of mistake and no one died or injured caused by delay of treatment outside A&E Department. Therefore, it is not a failure outcome; it can be either a midrange outcome or success outcome.

CMC has then followed the new guidelines from Hospital Authority and implemented "General principles for handling persons requiring emergency medical assistance in the vicinity of HA hospitals and clinics" after this crisis. As a result, CMC adapted a policy change. All along, there was no change to the leadership of the hospital due to the incident, and the two managerial persons only received a penalty of refrain from promotion and pay rise for a short period of time (Hospital Authority, 2008a). This may be regarded as ineffective learning outcome. But since CMC did not make the same mistake again, CMC is viewed as achieving a midrange outcome.

An organization which achieved a midrange outcome had a number of learning outcomes. Due to the incident, the organization has made various improvements, such as implementing new guidelines; provision of five sets of portable Automatic External Defibrillator within hospital premises, with training to all the hospital staff; renovation of A&E Department for the purpose of serving more patients and strengthening the training and manpower in A&E Department (Hospital Authority, 2008b) The above actions are able to improve the operation and services of CMC.

Last but not least, study of strategy posture towards crisis management is also important in different levels of learning. CMC showed a positive attitude as it has disclosed the full report to the public. The investigation report was attached as a Legislative Council paper and allows public access. Enough transparency could help reputation recovery. CMC is willing to learn, but outcome is not ascertained. This is because the guidelines of Hospital Authority and other improvements actions implemented are all new to CMC and their staff need time to pick up and to demonstrate whether such new measures could be executed effectively.

To summarize the case, the crisis of CMC achieved a midrange outcome, with new policies and remediation actions implemented within the organization. However, it really takes time for CMC to better demonstrate that the new measures and policy can be implemented effectively and properly.

Recommendations and conclusion

The crisis type for the first case is preventable crisis cluster since there were at least two human errors. The doctor was found negligence and had not told the nurses that the wound was a permanent tracheostomy. Also, the nurses wrongly put the gauze covering the patient's throat and blocked his breathing hole (Chan, 2013a; Cheung, 2018).

Based on the analysis for the second case, Hospital Authority, the doctor and the nurses had responded in the crisis. Hospital Authority confirmed that the event is an accident which is a denial response. The doctor passed the responsibility to the nurses which is a scapegoating response. The nurses tended to reduce the responsibility for the death of patient by excusing strategy. According to the principles in SCCT, it is wrong to use denial and diminishment posture at the same time. It gives stakeholders a bad impression that the organization contradicts itself in crisis response. It is because stakeholder outside the organization may find the responses from different parties within the same organization not consistent.

Kowloon Hospital does not have crisis history before and the case here is a preventable crisis. Rebuilding posture should be used instead of denial posture and diminishment posture. In addition, bolstering posture could be used to reduce the damage to its reputation. Kowloon Hospital should tell the stakeholders about its past contributions to the society under reminding method to regain trust.

It is suggested that a minor revamp is needed on the ward communication in Kowloon Hospital. Situation, Background, Assessment and Recommendation communication tool could be used to reduce the barrier during the communication process. It has been used in different healthcare setting (Kallestedt *et al.*, 2015).

As regards the second case, it is recommended that Caritas should do the rebuilding work first and give apology. The expression of concern and regret for the situation might

make people feel that Caritas is irresponsible. Caritas can also take diminishment strategy which is excusing. Caritas can try to minimize the responsibilities of the organization, for example, it emphasizes that although the staff of Caritas can do better, they do not have the intention to hurt anyone and the development of the situation is out of their control. Moreover, Caritas can take bolstering strategy at the same time; and use reminding method to tell people about their past good work. For example, it can emphasize that Caritas has already made a lot contributions to the society and helped many people in need in the past 44 years. Emphasizing positive things can alleviate the negative impact of the crisis.

Caritas should respond quicker and be consistent. In the case, the accident occurred at 2:00 p.m. on 20 December, but they made the first declaration only in the following early morning (Hospital Authority, 2008a). They missed the news deadline of some media like TV, online. People had already received the message from the media in the evening and midnight. The author points out that if Caritas was able to give a response quickly, the news would not focus only on the victim's son accusing Caritas on the first day. In the first statement, Caritas denied the responsibilities, but provided partial apology later under public pressure (Hospital Authority, 2008a). It made people think that Caritas did not really regret and handled improperly for the case. Second, they should improve the work of controlling claims. As the claims may affect the reputation of the organization, it should investigate the circumstances surrounding the claims. In this case, Caritas did not clarify the rumour about what their clerical staff said. It was claimed that the staff said that "it is not my work"; however, the report by Hospital Authority shown that it is not the fact. Therefore, if Caritas can clarify the claim immediately, the negative feeling from the public could probably be reduced.

In conclusion, for public organizations like public hospitals, the first response the spokesperson makes about the crisis should be as quickly as possible. That can avoid people forming bad first impression from the media based on sources other than official spokesperson. If possible, continuous updates should be released from time to time so that the public hospital can control the mindset of the receivers. Consistency is also an important consideration. It builds up the credibility of the organization's response. Finally, attention should be paid to the openness of the public hospitals. It means availability to the media, willingness to disclose information and honesty. In short, respond quickly, respond with one voice and show openness will be able to make the crisis response more believable and convincing.

References

Apple Daily (2005), "Kowloon Hospital installed closed circuit television cameras in the wards without notice (**九龍醫院錄影病房內情況**)", *Apple Daily*, 30 May, available at: https://hk.news.appledaily.com/local/daily/article/20050530/4927454 (accessed 26 September 2019).

Apple Daily (2008a), "A nurse lost a USB stored with the patient's data (**遺失存有病人資料**)", *Apple Daily*, 27 April, available at: https://hk.news.appledaily.com/local/daily/article/20080427/11039114 (accessed 26 September 2019).

Apple Daily (2008b), "A patient was dead outside Caritas Medical Centre (**病人死門前事件**)", *Apple Daily*, 23 December, available at: http://hk.apple.nextmedia.com/news/art/20081223/12004697 (accessed 26 September 2019).

Apple Daily (2010), "Lost 200 student nurse's data (**遺失一個儲存300多名護士學生資料**)", *Apple Daily*, 20 June, available at: https://hk.appledaily.com/news/art/20100620/14153665 (accessed 26 September 2019).

Apple Daily (2014), "A patient was dead in Caritas Medical Centre (**明愛派漏薄血藥害死病人**)", *Apple Daily*, 2 May, available at: https://hk.news.appledaily.com/local/daily/article/20140502/18707342 (accessed 26 September 2019).

Benoit, W.L. (1995), *Accounts, Excuses, and Apologies: A Theory of Image Restoration Strategies*, State University of New York Press, New York, NY.

Caritas Hong Kong (2009), "Medical services", available at: www.caritas.org.hk/en/service/hospital (accessed 26 September 2019).

Chan, T. (2013a), "Old man's airway was blocked by gauze, inquest told", *South China Morning Post*, available at: www.scmp.com/news/hong-kong/article/1136231/old-mans-airway-was-blocked-gauze-inquest (accessed 26 September 2019).

Chan, T. (2013b), "Kowloon Hospital staff's fatal mistake 'entirely feasible': CUHK professor", *South China Morning Post*, available at: www.scmp.com/news/hong-kong/article/1138146/kowloon-hospital-staffs-fatal-mistake-entirely-feasible-cuhk (accessed 26 September 2019).

Chan, T. (2013c), "Cancer man Wang Keng-kao's death was 'an accident': coroner", *South China Morning Post*, available at: www.scmp.com/news/hong-kong/article/1138803/cancer-man-wang-keng-kaos-death-was-accident-coroner (accessed 26 September 2019).

Cheung, E. (2018), "Hong Kong doctor Wong Cheuk-yi banned for six months over death of elderly cancer patient Wang Keng-kao at Kowloon Hospital", *South China Morning Post*, available at: www.scmp.com/news/hong-kong/health-environment/article/2145352/hong-kong-doctor-wong-cheuk-yi-found-guilty (accessed 26 September 2019).

Coombs, W.T. (2007), *Ongoing Crisis Communication: Planning, Managing and Responding*, Sage, London.

Crandall, W., Parnell, J. and Spillan, J. (2010), *Crisis Management in the New Strategy Landscape*, Sage, London.

Dhanesh, G. and Sriramesh, K. (2018), "Culture and crisis communication: nestle India's Maggi Noodles case", *Journal of International Management*, Vol. 24 No. 3, pp. 204-214.

Glesne, C. (2011), *Becoming Qualitative Researchers*, Pearson, Boston, MA.

Headline Daily (2010), "A patient was dead in Caritas Medical Centre due to natural causes (明愛失救事件裁定死於自然)", *Headline Daily*, 6 May, available at: http://news.hkhl.hk/instantnews/news_content/201005/06/20100506a155248.html?cat=a (accessed 26 September 2019).

Hospital Authority (2006), "Caritas Medical Centre press release surgical knife", available at: www.ha.org.hk/haho/ho/pad/130615e.pdf (accessed 26 September 2019).

Hospital Authority (2008a), "HA chief executive's statement on Caritas Medical Centre incident", available at: www.ha.org.hk/haho/ho/pad/0812225English.pdf (accessed 26 September 2019).

Hospital Authority (2008b), "Caritas Medical Centre response to patient collapsed incident", available at: www.ha.org.hk/haho/ho/pad/081221English1.pdf (accessed 26 September 2019).

Hospital Authority (2009), "HA Chief executive's statement on CMC Report", available at: www.ha.org.hk/haho/ho/pad/090105HEng.pdf (accessed 26 September 2019).

Hospital Authority (2011), "Announcement of an incident regarding blood transfusion", available at: www.ha.org.hk/haho/ho/pad/111109CMC.pdf (accessed 26 September 2019).

Kallestedt, M., Wallquist, W. and Hultgren, S. (2015), "Team-work and communication in emergency carein a regular ward", *Resuscitation*, Vol. 96, Suppl. 1, pp. 96-97.

Kowloon Hospital (2018), "Services", available at: www3.ha.org.hk/kh/ch/services/home.html (accessed 26 September 2019).

Ming Pao (2018), "Doctor expect can deal with the case independently (醫生期望護士處理)", *Ming Pao*, 9 May, available at: https://news.mingpao.com/ins/港聞/article/20180509/s00001/1525838246452/ (accessed 26 September 2019).

Sun Daily (2013), "A patient was dead in Kowloon Hospital due to accident (老翁封造口窒息裁死於意外)", *Sun Daily*, 30 January, available at: http://the-sun.on.cc/cnt/news/20130130/00407_019.html (accessed 26 September 2019).

Thomas, G. (2011), *How to do your Case Study*, Sage, London.

Tsang, E. (2016), "Three Hong Kong nurses guilty of professional misconduct after patient dies due to blocked airway", *South China Morning Post*, available at: www.scmp.com/news/hong-kong/health-environment/article/1959241/three-hong-kong-nurses-guilty-professional (accessed 26 September 2019).

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Innovation to improve patient care in Australian Primary Health Network: an insider's perspective

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Received 21 April 2019
Revised 8 September 2019
Accepted 24 September 2019

Abstract

Purpose – The purpose of this paper is to review the establishment of Primary Health Network (PHN) in Australia and its utility in commissioning Primary Health Care (PHC) services.
Design/methodology/approach – This study is an analysis of management practice about the establishment and development of a PHN as a case study over the three-year period. The PHN is the Hunter New England and Central Coast PHN (HNECCPHN). The study is based on "insiders perspectives" drawing from documentation, reports and evaluations undertaken.
Findings – HNECCPHN demonstrates a unique inclusive organisation across a substantial diverse geographic area. It has taken an innovative and evidence-based approach to its creation, governance and operation. HNECCPHN addresses the health challenges of a substantial Aboriginal and/or Torres Strait Islander population. It contains significant and diverse urban, coastal and distinct rural, regional and remote populations. It can be described as a "virtual" organisation, using a distributed network of practice approach to engage clinicians, communities and providers. The authors describe progress and learning in the context of theories of complex organisations, innovation, networks of practice, knowledge translation and social innovation.
Research limitations/implications – The study provides initial publication into the establishment phase of a PHN in Australia.
Practical implications – The study describes the implementation and progress in terms of relevant international practice and theoretical concepts. This paper demonstrates significant innovative practice in the short term.
Social implications – The study describes significant engagement and the importance of that with and between communities, service providers and health professionals.
Originality/value – This is the first study of the results of the implementation of an important change in the funding and delivery of PHC in Australia.

Keywords Communities of practice, Innovation, Commissioning, General practice, Primary Health Care (PHC), Primary Health Network (PHN)
Paper type Research paper

Introduction

The Australian health care system including that of Primary Health Care (PHC) is set in a Federation style of government, with each level of government having partial responsibility for both funding and delivery of services. Primary health care is substantially the responsibility of the federal or national government. Overall, the Australian health system is

Public Administration and Policy
Vol. 22 No. 2, 2019
pp. 111-124
Emerald Publishing Limited
1727-2645
DOI 10.1108/PAP-09-2019-0017

recognised as one of the best in terms of its OECD context (Briggs, 2017; Dixit and Sambasivan, 2018; Rapport *et al.*, 2017).

PHC has had a history of fragmented delivery, often with inadequate support to general practices. These concerns led to the establishment of "Divisions of General Practice" of 110 defined geographic areas. These divisions were subsequently recast into a smaller number of 61 geographically larger organisations called "Medicare Locals" (MLs). The MLs had a wider remit of population health planning and a mix of service delivery roles. They had a broader governance perspective that included GPs and other PHC clinicians as well as community representatives (Briggs, 2017).

MLs have been described as one of the "shortest – lived features of the Australian health care landscape" lasting just four years from 2011 (Javanparast *et al.*, 2015). Again, at a change of government, it was foreshadowed that MLs would not survive. A subsequent report suggested that they failed to appropriately support general practice and lacked clarity of purpose (Horvarth, 2014). However, a study in one Australian state suggested that MLs were successful in "identifying local needs and building good relationships with a range of stakeholders and health providers, particularly GPs and allied health professionals" (Javanparast *et al.*, 2015). This study suggested that "continual policy changes and uncertainty in the PHC landscape constrained collaboration and saw a loss of valued health workforce through the restructures" (Javanparast *et al.*, 2015, p. 219). This theme of constant health reform with no effective change or unexpected consequences and being "too complex to navigate" (Calder *et al.*, 2019) is consistent with the findings of other studies (Briggs *et al.*, 2012).

This paper adopts a descriptive qualitative case study approach, within a framework of relevant theoretical approaches of management learning through communities of practice (CoPs) and the innovative lens (Corradi *et al.*, 2010). The study utilises the experience of one Primary Health Network (PHN) to describe, from the "insiders" perspective, the experience that occurred in the establishment and development of the PHN. The PHN is the Hunter New England and Central Coast PHN, known as HNECCPHN. It provides a case study approach to describe a new innovative attempt to commission and fund primary health care in Australia.

Context of PHN in the Australian health system

PHNs have been established to improve health care outcomes of consumers and communities through commissioning of services through health care providers. This is achieved by competitive funding that requires providers to meet objectives in the contracts that emphasise quality outcomes required and new approaches to delivery and influence service design and pre-requisites of integration, coordination and collaboration to improve outcomes. Second, the PHN delivers capacity building and support services to providers to enhance both the service delivery and the quality of outcomes. These requirements are built into the contractual arrangements and, while evaluation processes are in place, the impact of this initiative will require a longer time frame to achieve credible evaluation. Importantly, PHNs do not directly provide health care services.

There was no restriction on who could submit an expression of interest (EOI) to establish a PHN; the successful applicants were substantially non-government organisations. They would be governed by a skills-based board accountable for performance, with contractual funding arrangements with the Commonwealth to commission and fund PHC services and to engage with and support general practice(s) but not to provide services directly.

The establishment of HNECCPHN occurred as a result of the vision of the pre-existing MLs who agreed to a joint bid to combine their previous geographical MLs of the New England, The Hunter Valley and the Central Coast. This marked an innovative approach in the establishment of a PHN in which the three areas were distinct, naturally occurring geographic regions. There is a diversity of major urban concentrations on the central coast, closely located to the Sydney Basin and the lower Hunter based around

Newcastle and significant regional, rural and remote populations from the upper Hunter valley, and the regional centre at Tamworth extending out to smaller and some remote communities that are geographically known sub-regions such as the Slopes, Plains and Tablelands that meet the Queensland border. Geographically, it is of the size of England; the driving distance from the southern perimeter of the PHN to its northern boundary of the Queensland border is more than 9 hours.

In 2016, this extended region had a population of 1,217,004. There are some 1,250 general practitioners, numerous allied health and PHC nursing roles, 12 Aboriginal Medical Services, more than 30 hospitals and 300 pharmacies across 23 local government areas.

Methodology

The authors adopted a theoretical framework, available to them from the inaugural considerations of the development of the proposal to establish the PHN. This theory and the use of the term innovative lens and the wider discourse of management learning recognise that management learning can be derived from practice and through CoPs. The practitioner views, experience and objects are observed through that lens and then looks to a range of theories as opposed to a single theory to inform knowledge and future practice. The framework is further developed through the analysis and described in our discussions and conclusions (Corradi *et al.*, 2010).

The authors contributed perceptions from their practical experience of involvement in the organisation through the analysis of the documentation available to them as "insiders". The data include the minutes and decision making that achieved agreement between the former MLs to bid for and establish a PHN, the contractual agreements with the Commonwealth, the subsequent minutes of the newly established Board and its subcommittees. It includes action and directions established in the strategic plan and subsequent iterations, as well as a range of consultant reports obtained for the purposes of commissioning services from internal staff and board evaluations of commissioning cycles, service co-design and provider engagement.

This research that is set in the dynamics of organisational culture and engages with disadvantaged communities, social entrepreneurial entities and non-government providers and is said to best fit into methodologies of the interpretive or hermeneutic traditions (Grimm *et al.*, 2013). The hermeneutic, phenomenology approach is relevant where making sense of experience to develop shared meaning is an objective and where the health management role requires understanding rather than explanation. In complex circumstance, we need to draw on knowledge embedded in experience. In other words, "things cannot be separated from the experience of them, and interpretation can only make explicit what is already understood" (Bassett, 2004, p. 158; Briggs *et al.*, 2012).

This context reinforces the need for "insiders" that have expertise and experience in both management and the health professional role to interpret findings. This is consistent with the Heideggerian view "that prior understanding is about knowing, not about being or just about acquiring new knowledge". This implies that what is already understood comes to be interpreted and our presuppositions help with the interpretation of meaning of the phenomenon (Briggs *et al.*, 2012). The findings have also been found to have meaning and confirmation in relevant organisational and management theory. Therefore, they reflect the position that the "insider" is both important and essential because it is about "interpreting frequently taken-for-granted shared practices and common meanings" (Briggs, 2009, p. 91).

The "insiders" are the authors, six in number, of this paper and represent board governance, chief executive (CE) and senior executive management personnel of the PHN who among them share a range of academic and clinical qualifications (physiotherapy and nursing), commercial, accounting and marketing qualifications and expertise. These insiders mostly have had extensive practice and expertise in the Australia health system including prior experience in the acute care sector and in PHC.

Health managers are central to reform and our objective is that our findings might be built on by others in further studies (Briggs *et al.*, 2012). The authors have used an "innovative lens" approach consistent with our HNECCPHN purpose "to deliver innovative, locally relevant solutions".

Importance of HNECCPHN Aboriginal and Torres Strait Islander (ATSI) population

HNECCPHN has an Aboriginal and/or Torres Strait Islander population that is above the average for NSW and Australia. The PHN proportion of Indigenous people is at 4.2 per cent compared to the NSW and Australian proportion of 2.5 per cent. Within HNECCPHN, there are between 10 and 20 per cent significant Indigenous populations, as well as those that reflect state and national percentages. HNECCPHN contains and acknowledges ten Aboriginal nations. Further data about the region can be found in Health Planning Reports and Profiles (HNECCPHN, 2019a).

Establishment of HNECCPHN

Discussions as to what might be possible and appropriate in establishing PHNs took into consideration that ideally the size and location of PHN boundaries should reflect the existing boundaries of local health districts (LHDs) or in some states, networks (LHDs) and the acute care providers. In HNECCPHN, this meant the consolidation of two MLs: the New England and the Hunter. However, once the PHN boundaries were announced by the Commonwealth Government, the Central Coast ML was also included, and the preference was to apply based on the three extant MLs and two LHDs combining.

A working party of the three MLs consisted of two board members and the CE of each was formed to quickly negotiate an agreement and submit a proposal to become a PHN. As an early exemplar of both vision and innovation, the working party invited the two LHDs into the working party. This board governance arrangement with the inclusion of the two LHD CEs remains innovative and, in comparison with other PHNs, is an outlier as most others have not purposely been identified with the local acute care sector in this way.

The board also agreed to the appointment of an independent chair, with skills based on consideration of the distinct geographical regions, and subsequently included Indigenous members. A distributed organisational network of office locations was adopted to consolidate support for the principles of localism and subsidiarity that is engaging with clinicians and communities at a local level, a specific requirement of PHN roles. It also reinforced the fact that this was a new organisation rather than a merging of existing MLs and that the governance should consider the differing clinical practice and communities of interest. These characteristics of HNECCPHN as a new entity with a distributed organisational network set its establishment as being distinctive. In the transition from MLs to HNECCPHN, the Commonwealth took a dividend (budget cut) in operational funds. This meant less resources for the PHN and not all staff could be transitioned across to PHNs.

The inaugural board determined that "innovation" was to be a continuing contribution to the organisational purpose. Second, the concepts of evidenced-based management and best practice clinical care/service were to underpin executive and governance decision making (Agterberg *et al.*, 2010, p. 87). Concepts of diversified senior executive locations and office accommodation were established that could be described as the organisation functioning in a virtual context using technology, to effectively engage with both clinicians and communities.

The creation of PHNs also emphasised that the organisation might increasingly operate in contexts of networks. Complex adaptative systems theories are also relevant because they add meaning to social organisational processes and challenge traditional models of change. This emphasises the importance of management focussing on networks and

systems and being aware of and resistant to the isomorphic tendency for organisation to become similar in structure and in practice (Briggs, 2009). For researchers, PHNs provide a rich field for further management and organisational empirical research.

Theoretical framework

Complex systems cannot be represented or explained by unified theory. Innovation is both a process and an outcome but is also an uncertain process with multiple meanings (Grimm *et al.*, 2013). Social innovation is seen as a move away from existing focus on technology and economic dogma to encourage "societal and systemic changes" and is said to be attractive to policy makers given the difficulty traditional welfare systems have in responding to communities such as those with which HNECCPHN is engaged. Social innovation can be described as a new combination or configuration of practice and as a "means to an end" that can be described as "a process oriented social innovation" (Grimm *et al.*, 2013. p. 450).

An appropriate theoretical framework was developed based on the application of complexity theory and management learning and knowledge theory and the concepts of innovation as a social organisational structure (Pestoff and Brandsen, 2010). This required us to adopt the concepts of knowing and the use of applying the lens to CoPs as previously described (Corradi *et al.*, 2010). The discussion of these theoretical concepts and their relevance follows.

Complexity and networks of practice (NOPs)

The concepts of networks, in CoPs and NOPs, within and across organisations is not new but a move in those directions has provided HNECCPHN with the potential to more effectively govern, manage and organise in a knowledge-based organisation. Managers must manage NOPs to reap the benefits of geographically dispersed knowledge. The inherently "emergent nature of NOPS implies that management control may frustrate practice-related knowledge to be shared" (Agterberg *et al.*, 2010, p. 85). The management of NOPs and the value of this approach is worthy of further research and evaluation in PHNs. This concept defines organisation management as having "a knowledge-based view of the firm" (Agterberg *et al.*, 2010, p. 86) that requires knowledge to be integrated and made available to all. This means that we need to re-imagine knowledge utilisation and frame knowledge as part of practice, not apart from it (Corradi *et al.*, 2010; Gkeredakis *et al.*, 2010, p. 2).

Networks and CoPs have currency in health services and our thesis is that there is a significant value in extending those practices into distributed networks of practice (Hustad, 2010). HNECCPHN has achieved this move across organisations, service providers and clinicians by the use and adaption of technology described as "PeopleBank" and more fully described later but accessible at HNECCPHN (HNECCPHN, 2019b). This provides a platform for organisations, clinicians and communities to engage, be sustained and cultivated in both open and closed forums (Hustad, 2010). HNECCPHN has established CoPs in specific programs such as youth mental health, chronic disease management and alcohol and other drugs treatment services.

Organisational learning and practice

Management and organisational learning is recognised as occurring at and within the workplace. This occurs through, observing and identifying through our own knowledge, our lens, to interpret practice and know new Knowledge (Corradi *et al.*, 2010).

Innovative context

The implementation of PHNs can be described as "innovative" in that for the first time the concept of commissioning of services was introduced to the context of the Australian health

care system. The knowledge of practice in commissioning needed to be sourced from the UK National Health System and elsewhere. The devolution of service planning and commissioning from direct Commonwealth Government agencies to PHNs was innovative in that, without debate, it heralded an unannounced commitment to the principles of localism and subsidiarity, suggesting that PHC requires local engagement with communities and providers and that this should occur at the lowest (or closest) point where the services are meant to be delivered. Localism is a form of governance that is based on the principle of subsidiarity that "government should only fulfil a subsidiary function for those tasks that cannot be dealt with by local tiers" (Hartwich, 2013).

In a UK-based review of reform of PHC this was described as a "handing back of PHC responsibility for local planning representing a return to the dominant model of primary care policy and that reorganisation of complex systems produces results in predictable and emergent change" (Checkland *et al.*, 2018, p. 266). Localism suggests that health services currently do not reflect local needs and are delivered in ways that do not engage communities and are focussed on sickness services, reducing illness without much emphasis on improving health and well-being or providing enough emphasis on public and population health and prevention. Localism provides the opportunity to work with others and across organisational boundaries.

The boundary alignment of PHNs with LHDs, the state based acute care providers is innovative and gives "licence" for the first time, to explore health service delivery at the local level, outside traditional normative approaches (Briggs, 2014). Ferlie (2010) suggested that localism is a reaction against top down target led approaches and that the new localist idea brings into prominence the role for non-profit organisations, giving managers permission to respond to opportunity and to also provide "generative space" to discuss and debate how to do things better (Briggs, 2014).

Innovation in HNECCPHN is given prominence by its inclusion in the name and activity of a specific board subcommittee, the Strategic, Innovation, Research Service Design Population Health Committee, with a strategic intent that innovation is part of our purpose at governance, executive and staff levels. This approach is further extended across our networks, described above through an online platform entitled "innov8", a health development initiative accessible at PHN webpage. The online hub is designed to share ideas and to meet other people with interest and expertise in aspects of health care.

One of the significant and enduring features of our innovation approach has regularly been generated "Pitch Nights". These nights are designed to seek innovative projects from organisations and communities that reflect a significant regional PHC need to gain some one-off funding to implement a specific project. Examples include healthy weight activities and Aboriginal health. Initiatives undergo rigorous assessment before the proponents pitch their idea to a public audience who then vote on the extent of "funds" each audience participant allocates to about three projects. The process builds on community need, community passion and clinician enthusiasm, and underlines a process of clinician and community engagement through innovation. This practice also depends on the characteristics of networks described as self-organising, shared practice, the acceptance of "weak ties" and technology support (Agterberg *et al.*, 2010) that can bring together the diversity of interests "to focus on complex, entrenched systemic problems" (Bailie *et al.*, 2018, p. 1).

Commissioning strategy

The rationale for establishing PHNs was to enable the planning, commissioning and funding of PHC services through the regionally established PHNs. General practice delivers PHC directly to patients through fee for service arrangements that could include reimbursement of some or all the costs via the Medical Benefits Scheme. A patient-based co-payment often applies. The PHNs are meant to sustain the delivery of quality primary

care in general practice by attracting and retaining general practitioners and other professions. This is achieved by support to general practice for education and quality improvement in clinical care and business practices, expansion of service-based health professionals into general practice, notably practice nurses and allied health professionals. PHNs in planning, commissioning and funding attempt to be inclusive of general practice through both formal engagement of clinical councils and the use of techniques of collaboration, connecting and integration, co-design, in persuasive ways as services are designed and commissioned.

HNECC has developed a "Commissioning Framework" which has been adapted by many of its counterparts. It guides the commissioning strategy. The commissioning process was developed within a short time frame based in part on HNECCPHN ideation of the existing "quadruple aim" as initiated by Bodenheimer and Sinsky (2014). This was a significant development as many other agencies continue to use the IHI triple aim.

While the commissioning process required almost immediate commencement, commissioning, staff, executive, the board and, importantly, providers had to be educated to demonstrate that the implementation was only the start of the process as commissioning was cyclical and dependant on population health planning and community, clinician and provider engagement. HNECCPHN strategic intent of commissioning was set in time frames over years called "horizons" and was understood by all to be a learning process requiring rigorous evaluation following each commissioning cycle or process and followed nationally agreed principles in commissioning health services.

Applying the theory to HNECCPHN practice

Performance of PHNs reflects practices and national headline indicators of potentially preventable hospitalisations, childhood immunisation rates, cancer screening rates and mental health treatment rates. The priority areas were further defined as mental health, ATSI health, population health, health workforce, digital health and aged care. Local priorities within the diverse HNECCPHN were determined to be cancer screening, mental health, ATSI populations needs, transport, health literacy, child, maternal and youth health care. Local priorities were assessed to be health risk behaviours, rural health access, health workforce, aged care and dementia, chronic disease, low birth weights and drug and alcohol treatment. These priorities resulted from the HNECCPHN needs assessment and the development of the "health planning compass" which defines and describes a range of specific demographic, socio-economic and health status data for the region and for each local government area within the region. The compass can be viewed at HNECCPHN (2019c).

HNECCPHN had to utilise new titles for staff, new organisational language, new and complex ways of designing and delivering PHC that in Australian contexts were unknown, not tested and required experimentation. Approaching complex challenges within systems can result in unpredictable and emergent changes that requires a cautious approach and incremental achievement requiring commissioners to build in "incompleteness" in change and implementation ahead of closure (Checkland *et al.*, 2018). Gkeredakis *et al.* (2010) suggested that for commissioning managers to be successful, they need to mediate national expectations in ways that make change understandable to the practice of practitioners use of knowledge in delivering services locally and building trust in how that is achieved.

The initial contracting was transactional but moved to a relational approach as the practice matured. An assessment of HNECC's capability to commission, through comparison with the NHS World Class Commissioning Competencies, identified that commissioners, providers and communities lacked capacity and capability in the processes (McCafferty *et al.*, 2012). These circumstances required the development of the relational

approach with and among stakeholders to ensure that the policy and processes were effective. This also led to a greater emphasis on network practice across disciplines, sectors within local contexts and resourcing of grants and scholarships for education across the sector.

The capacity building strategy undertaken by HNECCPHN was significant and within one six-month period, 162 education courses were delivered at a rate of more than 6 courses per week. More than half of the courses focused on national key performance indicators and the remainder were delivered to PHC staff around content that supported their collective and individual practice. More than 2,600 people attended those courses within that six months providing an average attendance above 22 people. Grants were made available to build capacity in the areas of Alcohol and Other Drugs and Indigenous Mental Health in response to an identified need. Scholarships have been provided to enhance workforce capacity in clinical areas, including Aboriginal Health, Primary Care Support, Practice Nursing and Diabetes Education. Practice support education, interactions and engagements were additional to the formal education events. This is a significant investment that is a continuing feature in both capacity and capability building across the PHN underpinning the PHNs understanding that the use of knowledge and learning is an interactive and iterative process that makes commissioning effective.

The ongoing evaluation of commissioning process also focussed on improving reporting measures and developing key performance indicators to include a suite of patient reported outcomes and patient reported experience measures. The use of patient reported measures as a measure of quality linked to payment has been tested by HNECC, a first in Australia. While the contractual and tendering aspects of the PHN are enshrined in processes that ensure probity, audit and independence from external influence, it is incumbent on PHNs to engage with PHC clinicians and communities. The input at the design stage and the adoption of recommendations does necessarily include public discussion and input from the clinical advisory and community advisory committees appointed by the board. A formal subcommittee of the board, the Quality and Safety Committee, monitors funded providers and recommends adoptions and changes to the board and monitors the contractual compliance of providers, particularly where questions of performance might arise.

Consistent with knowledge translation theory and the concept of organisations being described as learning organisations, the evaluative approach of practices and commissioning will continue as a focus. In recent contexts, a series of principles and practice enablers were developed in recognition that lessons from the NHS experience suggest that "progress is made in 'bite sized pieces of work' requiring substantial effort" (Shaw *et al.*, 2013). Billings and de Weger (2015) in a critical review of contracting for integrated health and social care suggest that we are learning by doing and will require continuous assessment around the suitability of commissioning requirements and that we should have debate about the best way to contract for health including critical debate about current models of care and their value.

The debate in our progression over three years of experience has included to what extent should the PHN determine what models of care should be funded. We have used published evidence, clinical experts and provider and community forums as well as our community and clinical councils to progress that debate. The option of one model of care across the region has been challenged given the tyranny of distance, variable access to health services, workforce shortages, and different forms of clinical practice across the very diverse region. In this debate, the importance of how communities' access distant services and the need to sustain a scarce health workforce together with avoiding the loss of social capital of rural communities are significant considerations. An effective commissioning system in our view needs to be iterative, adaptive and to be credible, needs to be receptive to context.

Through our evaluative processes, we have come to establishing principles and enablers for consistency of understanding across and within the organisation and to our providers and communities. These principles are:

(1) Models of care should be capable of variable adoption to meet community and clinical needs including the needs of ATSI communities and capacities in different geographic areas. We need to be open to different models of care being funded and different funding models being used.

(2) We should develop, sustain and increase an approach that commissions at a manageable scale but ensures that local provider or practice competitive and comparative markets exist and are sustained through contracting or sub-contracting arrangements under a value for money approach.

(3) While seeking to ensure value for money in service provision, we should avoid service provider changes that only achieve a relocation of existing staff and contractors rather than an increased workforce capacity.

(4) Consultation and engagement with clinicians and communities outside our established advisory committees should be dependent on how that might advance significant changes in practice and service delivery and be consistent with and limited by resource and time constraints available.

(5) Small funded projects or pilots should be aggregated up into larger and potentially longer term projects with the purpose delineated as an expected outcome.

(6) Geographic-based funding needs to consider local government boundaries, the established commercial trade routes of communities and traditional transport flows of communities to services.

(7) We should attempt to encourage local service delivery rather than drive/fly in and drive/fly out (DIDO or FIFO) providers.

(8) We utilise a range of approaches to commissioning that include open and selective tenders, EOI and direct approaches to existing approved providers. The rationale for the method selected needs to be confirmed as a desired approach, as required.

(9) Commissioning should include strategic requirements to encourage potential providers, within the process, to address how they will respond to outcome requirements for greater collaboration, integration, improved access, client/patient navigation through services, increased emphasis on prevention and promotion and innovation generally.

(10) The piloting of outcome measures, model comparison, service co-design approaches are consistent with these principles.

(11) As far as possible and within the limited available resources, we attempt to ensure that clinician and consumer and subject matter expertise consultations be completed before internal recommendations/decisions are attempted.

(12) The performance and effectiveness of existing providers be properly assessed and considered in the tender process, decision making and in management of the service contract.

The experience of the authors is that the PHN has adapted commissioning to the geographic and clinical realities evident in diverse sub-regions and has consistently and progressively applied the principles of localism and subsidiarity. The practices of innovating, coordinating and strategizing and so forth "constitute an emergent and complex social phenomenon that

depends on the active involvement of practitioners" (Gkeredakis *et al.*, 2010, p. 7). While practitioners exercise judgement, they are invariably "constrained by justification of a community of practitioners" (Gkeredakis *et al.*, 2010, p. 7). Managers in commissioning apply "norms and collective understandings" to constitute understanding and to resolve commissioning decisions, while practitioners use knowledge in action that makes a difference in practice (Gkeredakis *et al.*, 2010, p. 8). This theory represents the context and the reality in which the authors and the organisation operate.

Complex systems cannot be represented or explained by unified theory. Innovation is both a process and an outcome but is also an uncertain process with multiple meanings (Grimm *et al.*, 2013). Social innovation is seen as a move away from existing focus on technology and economic dogma to encourage "societal and systemic changes" and is said to be attractive to policy makers given the difficulty traditional welfare systems have in responding to communities such as those with which HNECCPHN is engaged. Social innovation can be described as a new combination or configuration of practice and as a "means to an end", that can be described as "a process oriented social innovation" (Grimm *et al.*, 2013, p. 450).

HNECCPHN outcomes

The authors offer the following evidence from their analysis of progress so far in innovative commissioning. The evidence is based on the identifiers of social innovation described by Pestoff and Brandsen (2010). They are examples of our initial and continuing contribution to health reform:

> Governance has been deliberately innovative in the inclusion of an independent Chair, the inclusion of CEs of the major acute care providers (LHD) on the Board and the inclusion of skilled based Indigenous persons on the Board.
>
> The establishment online of our engagement and innovation processes of "Peoplebank" and "Innovate8", supported by our "compass data" are innovative. This innovation has been supported by eight other PHNs adopting "Peoplebank" and two other PHNs adopting "Innovate8".
>
> The inclusion of clinical and community based advisory committees, actively engaged in the commission consultation processes has been significant. This has been enhanced with provider forums, engagement of clinicians and communities in "pitch nights" and extensive education forums that all give impetus to social innovation being about "new user – provider relationships, public consultations and participation in decision-making processes" (Grimm *et al.*, 2013, p. 440).
>
> Co-production and co design of services, include the youth complex mental health services, the diabetes alliance model utilising clinical case conferencing in general practice and the Mental Health and Suicide Prevention Access and Referral Service. These are exemplars of social innovative that suggest multi-method approaches, that engages directly with providers and target groups that might be marginalised and economically disadvantaged (Grimm *et al.*, 2013).
>
> An extensive investment in examining the impact of obesity as a pre-determinant of high levels of chronic disease has been achieved by the adoption of a healthy weight program. It has at its centre a randomised control research project that examines assessment and interventions through general practice. Early results of this study suggest very positive results that will be the subject of a future publication. The project has also provided funding and incentives for community-based action. The authors are confident that this will become an exemplar of innovation in improved PHC outcomes.
>
> The PHN is implementing an innovative rural communities project to allow the PHN to become more closely engaged with distant rural communities and the clinicians that do not have adequate access to health services. The project has engaged directly with two communities, clinicians, local government to assess their views of health status, and has sought community determination of what are priority health needs and how best to meet them. This innovation will allow the testing of placed based commissioning.

The PHN is implementing some navigation pilot programs where positions of "navigators" will be engaged, in some communities, to ensure connectedness between patients and their general practitioner diagnosis, treatment directions and access to those services. It will emphasise improved health literacy and the effectiveness of implementation of general practice advice. These pilots have potential to better support patients between general practice visits and visits to psychological, nursing, allied health, mental health and diagnostic services, particularly for those with a burden of chronic disease. A similar Aboriginal Health worker role in general practice also sustains mental health status with a focus on cultural and spiritual underpinnings and the two roles might prove to be at least complementary.

The engagement of Aboriginal communities is a considerable focus. HNECC has developed a set of principles to guide commissioning of funds which are culturally appropriate and deliver to locally identified needs of Aboriginal and Torres Strait Islander people while working closely with local Aboriginal Community Controlled Health Organisations (ACCHOs) (HNECCPHN, 2019d). These principles are available at HNECCPHN website. We have used the community of practice approach to determine the best ways to deliver services in different communities. The challenge of responding culturally to local communities, while managing service demand has been significant. Capacity building grants have been made available for local ACCHOs, to enhance their current services or to offer programs which build the health literacy and self-management of the community.

The strength of the partnerships that HNECCPHN has formed with the Local Health Districts within the region has enabled a maturity in the area of joint commissioning that has yet to be achieved by other PHNs. Both HNELHD and CCLHD have established formal alliances with HNECC which enable clinicians and managers from partnered organisations to work on truly integrated programs to develop and test new models of care. The alliances have shared agreed performance measures which enable the partners to evaluate the impact of programs on the goals of each of the partners. This has also enabled the partners to combine funding and resources to enable integrated care across a range of clinical treatment areas. These include diabetes, chronic obstructive airways disease and urgent care.

Conclusion

The authors conclude that the early insistence on giving priority to innovation and wherever possible evidence-based decision making has provided an internal organisational discipline that has had a positive effect on the work we do. This approach has enabled us to re-imagine knowledge and better frame it as part of what we all do in our daily work practices. The practices of innovating, coordinating, collaborating and strategizing in the PHN are examples of the language we use in our daily work practices that require us to be skilled in being adaptive.

The funding of the PHN has increased exponentially reflecting a significant increase of PHC services across the region. The funding is defined mostly through contractual relationships. The core funding supports the PHN operational purposes including support services to PHC practitioners, the bulk of the funding is provided in specific funding for services, notably mental health, drug and alcohol services, aboriginal health to name a few. The purpose of the funding is defined in contracts and mostly limited to annual funding. The authors conclude that this reflects a resource difficulty in annual re-negotiation for continued funding and presents hesitancy for providers and contracted health professions to be committed to a service or location. The authors suggest a longer contractual term.

The authors agree that networks developed have played a significant role in the commissioning purpose of the PHN, particularly in enacting health system strengthening through effecting greater stakeholder engagement to focus on solving complex and often entrenched systemic problems.

In conclusion, the first three years of progress of PHNs and HNECCPHN has achieved a rich tapestry of services and interconnections between providers, clinicians and communities. It provides the potential to build on what has been achieved and to meet identified significant priorities.

The authors acknowledge the commitment and dedication of staff in coming together in a new organisation that has asked much of them in terms of workload and travel across the region. Considerable effort has been made to build and monitor a positive and engaged culture across the organisation. This reinforces the view of the authors that health care is essentially a value-based industry where people are engaged in delivering services and care to other people.

References

Agterberg, M., Van den Hooff, B., Huysman, M. and Soekijad, M. (2010), "Keeping the wheels turning: the dynamics of managing networks of practice", *Journal of Management Studies*, Vol. 47 No. 1, pp. 85-108.

Bailie, J., Cunningham, F.C., Bainbridge, R.G., Passey, M.E, Laycock, A.F., Bailie, R.S., Larkins, S.L, Brands, J.S.M., Ramanathan, S., Abimbola, S. and Peiris, D. (2018), "Comparing and contrasting 'innovation platforms' with other forms of professional networks for strengthening primary healthcare systems for Indigenous Australians", *BMJ Global Health*, Vol. 3 No. 3, pp. 1-8.

Bassett, C.C. (2004), "Phenomenology", in Bassett, C.C. (Ed.), *Qualitative Research in Health Care*, Whurr, London, pp. 1-185.

Billings, J.R. and de Weger, E. (2015), "Contracting for integrated health and social care: a critical review of four models", *Journal of Integrated Care*, Vol. 23 No. 3, pp. 153-175.

Bodenheimer, T. and Sinsky, C. (2014), "From triple to quadruple aim: care of the patient requires care of the provider", *Annals of Family Medicine*, Vol. 12 No. 6, pp. 573-576.

Briggs, D.S. (2009), "The lived experience of health services managers, their perceptions of the health system and the health management role", unpublished doctoral thesis, University of New England, Armidale.

Briggs, D.S. (2014), "Localism: a way forward?", *Asia Pacific Journal of Health Management*, Vol. 9 No. 1, pp. 4-6.

Briggs, D.S. (2017), "Challenges for health systems: Australian perspectives", *Public Administration and Policy*, Vol. 20 No. 1, pp. 6-17.

Briggs, D.S., Cruickshank, M. and Paliadelis, P. (2012), "Health managers and health reform", *Journal of Management and Organization*, Vol. 18 No. 5, pp. 641-658.

Calder, R., Dunkin, R., Rochford, C. and Nichols, T. (2019), "Australian health services: too complex to navigate, a review of the national reviews of Australia's health service arrangements", Australian Health Policy Collaboration, Melbourne, available at: www.mitchellinstitute.org.au/reports/australian-health-services-too-complex-to-navigate/

Checkland, K., McDermott, I., Coleman, A., Warwick-Giles, L., Bramwell, D., Allen, P. and Peckham, S. (2018), "Planning and managing primary care services: lessons from the NHS in England", *Public Money and Management*, Vol. 38 No. 4, pp. 261-270.

Corradi, G., Gherardi, S. and Verzelloni, L. (2010), "Through the practice lens: where is the bandwagon of practise – based studies heading?", *Management Learning*, Vol. 41 No. 3, pp. 265-283.

Department of Health, Australian Government (2018), "Hunter New England and Central Coast PHN profile", available at: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Hunter_New_England_Central_Coast (accessed 18 November 2019).

Dixit, S.K. and Sambasivan, M. (2018), "A review of the Australian healthcare system: a policy perspective", *SAGE Open Medicine*, Vol. 6, pp. 1-14, available at: https://journals.sagepub.com/doi/10.1177/2050312118769211#articleCitationDownloadContainer

Ferlie, W. (2010), "Public management 'reform' initiatives and the changing organization of primary care", *London Journal of Primary Care*, Vol. 3, December, pp. 76-80, doi: 10.1080/17571472.2010.11493306.

Gkeredakis, E., Swan, J., Clarke, A., Powell, J., Nicolini, D., Scarbrough, H., Roginski, C. and Taylor-Phillips, S. (2010), "Understanding knowledge utilisation in healthcare management practice", paper submitted to the 7th Biennial International Conference in Organisational Behaviour in Health Care (OBHC), University of Birmingham, Warwick.

Grimm, R., Fox, C., Baines, S. and Albertson, K. (2013), "Social innovation, an answer to contemporary societal challenges? Locating the concept in theory and practice", *Innovation – The European Journal of Social Science Research*, Vol. 26 No. 4, pp. 436-455.

Hartwich, O. (2013), "A global perspective on localism", occasional paper, The New Zealand Initiative and LGNZ, Wellington, available at: http://nzinitiative.org.nz/reports-and-media/reports/a-global-perspective-on-localism/

HNECCPHN (2019a), "Health planning reports and profiles", available at: www.hneccphn.com.au/planning-commissioning/health-planning-reports-profiles/ (accessed 18 November 2019).

HNECCPHN (2019b), "PeopleBank", available at: https://peoplebank.hneccphn.com.au/ (accessed 18 November 2019).

HNECCPHN (2019c), "Profiles", available at: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Profiles (accessed 18 November 2019).

HNECCPHN (2019d), "Indigenous commissioning", available at: www.hneccphn.com.au/media/13920/indigenous-commissioning-principles-oct16.pdf (accessed 18 November 2019).

HNECCPHN (2019e), "Commissioning strategy", available at: www.hneccphn.com.au/media/14991/016753-phn-hnecc-commissioning-strategy.pdf (accessed 18 November 2019).

Horvarth, J. (2014), "Review of Medicare Locals: report to a the Minister for Health and Sport", available at: www.health.gov.au/internet/main/publishing.nsf/Content/review-medicare-locals-final-report (accessed 18 November 2019).

Hustad, E. (2010), "Exploring knowledge work practices and evolution in distributed networks of practice", *Electronic Journal of Knowledge Management*, Vol. 8 No. 1, pp. 69-78.

Javanparast, S., Baum, F., Barton, E., Freeman, T., Lawless, A., Fuller, J., Reed, R. and Kidd, M. (2015), "Medicare Locals: local health network partnerships in south australia: lessons for primary health networks", *The Medical Journal of Australia*, Vol. 203 No. 5, pp. 219.e1-219.e6.

McCafferty, S., Williams, L., Hunter, D., Robinson, S., Donaldson, C. and Bate, A. (2012), "Implementing world class commissioning competencies", *Journal of Health Services Research and Policy*, Vol. 17 No. 1, pp. 40-48.

Pestoff, V. and Brandsen, T. (2010), "Public governance and the third sector: opportunities for co-production and innovation?", in Osborne, S.P. (Ed.), *The New Public Governance? Emerging Perspectives on Theory and Practice of Public Governance*, Routledge, London and New York, NY, pp. 223-236.

Rapport, F., Braithwaite, J., Mitchell, R., Westbrook, J. and Churruca, K. (2017), "Transitional care in a federated landscape", in Aase, K., Waring, J. and Schibevaag, L. (Eds), *Researching Quality in Care Transitions: International Perspectives*, Palgrave Macmillan, London, pp. 179-200.

Shaw, S.E., Smith, J.A., Porter, A., Rosen, R. and Mays, N. (2013), "The work of commissioning: a multisite case study of healthcare commissioning in England's NHS", *BMJ Open*, Vol. 3 No. 9, pp. 1-10.

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Impacts of social welfare system on the employment status of low-income groups in urban China

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Received 2 March 2019
Revised 3 June 2019
13 August 2019
Accepted 25 September 2019

Abstract

Purpose – Aiding employment is an important poverty reduction strategy in many countries' social welfare systems, as this strategy can help empower the recipients with a better living standard, development and social inclusion. The purpose of this paper is to identify the most significant individual and systematic variables for the employment status of low-income groups in urban China.

Design/methodology/approach – The data of this study are drawn from "Social Policy Support System for Poverty-stricken Families in Urban and Rural China 2015" report. The Ministry of Civil Affairs of the People's Republic of China appointed and funded the Institute of Social Science Survey (ISSS) at Peking University to deliver the related project and organize a research team to write the report. Multiple binary logistic regression analysis is adopted to identify both individual and systematic factors that affect the employment status among low-income groups in urban China.

Findings – According to the results of the binary logistic regression model, individual factors, including: gender; householder status; education; and self-rated health status, play a significant role in determining the employment status of low-income groups in urban China. Clearly, the impacts of individual factors are more influential to marginal families than to families entitled to receive Basic Living Allowance. In contrast, compared with marginal families, systematic factors are more influential to families entitled to receive Basic Living Allowance.

Originality/value – This study highlights the importance of precise poverty reduction strategy and the issue of "welfare dependence" among low-income groups in urban China. Policy recommendations derived from the findings are hence given, including: the promotion of family-friendly policies; the introduction of a smart healthcare system; the establishment of a Basic Living Allowance adjustment mechanism; and the provision of related social services.

Keywords Employment, Urban China, Low-income groups, Basic Living Allowance, Welfare dependence

Paper type Research paper

Introduction

The relationship between poverty and unemployment has always been a controversial topic, especially for developing countries (Visaria, 1981). Employment empowers the poor to adapt to development of the society, and therefore, the employment of the poor is always at the core of poverty alleviation strategies (Corcoran and Hill, 1980). However, some scholars now argue that globalization presents new challenges to traditional poverty alleviation strategies because of intense global competition, the technological displacement of low-skilled workers and slimmer chances of upward social mobility for

Public Administration and Policy
Vol. 22 No. 2, 2019
pp. 125-137
Emerald Publishing Limited
1727-2645
DOI 10.1108/PAP-09-2019-0020

younger generations (Ukpere and Slabbert, 2009). Generally, the unemployment rate of low-income groups is higher than medium- and high-income groups. The reasons for adverse employment status among low-income groups include irregular employment, lack of social security, long working hours, low income and a lower chance of changing job (Wu, 1994; Yin and Wang, 2015). Worse still, unemployment has more adverse impacts on low-income groups and is now one of the main drivers of poverty and inequality in Chinese cities (Xue and Zhong, 2003).

This problem is not unique to China, and so, in the hope of alleviating poverty, increasing labor participation and lowering unemployment among low-income groups have become standard policy and practice across many countries. Some studies have shown that an increase in public capital, especially on infrastructure, can reduce the unemployment rate by improving the quality of human capital (Akinbobola and Saibu, 2004). Governments around the world have experimented with several innovative measures, that differ from traditional social security systems. For example, the government of Botswana has long made use of its informal sector economy to ease the uneven regional development, like unemployment and poverty (Hope, 1996). The government of India introduced the National Rural Employment Guarantee Act (NREGA) in 2006, which stipulates that federal and local governments should provide at least 100 days of work and pay for the rural poor families with predetermined remuneration. Therefore, poor farmers are provided with a sustainable and Basic Living Allowance, which increases their chances of improving their socio-economic conditions (Haque, 2011). It has also been shown that there is strong relationship between income distribution and the growth of the employment rate in Pakistan (Aurangzeb and Asif, 2013). In South Africa, the government has introduced proactive measures which enable the young poor to select a grant with pro-employment arrangements, such as grants conditional on accepting training and education, as well as, opportunity vouchers for employers (Altman *et al.*, 2014). For the sake of dealing with the issue of welfare dependence, Orszag and Snower proposed to adopt unemployment accounts rather than traditional unemployment benefits (Orszag and Snower, 2002). Most programs of employment promotion or poverty alleviation here can be considered a social investment and are operated under the principle of cost-effectiveness (Hope, 1992; Hope, 1996).

Due to the transition from a centrally planned economy to a market economy, the Chinese Central government has already adopted various measures to ease conflicts that have arisen from the transition, such as the New Labor Contract Law – intended to balance labor market flexibility, labor protection, and assistance to laid-off workers at state-owned enterprises (SOEs) following reforms. As a result, the relationship between social assistance and employment in China could be different from those of other countries.

China's social assistance system

Being a responsible government of a developing economy, the Chinese government has always paid attention to the employment situation of low-income groups, and has traditionally maintained a reasonable living standard for low-income groups through measures like employment assistance and aid. However, the government has recently experimented with some proactive measures, including the introduction of public posts and the enrichment of a spectrum of social assistance measures (Han, 2016). In order to fulfill China's precise poverty reduction strategy, the government has carried out family budget investigations and then designed employment aid, monetary support and employment services based on their findings, and offered social assistance to help maintain their living standards (Han, 2016). However, several studies indicate that these policy attempts have achieved little progress, and the low employment rate of low-income groups still regularly

captures public attention (Wang, 2009, 2017). Other studies further prove that the proportion of the related policy coverage (low-income groups with working capacity receiving Basic Living Allowance in urban China) was 75 percent in 2007 (Wang, 2009) and 63 percent in 2015 (Wang, 2017). To address this gap, this study focuses on how poverty alleviation strategy in China should switch from a traditional welfare system, to instead, one that identifies the barriers to job-seeking low-income groups, in addition to promoting the effectiveness of poverty reduction measures.

Individual factors that affect the employment prospects of low-income groups have already been identified in several studies, which include: age, gender, education, health condition and attitude. For example, the relatively older people have stronger desire to seek work (Wang, 2011). Males are more likely to have a stronger aspiration to be reemployed than females (Wang, 2012). Individuals with higher education tend to have more aspiration to seek work (Huang, 2007). Middle-aged and older adults, due to their inferior working capacity, have fewer opportunities to be employed (Lin and Lu, 2012). Finally, some studies demonstrate that the awareness of the responsibilities of the unemployed or the responsibility to work could affect the likelihood of being reemployed (Ci, 2003; Huang, 2007).

Systematic factors can also weaken the effectiveness of poverty reduction measures, with the two main issues being welfare dependence (Hong, 2005; Bian, 2014) and a significant degree of fragmentation among poverty reduction measures (Huang, 2007; Qiao, 2009). First, the current system guarantees beneficiaries a relatively stable expectation of payments. As long as there is no significant income increase, they can expect a monthly fixed payment given by the government. This has been shown to fuel dependency among recipients (Hong, 2005). This form of compensation also discourages beneficiaries from seeking better paid jobs because it means that earning more from employment reduces the amount of subsidy payments (Bian, 2014; Li and Xiao, 2007). Second, some studies have found that the irrational design of the tied aid system – such as the high level of Basic Living Allowance and corresponding benefits – reinforces the incentives of low-income groups to stay in the social security system (Xiao and Li, 2016). Replacement ratio is an important indicator of measuring the relation between social aid and working motive – the lower replacement ratio is, the higher the motivation to work is (Qiao, 2009). However, the gap between the current minimum wage and Basic Living Allowance is too narrow, leading to a very high replacement ratio, which adversely impacts working motive (Zhou, 2012). Finally, there is no positive correlation between Basic Living Allowance and reemployment. As a result, the current employment service cannot assist low-income individuals in exiting the social security system, and other services like employment and training agencies cannot be put into effective practice (Qin, 2017). Although many cities have adopted policies to "withdraw aid step by step," their execution time has been too short and the outcomes have been unsatisfactory (Li and Xiao, 2007).

In 2007, China's central government enacted the New Labor Contract Law to balance labor market flexibility and labor protection. However, some studies have shown that the law has increased the probability of laying-off workers with more than 10 years of employment (Akee *et al.*, 2019). Furthermore, due to SOE restructuring in the late 1990s, around 30m laborers were laid off, but they maintained a relationship with their work unit and hence entitled to receive Basic Living Allowance. The laid-off SOE workers were not counted as unemployed, because they are not eligible for social assistance benefits (Günter, 2009). Moreover, many workers without urban *hukou* (household registration) are also not qualified for unemployment benefits (Cai and Chan, 2009). The Chinese government focuses on the development of labor-intensive industries, like automobile manufacturing and machine-building, to absorb low-skilled laborers and low-income groups (Cai and Chan, 2009). Such labor policies can mediate the impacts of social assistance system on the employment prospects of low-income groups.

Aside from discussing how the effectiveness of poverty alleviation strategies is affected by individual and systematic factors, limitations which also raise concerns include the ignorance of marginal or low-income groups at legal working age and with working capacity. In this context, on the basis of differentiating the beneficiary and marginal groups of the current security system, this study explores the internal mechanisms that affect the employment of low-income groups – specifically citizens at legal working age with working capability – in regard to both individual and systematic factors.

Methodology

Sampling

The data of this study is drawn from the "Social Policy Support System for Poverty-stricken Families in Urban and Rural China 2015" report. The Ministry of Civil Affairs of the People's Republic of China appointed and funded the Institute of Social Science Survey (ISSS) at Peking University to deliver the related project and organize a research team to write the report. As the target population is low-income groups, purposive sampling is adopted. The sampling frame is provided by the Ministry of Civil Affairs, while ISSS executes administrative procedures, such as proportional population sampling, interviewer training and data collection by Computer Assisted Personal Interviewing (CAPI) (Peking University Open Research Data, 2016). The sample size is made up of more than 170,000 individuals in 29 provinces (excluding the Tibet Autonomous Region, Xinjiang Uygur Autonomous Region, Taiwan, Hong Kong and Macau) between July and December 2015. The report collected data from 4,232 rural families, 7,338 urban families, and 2,609 migrant families. Since the target population of the study is urban families, the authors have excluded ineligible respondents, such as students, retired people, people with no formal education and those lacking working capability. This means the sample size of the study is narrowed down to 2,973. The data have previously been adopted in some studies, like medical financial assistance program (Liu *et al.*, 2017) and the situation of low-income groups (Han and Tang, 2018).

Variables and measurement

Dependent variable. "The Status of Employment of Respondents" serves as the dependent variable in this study. This variable is further divided into two categories, namely, the employed and the unemployed. The employed include establishment, contract and temporary workers, self-employed people and farmers; the unemployed include but not limited to laid-off workers, jobless people with working capability, and long-term housekeepers.

Independent variable. The selected independent variables, referenced to the study conducted by Han and Guo (2012), are divided into both individual and systematic variables. Individual variables include gender, age, marital status, education and health condition. The authors have also added a variable by listing the role of respondents in their family so as to examine the impact of family role on the process of job seeking. Systematic variables are divided into three categories, namely, subsistence security system, tied aid system and employment system. The characteristic variables of the subsistence security system include low-income family, the amount of Basic Living Allowance, the length of time to receive Basic Living Allowance, and the evaluation of a sense of stigma to receive Basic Living Allowance. The characteristic variables of the tied aid system include types of per capita tied aid services and per capita government assistance income. The characteristic variables of the employment system include types of per capita employment and entrepreneurship services. The definition of evaluating dependent variable and independent variable can be further seen in Table I.

Dependent variable		1 = Employment; 0 = Unemployment
Independent variable		
Characteristic variable of individual	Gender	1 = Male; 0 = Female
	Age	The actual age of respondents
	Marital status	1 = Married; 0 = Single, divorced or widowed
	Self-rated health status	1 = Very poor; 2 = Poor; 3 = Normal; 4 = Good; 5 = Very good
	Education	1 = High School or Above; 0 = Below High School
	Householder	1 = Yes; 0 = No
Characteristic variable of system	Low-income family	1 = Yes; 0 = No
	The amount of per capita basic living allowance	Per capita basic living allowance acquired by interviewed family (Hundred yuan)
	The length of receiving basic living allowance	The length of time to receive basic living allowance by interviewed family (Month)
	The level of agreement on sense of stigma to receive basic living allowance	1 = Strongly disagree; 2 = Partially disagree; 3 = Not Matter; 4 = Agree; 5 = Strongly Agree
	Per capita government assistance income	Per capita government assistance subsidy acquired by interviewed family (Hundred yuan)
	Types of per capita tied aid services	Per capita tied aid services enjoyed by interviewed family
	Types of per capita employment and entrepreneurship services	Per capita employment and entrepreneurship services enjoyed by interviewed family

Table I.
The evaluation status of variables in the regression model

Analytical methods

This study adopts Stata 14.0 as a tool to do the data analysis. When it comes to the statistic model, this study adopts the binary logistic regression model and concludes its mathematical expression as follows:

$$\log it(p) = \ln\left(\frac{p}{1-p}\right) = \beta_0 + \beta_1 RWC + \beta_2 MIGC,$$

where p represents the probability of the occurrence of an event and also represents the probability of the respondents to be employed. log$it(p)$ represents the natural logarithm of the ratio of the probability of occurrence and nonoccurrence. In other words, the more positive the value of log$it(p)$ the higher the likelihood for the respondents to be employed. β_0 is the intercept term of the regression; whereas β_1 and β_2 are the coefficients of *RWC* and *MIGC*, respectively. *RWC* is the individual variables and *MIGC* is the systematic variable.

Results

Descriptive statistics

As shown in Table II, the employment proportion of the respondents is 62.5 percent, among which the proportion of urban beneficiaries (people entitled to Basic Living Allowance) is 53.0 percent. Urban marginal families (people disqualified from Basic Living Allowance) make for 72.2 percent. It is more likely for beneficiaries to be unemployed.

	Employment	Unemployment
Families entitled to basic living allowance	798 (53.0%)	708 (47.0%)
Marginal families	1,059 (72.2%)	408 (27.8%)
All	1,857 (62.5%)	1,116 (37.5%)

Table II.
The employment status of marginal families and families entitled to basic living allowance

Table III demonstrates the current amount of Basic Living Allowance received in urban China is relatively low overall with per capita allowance of only 246 yuan per month, while the length of receiving the allowance is close to six years on average and relatively long compared with western countries, in which citizens spend around one year on equivalent allowances (Immervoll *et al.*, 2015). Compared with unemployed beneficiaries, the length of time during which employed people receive the Basic Living Allowance and the amount of Basic Living Allowance per capita they get are lower by 8.4 months and 80 yuan, respectively. The gap of Basic Living Allowance is closely associated with the implementation of the corresponding compensation system and the gap of time to receive allowance may result in beneficiaries without jobs having a higher degree of dependence on the system.

Table IV shows which types of current low-income families in urban China enjoy tied aid services of 0.40 per capita. Meanwhile, employment and entrepreneurship services were only 0.13 per capita, indicating an obvious deficiency of employment and entrepreneurship services provided for low-income families. Such a condition may help conclude that the Basic Living Allowance beneficiaries enjoy more types of tied aid services than the marginal ones, and this finding reflects that the procedure of combining social welfare system in urban China with tied aid services significantly constrains marginal beneficiaries from receiving tied aid services.

Regression model

This study establishes three models. Model 1 focuses on the overall sample of low-income groups. Model 2 concentrates on the sample of marginal groups. Model 3 centers on the sample of families entitled to Basic Living Allowance.

Among all individual factors, the three models have similar significant factors for promoting the likelihood of being employed, including being male, having a high self-rated health status, and being a householder. Having a high school education lowers the likelihood of being employed among families entitled to Basic Living Allowance. As a whole, the magnitude of the coefficients in the model of marginal families is higher than that in the model of the families entitled to Basic Living Allowance.

Among all systematic factors, the three models do not share the same set of significant systematic factors. Generally, the higher the income from government assistance, Basic

Table III.
The length of time of receiving basic living allowance and the amount of per capital basic living allowance against employment status

	The length of receiving basic living allowance (month)	The amount of per capital basic living allowance (yuan)
Employed	65.47	210
Unemployed	73.87	290
All	69.06	246

Table IV.
Tied aid and employment and entrepreneurship services per capita among marginal families and families entitled to basic living allowance

	Per capita entitled tied aid services	Per capita entitled employment and entrepreneurship services
Families entitled to basic living allowance	0.55	0.14
Marginal families	0.23	0.13
All	0.40	0.13

Living Allowance and entitled tied aids, the smaller the likelihood of being employed. However, those who use employment and entrepreneurship services increase the likelihood of being employed. Among marginal families, those entitled to employment and entrepreneurship services have a higher likelihood of being employed. Among families entitled to Basic Living Allowance, the likelihood of being unemployed is increased by the higher per capita of Basic Living Allowance they receive, a higher perceived level of social stigma; and the higher per capita of tied aids. The identified significant factors in the full model may simply consist of all the factors in the model of marginal families and the families entitled to Basic Living Allowance. Without doubt, systematic factors have significant effect on families entitled to Basic Living Allowance.

This data demonstrates that individual factors are more influential to the likelihood of being employed among marginal households, whereas more systematic factors affect the likelihood of being employed among the families entitled to Basic Living Allowance (Table V).

Conclusion

The challenges of social assistance in China include decreasing the number of beneficiaries – via stringent requirements – and introducing target methods, derived from more precise and comprehensive information about applicants, so that some low-income families are dropped from China's social assistance system (Yang, 2018). It is therefore necessary to examine the differences among the different low-income groups, such as marginal families and families

Name of variable	Model 1 (all objects) β	Model 1 (all objects) OR	Model 2 (marginal families) β	Model 2 (marginal families) OR	Model 3 (families entitled to basic living allowance) β	Model 3 (families entitled to basic living allowance) OR
Individual factors						
Male	*0.453***	*1.573***	*0.702***	*2.018***	*0.329**	*1.390**
Age	−0.003	0.997	0.002	1.002	−0.005	0.995
Married	0.064	1.067	0.054	1.056	−0.265	0.767
Self-rated health status	*0.415***	*1.515***	*0.530***	*1.698***	*0.308***	*1.361***
Having high school education	−0.087	0.917	0.138	1.148	*−0.405***	*0.667***
Householder	*0.659***	*1.933***	*0.731***	*2.078***	*0.628***	*1.875***
Systematic factors						
Per capita government assistance income	*−0.009***	*0.991***	−0.015	0.986	0.005	1.005
People entitled to basic living allowance	*−0.444***	*0.642***	–	–	–	–
The amount of per capita basic living allowance	–	–	–	–	*−0.368***	*0.692***
The length of time to receive basic living allowance	–	–	–	–	−0.002	0.998
The level of agreement on the sense of stigma to receive basic living allowance	−0.006	0.994	0.08	1.084	*−0.098**	*0.906**
Number of per capita entitled tied aid	*−0.312***	*0.732***	0.032	1.032	*−0.227**	*0.796**
Number of per capita entitled employment and entrepreneurship service	*0.299**	*1.349**	*0.673**	*1.961**	0.298	1.347
Constant term	−0.820*	0.440*	−1.923***	0.146***	0.431	1.539
Pseudo R^2	0.098		0.114		0.098	
n	2,890		1,432		1,237	

Notes: *,**,***Significant at 10, 5 and 1 percent levels, respectively

Table V.
The regression result of the logistic model on the working situation of respondents

entitled to Basic Living Allowance. In the midst of reforms in China's social assistance system, the shrinking demographic dividend and the narrowing wage gap between unskilled and skilled workers is leading to lower incentives for schooling and a higher replacement ratio of social assistance (Cai and Du, 2011), as well as, multidimensional objectives of poverty reduction strategies (Wang *et al.*, 2016). Expectedly, poverty reduction should be approached differently when it comes to marginal families and those entitled to Basic Living Allowance. The impacts of individual factors are more influential in marginal families than families entitled to Basic Living Allowance, which are more affected by systematic factors.

This study also concludes that the identified individual factors, including being a householder, male and good self-rated health status, are similar to the finding of previous studies. Age and marriage status are not identified as significant factors, perhaps because people across the spectrum in these categories may also be both a householder (which is less likely to be adopted as an independent variable in previous studies) and male. The results also echo research showing that single-mother families face lower chances of employment and a higher risk of poverty (Damaske *et al.*, 2017; Wu, 2011), because female householders spend more time on raising their children and caring for their families. This study also finds that, among families entitled to Basic Living Allowance, having a higher education leads to lower likelihood of being employed. This conflicts with the commonly accepted belief that higher education leads to higher incentive to find work. One of the possible explanations to this is that respondents with higher education often demand better jobs. In other words, it is difficult for the respondents with higher education to find their jobs (usually non-labor-intensive jobs). Perhaps it is more likely for the respondents with higher education to be unemployed intentionally. Indeed, Zhang (2018) verifies that current employment assistance has limited power to encourage young recipients to join the labor market.

As for the most significant systematic factors, our models indicate that families entitled to Basic Living Allowance are less likely to be employed than marginal families. This difference in the two models highlights the adverse effects of "welfare dependence" (among families entitled to Basic Living Allowance) brought about by China's poverty reduction strategy. The finding that employment and entrepreneurship services (wider range of related services) lead to a higher likelihood of being employed among marginal families demonstrates that, compared to families entitled to Basic Living Allowance, employment and entrepreneurship services provide stronger incentives or more relevant services for marginal families to join the labor market.

Compared with labor protection laws of most western countries, China has stronger employment protection regulations, like higher dismissal requirements and more stringent working conditions, i.e. wage and working time (Xie, 2017). According to a recent study, employers avoid the adverse impacts of the Labor Contract Law, by being more likely to dismiss formal-contract workers (Akee *et al.*, 2019). This results in low-skilled workers and poorly educated residents being forced to rely on the social assistance system. Because of this, vocational training is an important element of poverty reduction strategy (Chakravarty *et al.*, 2019) as it equips laborers with suitable and sought-after skills. Therefore, it is more likely for the recipients of employment and entrepreneurship services to be employed, and hence to leave the safety net. Chen and Funke (2009) recognize that the present Labor Contract Law encourages companies to innovate and motivate themselves to employ more high-skilled and highly educated workers. Highly educated workers have a higher expectation of their jobs, and are willing to spend more time on job searching, therefore, higher productivity can lead to further unemployment in urban China (Liu, 2013).

Policy recommendations

As gender and householder status are significant variables among low-income groups in urban China, the patriarchy must have a large effect on the employment prospects of

family workforce. In a male-dominated society, wage labor takes precedence over house work and people are mostly assigned to these two kinds of work according to their gender. Females need to take care of chores and are therefore forced to be jobless, while males are expected to be wage labors outside of their homes. Clearly, the equality of men and women should be actively advocated so as to solve the problem of gender discrimination (especially invisible discrimination) in the labor market. Family-friendly policies should be developed with the goal of building a harmonious working and family relationship, i.e., binding government, community and family together to help promote women's employment.

Health is one of the most crucial factors influencing the employment prospect of the workforce (Luo *et al.*, 2010). Illness derived from poverty and poverty caused by illness are both common phenomena that greatly hinder the employment prospects of many low-income people in urban China (Liu and Zhang, 2018). As a result, the improvement of healthcare systems, including, but not limited to, basic medical insurance, and medical assistance and healthcare, would improve the health of the young workforce in urban China in poverty. In particular, medical assistance policies should be strengthened and earnestly implemented, in order to provide low-income workers with better and more precise medical care (He and Nolen, 2019).

The current social assistance system reduces low-income people's incentive to work and encourages welfare dependence among its beneficiaries. It is necessary to note that "welfare dependence" can have different meanings in China and the West. In Western welfare states, "welfare dependence" is mainly measured by indicators, such as the length of time welfare is received, the number of instances a recipient has claimed welfare and the amount of subsidizations. It is usually concluded that subsidization is too high (Barrett, 2000). However, welfare dependence in China, as discussed in this study, places greater focus on the adverse incentive impacts generated by welfare systems. The authors make no suggestion that welfare dependence is caused by the current subsistence security system in urban China being too generous. Furthermore, "welfare dependence" is often employed by neo-conservatives in Western welfare states to attack their own welfare systems. Thus, from the perspective of the Chinese government, a balanced development of the welfare system is certainly a critical key to implementing its poverty alleviation strategy. In the midst of a diminishing demographic dividend and the rising burden of an aging population, the welfare system's adverse incentive impacts on employment should be highly stressed, but not the benefit level. Borrowing the findings of this study, an increase of per capita Basic Living Allowance, would help generate more obvious adverse incentive impacts on low-income groups. As a solution, a scientifically based Basic Living Allowance adjustment mechanism in urban China should be established (Zhong, 2012). Followed by changes in both the domestic and the international economic environments, such a standard can be adjusted in a comprehensive way with the per capita income of residents as the main factor and expenditure as a supplement. In this context, "welfare dependence" resulting from a very high standard, and lack of benefit deriving from a very low standard are, as a result, to be practically prevented (Wong *et al.*, 2014).

A reduction in stigma to receiving Basic Living Allowance as expected would lower the likelihood of being employed among the families entitled to Basic Living Allowance (Contini and Richiardi, 2012). The finding indicates that among welfare recipients, the "stigmatization effect" of social assistance is diminishing; in other words, the welfare recipients believe that it is reasonable for them to depend on the welfare system. Moreover, the tied aid system is still considered as an important cause of unemployment to its beneficiaries. Most of them are therefore reluctant to seek jobs and exit from this system, as they rely too much on their fringe benefits, especially housing and medical assistance. Furthermore, the current employment and entrepreneurship service system cannot work effectively to encourage its beneficiaries to work. This is because the beneficiaries have

working capability but are lacking adequate education and working skills, or the channel and function of their investment in human capital would still have certain restrictions. For example, some projects in the employment and entrepreneurship service system fail to meet all the needs of low-income groups and employers. Being a main form of the supply of employment and entrepreneurship service, occupation programs can only offer menial and labor-intensive jobs, like security guards and cleaners, who are paid the minimum wage or slightly above (Wang, 2018). Worse still, the income of such jobs is not steady, so that the impetus of systems on employment is relatively weak. For the sake of being entitled to Basic Living Allowance, few beneficiaries would turn down their potential job offers three times in a row. Even though they have to take up the job offered by the system, they would normally quit the jobs by very similar reasons of poor health or having no related skills, and again, they become unemployed in order to benefit from Basic Living Allowance and the corresponding fringe benefits. To effectively overcome such a serious policy dilemma, targeted occupational assistance and guidance should be further introduced by the Chinese government, in order to help current beneficiaries in accordance with their education, working skills, service hours and workplace (Duckett and Hussain, 2008). In particular, vocational training and education should be provided to recipients who lack working skills to strengthen their competitiveness in the job market; counseling services should be given to those who are reluctant to work to increase their willingness to work; and social services should be provided to the female recipients to ease their barriers to join the labor market again (Guan, 2014; Solinger, 2005). In China, the balance between work and family life has become one of the most crucial aspects of its poverty reduction strategy, which can be considered as a Pareto improvement to cater for the needs among different stakeholders.

References

Akee, R., Zhao, L.Q. and Zhao, Z. (2019), "Unintended consequences of China's new Labor Contract Law on unemployment and welfare loss of the workers", *China Economic Review*, Vol. 53, pp. 87-105.

Akinbobola, T.O. and Saibu, M.O.O. (2004), "Income inequality, unemployment, and poverty in Nigeria: a vector autoregressive approach", *The Journal of Policy Reform*, Vol. 7 No. 3, pp. 175-183.

Altman, M., Mokomane, Z. and Wright, G. (2014), "Social security for young people amidst high poverty and unemployment: Some policy options for South Africa", *Development Southern Africa*, Vol. 31 No. 2, pp. 347-362.

Aurangzeb, D.R. and Asif, K. (2013), "Factors effecting unemployment: a cross country analysis", *International Journal of Academic Research in Business and Social Sciences*, Vol. 3 No. 1, pp. 219-230.

Barrett, G.F. (2000), "The effect of educational attainment on welfare dependence: evidence from Canada", *Journal of Public Economics*, Vol. 77 No. 2, pp. 209-232.

Bian, S. (2014), "A study on the step-wise assistance of Basic Living Allowance of urban residents and its negative income tax mechanism", *Chinese Journal of Population Science*, No. 1, pp. 7-19 (in Chinese).

Cai, F. and Chan, K.W. (2009), "The global economic crisis and unemployment in China", *Eurasian Geography and Economics*, Vol. 50 No. 5, pp. 513-531.

Cai, F. and Du, Y. (2011), "Wage increases, wage convergence, and the Lewis turning point in China", *China Economic Review*, Vol. 22 No. 4, pp. 601-610.

Chakravarty, S., Lundberg, M., Nikolov, P. and Zenker, J. (2019), "Vocational training programs and youth labor market outcomes: evidence from Nepal", *Journal of Development Economics*, Vol. 136, pp. 71-110.

Chen, Y.F. and Funke, M. (2009), "China's new Labor Contract Law: no harm to employment?", *China Economic Review*, Vol. 20 No. 3, pp. 558-572.

Ci, Q.Y. (2003), "Taking Wuhan, social assistance and choices of reemployment of the unemployed: taking Hubei province as an example", *Chinese Journal of Population Science*, No. 4, pp. 63-78 (in Chinese).

Contini, D. and Richiardi, M.G. (2012), "Reconsidering the effect of welfare stigma on unemployment", *Journal of Economic Behavior & Organization*, Vol. 84 No. 1, pp. 229-244.

Corcoran, M. and Hill, M.S. (1980), "Unemployment and poverty", *Social Service Review*, Vol. 54 No. 3, pp. 407-413.

Damaske, S., Bratter, J.L. and Frech, A. (2017), "Single mother families and employment, race, and poverty in changing economic times", *Social Science Research*, Vol. 62, pp. 120-133.

Duckett, J. and Hussain, A. (2008), "Tackling unemployment in China: state capacity and governance issues", *The Pacific Review*, Vol. 21 No. 2, pp. 211-229.

Guan, X.P. (2014), "Towards a more active social assistance system", *Chinese Public Administration*, Vol. 349 No. 7, pp. 16-20 (in Chinese).

Günter, S. (2009), "China's employment crisis – a stimulus for policy change?", *Journal of Current Chinese Affairs*, Vol. 38 No. 2, pp. 121-144.

Han, K.Q. (2016), "The international experiences and reflection on systems of employment assistance", *Journal of the Party School of the Central Committee*, Vol. 20 No. 5, pp. 75-81 (in Chinese).

Han, K.Q. and Guo, Y. (2012), "The myth of welfare dependency in China: an empirical study on Basic Living Allowance in urban China", *Sociological Studies*, No. 2, pp. 149-167 (in Chinese).

Han, K.Q. and Tang, J. (2018), "The development of the definition and evaluation of poverty in China", *Jiangsu Social Sciences*, No. 2, pp. 24-30 (in Chinese).

Haque, T. (2011), "Socio-economic impact of implementation of Mahatma Gandhi National Rural Employment Guarantee Act in India", *Social Change*, Vol. 41 No. 3, pp. 445-471.

He, H.J. and Nolen, P.J. (2019), "The effect of health insurance reform: evidence from China", *China Economic Review*, Vol. 53, pp. 168-179.

Hong, D.Y. (2005), "When morality and justice become systems: a discussion on the extension effect and evolution of the practice of urban subsistence security system", *Comparative Economic and Social Systems*, No. 3, pp. 16-25 (in Chinese).

Hope, K.R. (1992), *Development Policy and the Poor: Toward a Reform Framework*, International Development Research Centre, Ottawa.

Hope, K.R. (1996), "Growth, unemployment and poverty in Botswana", *Journal of Contemporary African Studies*, Vol. 14 No. 1, pp. 53-67.

Huang, C.X. (2007), "Job-seeking behaviors of clients of MLSGS-UR and related institutional arrangements in shanghai", *Sociological Studies*, No. 1, pp. 137-160 (in Chinese).

Immervoll, H., Jenkins, S.P. and Königs, S. (2015), "Are recipients of social assistance 'Benefit Dependent'? Concepts, measurement and results for selected countries", IZA Discussion Papers, No. 8786, Institute for the Study of Labor (IZA), Bonn.

Li, Y.S. and Xiao, Y.F. (2007), "The realistic dilemma of the practice of urban subsistence security system and the choice of its reform path", *Jianghai Academic Journal*, No. 2, pp. 120-126 (in Chinese).

Lin, C.L. and Lu, X.T. (2012), "An analysis on policies affecting the employment of urban groups entitled to Basic Living Allowance: binary logistic regression model and empirical research on interviews of employment", *China Soft Science*, No. 8, pp. 23-34 (in Chinese).

Liu, K., Yang, J. and Lu, C. (2017), "Is the medical financial assistance program an effective supplement to social health insurance for low-income households in China? A cross-sectional study", *International Journal for Equity in Health*, Vol. 16 No. 1, pp. 138-151.

Liu, L. and Zhang, Y.T. (2018), "Does non-employment based health insurance promote entrepreneurship? Evidence from a policy experiment in China", *Journal of Comparative Economics*, Vol. 46 No. 1, pp. 270-283.

Liu, Y. (2013), "Labor market matching and unemployment in urban China", *China Economic Review*, Vol. 24, pp. 108-128.

Luo, J., Qu, Z., Rockett, I. and Zhang, X. (2010), "Employment status and self-rated health in Northwest China", *Public Health*, Vol. 124 No. 3, pp. 174-179.

Orszag, J.M. and Snower, D.J. (2002), "From unemployment benefits to unemployment accounts", IZA Discussion Paper No. 532, Bonn, available at: https://ssrn.com/abstract=323563

Peking University Open Research Data (2016), "Social policy support system for poverty-stricken families in urban and rural China 2015", Peking University Open Research Data, available at: http://opendata.pku.edu.cn/dataset.xhtml?persistentId=doi:10.18170/DVN/HFLLFO (accessed March 19, 2019).

Qiao, S.D. (2009), "The existing problems and countermeasure study of exit mechanism of urban Basic Living Allowance: taking Jinan as an example", *Dongyue Tribune*, No. 10, pp. 34-38 (in Chinese).

Qin, G. (2017), *Welfare, Work and Poverty: Social Assistance in China*, Oxford University Press, Oxford and New York, NY.

Solinger, D. (2005), "Path dependency reexamined: Chinese welfare policy in the transition to unemployment", *Comparative Politics*, Vol. 38 No. 1, pp. 83-101.

Ukpere, W.I. and Slabbert, A.D. (2009), "A relationship between current globalisation, unemployment, inequality and poverty", *International Journal of Social Economics*, Vol. 36 Nos 1/2, pp. 37-46.

Visaria, P. (1981), "Poverty and unemployment in India: an analysis of recent evidence", *World Development*, Vol. 9 No. 3, pp. 277-300.

Wang, L. (2009), "Game analysis on the assistance and employment of urban Basic Living Allowance beneficiaries", *Research on Financial and Economic Issues*, No. 5, pp. 112-116 (in Chinese).

Wang, S.C. (2018), "The cohesion between Basic Living Allowance of urban residents and unemployment assistance: a theoretical perspective of policy group", *China Labor*, No. 8, pp. 23-29 (in Chinese).

Wang, W.J. (2017), "Countermeasures and advice on the prevention of welfare of Basic Living Allowance", *Social Governance*, No. 4, pp. 49-54 (in Chinese).

Wang, X. (2011), "An analysis based on job intention and job seeking behavior: a study on the reemployment promotion of groups difficult to find jobs of Beijing", *Population and Economics*, No. 2, pp. 52-55 (in Chinese).

Wang, X., Feng, H., Xia, Q. and Alkire, S. (2016), "On the relationship between income poverty and multidimensional poverty in China", The Oxford Poverty and Human Development Initiative (OPHI) Working Paper No. 101, University of Oxford, Oxford.

Wang, Z.W. (2012), "A study on factors influencing the reemployment willingness of groups entitled to social assistance in rural areas", *Population Journal*, No. 6, pp. 64-71 (in Chinese).

Wong, Y.C., Chen, H.L. and Zeng, Q. (2014), "Social assistance in Shanghai: dynamics between social protection and informal employment", *International Journal of Social Welfare*, Vol. 23 No. 3, pp. 333-341.

Wu, C.F. (2011), "Long-term employment and earnings among low-income families with children", *Children and Youth Services Review*, Vol. 33 No. 1, pp. 99-101.

Wu, Y.D. (1994), "Overview and introduction of economic theory and welfare state (ii)", *Journal of Translation from Foreign Literature of Economics*, No. 4, pp. 1-27 (in Chinese).

Xiao, M. and Li, F.Y. (2016), "Why is it difficult for beneficiaries of urban subsistence security system to exit this system: an interpretation of social policies about Chinese-style 'welfare dependence' ", *Social Security Studies (Beijing)*, Vol. 24 No. 2, pp. 191-200.

Xie, Z.Y. (2017), "The flexibility of labor market and the amendment of Chinese Labor Contract Law", *Chinese Journal of Law*, Vol. 2017 No. 2, pp. 95-112 (in Chinese).

Xue, J.J. and Zhong, W. (2003), "Unemployment, poverty and income disparity in urban China", *Asian Economic Journal*, Vol. 17 No. 4, pp. 383-405.

Yang, L.X. (2018), "The social assistance reform in China: toward a fair and inclusive social safety net", The United Nations, available at: www.un.org/development/desa/dspd/wp-content/uploads/sites/22/2018/06/The-Social-Assistance-Reform-in-China.pdf (accessed April 25, 2019).

Yin, H.J. and Wang, Y.J. (2015), "A survey from Harbin, Changchun and Shenyang: a Study on the quality of employment of poverty-stricken workers in urban areas of Northeast China", *Chinese Journal of Population Science*, No. 3, pp. 116-125 (in Chinese).

Zhang, H.M. (2018), "Employment assistance in urban China: a qualitative study from the youth recipients' perspective", *Children and Youth Services Review*, Vol. 88, pp. 521-527.

Zhong, Y.Y. (2012), "Social assistance reform of foreign countries and its references to China", *Chinese Public Administration*, Vol. 330 No. 12, pp. 74-77 (in Chinese).

Zhou, J.S. (2012), "The impact of Basic Living Allowance and the minimum salary on the motivation of employment of workers", *Population and Economics*, No. 1, pp. 37-38 (in Chinese).

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Costs of hospitalization for chronic kidney disease in Guangzhou, China

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Received 6 May 2019
Revised 25 August 2019
Accepted 16 September 2019

Abstract

Purpose – Chronic kidney disease (CKD) is a worldwide public health problem which imposes a significant financial burden not only on patients but also on the healthcare systems, especially under the pressure of the rapid growth of the elderly population in China. The purpose of this paper is to examine the hospitalization costs of patients with CKD between two urban health insurance schemes and investigate the factors that were associated with their inpatient costs in Guangzhou, China.

Design/methodology/approach – This was a prevalence-based, observational study using data derived from two insurance claims databases during the period from January 2010 to December 2012 in the largest city, Guangzhou in Southern China. The authors identified 5,803 hospitalizations under two urban health insurance schemes. An extension of generalized linear model – the extended estimating equations approach – was performed to identify the main drivers of total inpatient costs.

Findings – Among 5,803 inpatients with CKD, the mean age was 60.6. The average length of stay (LOS) was 14.4 days. The average hospitalization costs per inpatient were CNY15,517.7. The mean inpatient costs for patients with Urban Employee-based Basic Medical Insurance (UEBMI) scheme (CNY15,582.0) were higher than those under Urban Resident-based Basic Medical Insurance (URBMI) scheme (CNY14,917.0). However, the percentage of out-of-pocket expenses for the UEBMI patients (19.8 percent) was only half of that for the URBMI patients (44.5 percent). Insurance type, age, comorbidities, dialysis therapies, severity of disease, LOS and hospital levels were significantly associated with hospitalization costs.

Originality/value – The costs of hospitalization for CKD were high and differed by types of insurance schemes. This was the first study to compare the differences in hospitalization costs of patients with CKD under two different urban insurance schemes in China. The findings of this study could provide economic evidence for understanding the burden of CKD and evaluating different treatment of CKD (dialysis therapy) in China. Such useful information could also be used by policy makers in health insurance program evaluation and health resources allocation.

Keywords Health insurance, Hospitalization, Guangzhou, Chronic kidney disease, Cost of illness
Paper type Research paper

Introduction

As a global public health problem, chronic kidney disease (CKD) was ranked among the top 25 leading cause of death globally (Lozano *et al.*, 2012). In China, the overall prevalence of CKD was 10.8 percent, and it was estimated that 119.5m Chinese were patients with CKD (Zhang *et al.*, 2012). A study from Southern China suggested that 12.1 percent adults 20 years or older had at least one indicator of kidney damage, indicating the presence of

With the support of National Natural Science Foundation of China (71704194) and the Natural Science Foundation of Guangdong Province (2016A030313204), the study of this paper has been approved by the Institutional Review Board of the School of Public Health, Sun Yat-sen University (Approval No. 2017012).

Public Administration and Policy
Vol. 22 No. 2, 2019
pp. 138-151
Emerald Publishing Limited
1727-2645
DOI 10.1108/PAP-09-2019-0018

kidney damage with an awareness of only 9.6 percent (Chen *et al.*, 2009). The high prevalence and low awareness of CKD suggested that critical information regarding CKD was needed for healthcare planning and financing, especially under the pressure of the rapid growth of the elderly population in China.

CKD imposed a heavy financial burden on the healthcare systems. In the USA, treatment of CKD was estimated at $48bn in 2015, consuming 6.7 percent of the total Medicare budget to care for less than 1 percent of the covered population (World Kidney Day, 2015). China's economy was estimated to lose $558bn over the next decade due to morbidity and mortality attributable to heart disease and kidney disease (World Kidney Day, 2015).

Nowadays, China has expanded the coverage of social health insurance to all urban residents with two social health insurance schemes – the Urban Employee-based Basic Medical Insurance (UEBMI) and the Urban Resident-based Basic Medical Insurance (URBMI) (Meng *et al.*, 2015). The UEBMI scheme for the urban employees and the URBMI scheme for the urban non-employed residents have different financing sources, and varied benefit levels and different financial protection (Meng *et al.*, 2015). Furthermore, the Chinese Government enhanced insurance reimbursement for patients with major catastrophic diseases including CKD, in order to reduce the out-of-pocket (OOP) costs for these patients (Liu, 2013). Information on the hospitalization costs associated with CKD and the differences in costs between two health insurance schemes is needed for health insurance program evaluation and health policy in China.

Many countries have evaluated the economic burden and direct medical costs of CKD (Ahlawat *et al.*, 2017; Eriksson *et al.*, 2016; Kim *et al.*, 2017; Ozieh *et al.*, 2017; Roggeri *et al.*, 2017). However, only one study examined the hospitalization costs of CKD in China (Liang *et al.*, 2016). However, this study did not compare the differences in medical costs for CKD patients between the two urban health insurances in China. Furthermore, this study collected data from only one selected hospital with small sample sizes.

This study aimed to examine the hospitalization costs of patients with CKD between two urban health insurance schemes (UEBMI and URBMI) and investigated the factors that were associated with their inpatient costs using insurance claims data from Guangzhou.

Research methods

Data source

Guangzhou is the capital city of Guangdong Province, the largest and most developed city in Southern China. Data in this study were obtained from the UEBMI and URBMI hospitalization claims databases of Guangzhou for the years 2010–2012, including socio-demographic information, medical conditions, hospital information and hospitalization costs based on actual payments to providers. The detailed benefits and reimbursement policies of the UEBMI and URBMI schemes were shown in Table I. The dialysis therapies haemodialysis (HD) or peritoneal dialysis (PD) in the outpatient sector was matched using personal identifiers with a dialysis patient data set from the Outpatient Catastrophic Disease Program under these two insurance schemes. In addition, the most common comorbidities (hypertension, diabetes and coronary heart disease) was matched using personal identifiers with a chronic patient data set from the Outpatient Chronic Disease Program under these two insurance schemes. By 2012, 93.4 percent of the registered residents were enrolled in these two insurance programs in Guangzhou (Guangzhou Statistics Bureau, 2012). This study was approved by the Institutional Review Board of the School of Public Health, Sun Yat-sen University (Approval No. 2017012).

	UEBMI			URBMI		
Inception year	2002			2008		
Eligible population	Urban employed (employees; retirees)			Urban non-employed (children and full-time students; unemployed adults; elderly residents not covered by the UEBMI scheme)		
Sources of funding	The employers contribute 6% of the employee's salary whilst the employees contribute 2%; retirees are exempted from premium contribution			Government subsidy (70%) and individual premium (30%) CNY440 to CNY1800 per person per year for residents (including government subsidy)		
Accounts	Medical Savings Account (including employee contributions and 30% of employer contributions) for outpatient care; Social Risk-pooling Account (70% of employer contributions) for inpatient care and critical (i.e. chronic or fatal diseases including ESKD) outpatient care			Social Risk-pooling Account (all funds) for inpatient care and critical (i.e. chronic or fatal diseases including ESKD) outpatient care		
	Inpatient				Inpatient	
Deductible: (inpatient care)	Employees	Primary hospitals	CNY400	Children and students	Primary hospitals	CNY120
		Secondary hospitals	CNY800		Secondary hospitals	CNY240
		Tertiary hospitals	CNY1600		Tertiary hospitals	CNY480
	Retirees	Primary hospitals	CNY280	Unemployed adults and	Primary hospitals	CNY280
		Secondary hospitals	CNY560	Elderly residents	Secondary hospitals	CNY560
		Tertiary hospitals	CNY1120		Tertiary hospitals	CNY1120
Reimbursement rate[a] (inpatient care)	Employees	Primary hospitals	90%	Children and students	Primary hospitals	85%
		Secondary hospitals	85%		Secondary hospitals	75%
		Tertiary hospitals	80%		Tertiary hospitals	65%
	Retirees	Primary hospitals	93%	Unemployed adults and	Primary hospitals	75%
		Secondary hospitals	89.5%	Elderly residents	Secondary hospitals	65%
		Tertiary hospitals	86%		Tertiary hospitals	55%
Reimbursed ceiling (inpatient care)	Six times of local employees' annual average wage CNY295,680 (in 2012)			Six times of local household disposable income CNY206,628 (in 2012)		

Table I.
Comparison of UEBMI and URBMI policies for CKD patients in Guangzhou in 2012

Notes: UEBMI, Urban Employee-based Basic Medical Insurance scheme; URBMI, Urban Resident-based Basic Medical Insurance scheme; CKD, chronic kidney disease; CNY, Chinese Yuan. Policy information was obtained from Statistical Bulletin of Guangzhou Social Insurance Bureau, and policy documents. [a]The percentages were the reimbursement rates of the eligible medical expenses that could be reimbursed from the Social Risk-pooling Account in Guangzhou

Patient selection

This was a retrospective, prevalence-based study designed to examine the hospitalization costs of patients with CKD. The authors obtained all the reimbursement claims submitted for inpatient care from January 2010 to December 2012 using the International

Classification of Diseases tenth version (I12, N18, N19). Patients who were under 18 years old ($n = 25$) were excluded. In total, 5,242 inpatients from the UEBMI scheme and 561 inpatients from the URBMI scheme were selected. The final sample size included 5,803 inpatients.

Theoretical framework

The Andersen's behavioral model (Andersen, 1995) was adopted as the theoretical framework to identify the predictors of hospitalization costs for patients with CKD. Individual characteristics were chosen based on: predisposing factors – existing conditions with predispose individuals to use or not use services (age, gender); enabling factors – conditions that facilitate or impede the use of services (type of insurance); and need factors – conditions that healthcare providers recognize as requiring medical treatment (e.g. comorbidities, dialysis therapies, severity of disease, hospital levels and length of stay (LOS)) (Andersen, 1995).

The dependent variable in this study was total hospitalization costs per inpatient. The primary independent variable was type of health insurance and was dichotomized as UEBMI and URBMI. Additional confounders included in the model were: age, gender, comorbidities, dialysis therapies (HD, PD), severity of disease (kidney transplantation, intensive care unit (ICU) admission, readmission in 15 days or referral from other hospitals), hospital levels (primary, secondary and tertiary) and LOS.

Cost estimation

The claims databases contained information on the direct medical costs of inpatients with CKD from the payers' perspective, including the total amount paid by the insurers and the patients. The total direct hospitalization costs were categorized as laboratory and diagnostic costs, non-medication treatment costs, medication costs, bed fees and the costs of other services, including special caring fees and air-conditioning, based on the classification of costs used in the health insurance claims database. Laboratory and diagnostic costs referred to the costs of physical examinations and biochemical tests. Medication costs were grouped into traditional Chinese medicine and western medicine costs. Non-medication treatment costs referred to the costs for any other treatments except for medication, which included blood transfusions, surgery fees, anesthesia charges and costs for medical consumables. Bed fees were the accommodation costs during hospitalization.

Costs were adjusted considering the urban residents consumer price index of 2012 in Guangzhou (Guangzhou Statistics Bureau, 2012) and were reported in CNY. The annual exchange rate between US dollar and CNY in 2012 was: $\$1.0 = \text{CNY}6.3125$.

Statistical analysis

Descriptive statistics (frequency, percentage, mean and standard deviation (SD)) were calculated for demographic information and costs. Since the medical costs data usually have a skewed distribution, a series of non-parametric tests, the Mann–Whitney test, the Kruskal–Wallis test and the Friedman's two-way non-parametric analysis of variance (ANOVA) test, was used to investigate the differences in patient characteristics associated with inpatient costs by insurance types. To identify the predictors of total inpatient costs, the extension of generalized linear model – the extended estimating equations (EEE) approach (Basu and Rathouz, 2005) – was performed in this study. All statistical calculations were performed using Stata version 12.0 (Stata Corporation, College Station, TX, USA).

Results

Patient characteristics

A total of 5,803 inpatients were identified (Table II). More than half of the patients were male (55.1 percent). The average age was 60.6 years old (SD = 17.2). Overall, 55.2 and 27.6 percent of the patients had hypertension and diabetes. Regarding dialysis therapies in the outpatient sector, more than half of the patients had haemodialysis (HD) only (58.3 percent), while 13.1 and 4.5 percent had PD only and both HD and PD, respectively. Most of the patients were under the UEBMI scheme (90.3 percent) and received medical treatment in tertiary hospitals (82.5 percent). The mean LOS was 14.4 days (SD = 11.6). Only a small proportion underwent readmission in 15 days (2.0 percent), hospital referral (1.4 percent) and ICU admission (0.3 percent).

Hospitalization costs and cost composition by insurance types

Overall, the mean direct medical costs per inpatient were CNY15,517.7 ($2,458.2) (see Table III). The OOP spending represented 22.1 percent of the total hospitalization costs.

Characteristics	Overall $n = 5,803$	UEBMI $n = 5,242$	URBMI $n = 561$
Gender			
Male	3,198 (55.1)	2,938 (56.0)	260 (46.3)
Female	2,605 (44.9)	2,304 (44.0)	301 (53.7)
Age (years)			
Mean ± SD	60.6 ± 17.2	60.3 ± 17.3	64.1 ± 16.2
Age group			
18 ⩽ Age < 45	1,181 (20.4)	1,126 (21.5)	55 (9.8)
45 ⩽ Age < 60	1,324 (22.8)	1,200 (22.9)	124 (22.1)
60 ⩽ Age < 75	1,800 (31.0)	1,571 (30.0)	229 (40.8)
⩾75	1,498 (25.8)	1,345 (25.7)	153 (27.3)
Comorbidities			
None	2,338 (40.3)	2,082 (39.7)	256 (45.6)
Hypertension	3,203 (55.2)	2,919 (55.7)	284 (50.6)
Diabetes	1,599 (27.6)	1,454 (27.7)	145 (25.8)
Coronary	505 (8.7)	468 (8.9)	37 (6.6)
Dialysis therapies in outpatient			
None HD or PD	1,288 (22.2)	1,147 (21.9)	141 (25.1)
HD only	3,383 (58.3)	3,034 (57.9)	349 (62.2)
PD Only	758 (13.1)	707 (13.5)	51 (9.1)
HD + PD	259 (4.5)	239 (4.6)	20 (3.6)
Kidney transplantation	115 (2.0)	115 (2.2)	0 (0.0)
ICU admission	18 (0.3)	18 (0.3)	0 (0.0)
Referral from other hospitals	80 (1.4)	74 (1.4)	6 (1.1)
Readmission in 15 days	117 (2.0)	102 (1.9)	15 (2.7)
Length of stay (days)			
Mean ± SD	14.4 ± 11.6	14.5 ± 11.5	13.6 ± 12.0
Length of stay groups			
< 10	2,222 (38.3)	1,974 (37.7)	248 (44.2)
10 ⩽ Days < 20	2,376 (40.9)	2,165 (41.3)	211 (37.6)
⩾20	1,205 (20.8)	1,103 (21.0)	102 (18.2)
Hospital level			
Primary	43 (0.7)	35 (0.7)	8 (1.4)
Secondary	970 (16.7)	847 (16.2)	123 (21.9)
Tertiary	4,790 (82.5)	4,360 (83.2)	430 (76.6)

Notes: UEBMI, Urban Employee-based Basic Medical Insurance scheme; URBMI, Urban Resident-based Basic Medical Insurance scheme; HD, haemodialysis; PD, peritoneal dialysis

Table II. Socio-demographic characteristics of inpatients by insurance types, *n* (%)

Composition of total costs	Overall $n = 5,803$	UEBMI $n = 5,242$	URBMI $n = 561$	p-value
Total inpatient costs				
Mean (CNY)	15,517.7	15,582.0	14,917.0	< 0.01
SD	14,790.1	14,885.6	13,864.2	
Laboratory and diagnostic costs				
Percentage of total inpatient cost (%)	6.8	6.7	7.9	
Mean(CNY)	1,057.6	1,044.6	1,179.1	0.031
SD	1,486.7	1,394.3	2,165.7	
Non-medication treatment costs				
Percentage of total inpatient cost (%)	47.9	48.1	46.9	
Mean (CNY)	7,439.7	7,487.3	6,994.4	< 0.01
SD	7,373.2	7,420.4	6,907.8	
Medication costs				
Percentage of total inpatient cost (%)	38.8	38.8	39.2	
Mean (CNY)	6,022.9	6,041.1	5,853.3	< 0.01
SD	7,078.4	7,129.6	6,583.9	
Bed fees				
Percentage of total inpatient cost (%)	4.4	4.5	4.1	
Mean (CNY)	688.6	696.3	616.8	< 0.01
SD	711.7	721.7	606.4	
Other fees				
Percentage of total inpatient cost (%)	2.0	2.0	1.8	
Mean (CNY)	311.8	315.9	273.5	0.308
SD	441.7	453.3	311.9	
Out-of-pocket spending				
Percentage of total inpatient cost (%)	22.1	19.8	44.5	
Mean (CNY)	3,431.5	3,088.1	6,641.0	< 0.01
SD	3,964.0	3,467.0	6,235.7	

Notes: UEBMI, Urban Employee-based Basic Medical Insurance scheme; URBMI, Urban Resident-based Basic Medical Insurance scheme. p-values are based on the Mann–Whitney test

Table III. Direct inpatient costs by insurance types

The mean total inpatient costs for CKD patients with the UEBMI scheme (CNY15,582.0 = $2,468.4) were higher than those for patients with the URBMI scheme (CNY14,917.0 = $2,363.1) ($p < 0.01$). However, the percentage of OOP expenses out of the total costs for the UEBMI scheme patients (19.8 percent) was only half of that for the URBMI patients (44.5 percent).

Regarding cost composition, the non-medication treatment costs occupied the biggest proportion of total inpatient costs for both UEBMI (48.1 percent) and URBMI (46.9 percent) schemes (see Figure 1). The medication costs accounted for 38.8 and 39.2 percent for the UEBMI inpatients and URBMI inpatients, respectively. In addition, inpatient costs between the UEBMI subgroup and URBMI subgroup significantly differed according to age group, comorbidities, dialysis therapies in the outpatient sector, LOS and hospital levels ($p < 0.001$) (see Table IV).

Predictors of total inpatient costs

Table V shows factors associated with total inpatient costs. Regarding the full sample, this study found that insurance type, age, comorbidities (diabetes), dialysis therapies, severity of disease (kidney transplantation, ICU admission, referral from other hospitals), LOS and

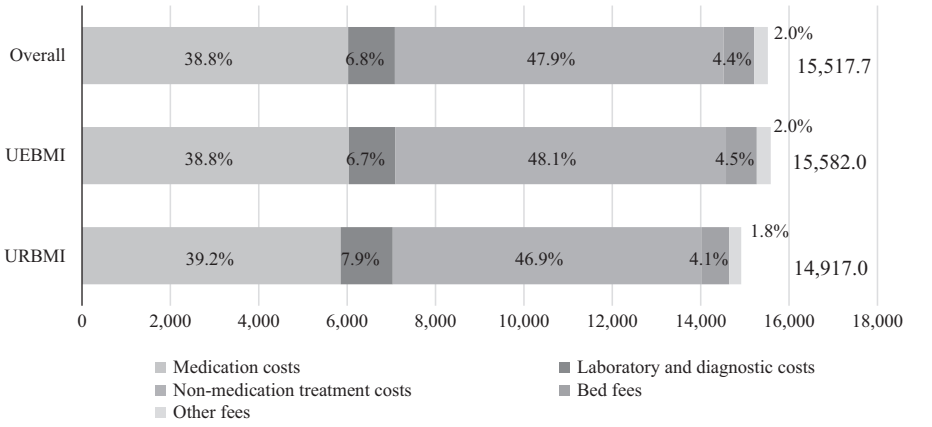

Figure 1.
Composition of inpatient costs by insurance types

hospital levels were significantly associated with inpatient costs of CKD. Compared with patients with the URBMI scheme, the inpatient costs of CKD were CNY1,004.4 lower for patients under the UEBMI scheme ($p < 0.01$). Compared with the youngest age group ($18 \leqslant \text{age} < 45$), the hospitalization costs for older age groups of CKD patients aged 45–60, 60–75 and over 75 were CNY1,257.7, CNY1,569.4 and CNY2,494.2 higher, respectively, after controlling for other factors ($p < 0.01$). Patients having diabetes had significantly higher hospitalization costs ($p < 0.01$). With regard to kidney transplantation, CKD patients having transplant surgery incurred significantly CNY27,400.7 higher hospitalization costs ($p < 0.01$). The ICU admission and hospital referral were significantly correlated with higher inpatient costs ($p < 0.01$). Patients with longer LOS and higher hospital levels (e.g. secondary and tertiary level) had significantly higher hospitalization costs ($p < 0.01$).

Regarding the insurance subgroups, age groups were significant only among the UEBMI subgroup, and the inpatient costs for patients aged over 75 were CNY2,546.3 higher than those aged 18–45 ($p < 0.01$). With regard to dialysis therapies in the outpatient sector, the results were obviously different between the UEBMI and URBMI subgroups. Compared with those without any dialysis therapy in the outpatient sector, inpatient costs for CKD patients having HD only, both HD and PD, were CNY1,660.1 and CNY1,736.9 significantly higher among the UEBMI patients, while inpatient costs for CKD patients having PD only were CNY2,058.1 lower among the URBMI patients ($p < 0.01$).

Discussion

In this observational study, the authors found that the average hospitalization costs of patients with CKD were CNY15,517.7 ($2,458.2). The mean total inpatient costs for CKD patients with UEBMI scheme (CNY15,582.0) were higher than those for patients with the URBMI scheme (CNY14,917.0). The type of insurance, age, comorbidities (diabetes), dialysis therapies, severity of disease (kidney transplantation, ICU admission, referral from other hospitals), LOS and hospital levels were significantly associated with hospitalization costs of CKD. This was the first study to compare the differences in hospitalization costs of patients with CKD between two different urban insurance schemes in China.

Costs comparison with previous studies in other countries

After comparing our costs with the results in other countries, a large variation in costs was observed. The average hospitalization cost (CNY15,517.7 = $2,458.2) in this study was much

	Overall $n = 5,803$	UEBMI $n = 5,242$	URBMI $n = 561$	
Total inpatient costs	15,517.7	15,582.0	14,917.0	
Gender	0.744[a]	0.611[a]	0.731[a]	0.620[c]
Male	15,658.7	15,750.3	14,623.0	
Female	15,344.6	15,367.3	15,171.0	
Age group	0.002[b]	< 0.001[b]	0.266[b]	< 0.001[c]
18 ⩽ Age < 45	15,926.0	16,067.1	13,037.5	
45 ⩽ Age < 60	14,350.4	14,211.9	15,690.7	
60 ⩽ Age < 75	15,470.2	15,739.6	13,621.9	
⩾75	16,284.6	16,214.1	16,904.1	
Comorbidities	< 0.001[b]	< 0.001[b]	0.055[b]	< 0.001[c]
None	15,546.3	15,621.8	14,931.6	
Hypertension	15,482.7	15,519.2	15,107.0	
Diabetes	16,213.3	16,347.5	14,867.4	
Coronary	16,786.3	16,824.3	16,306.2	
Dialysis therapies in outpatient	< 0.001[b]	< 0.001[b]	0.653[b]	< 0.001[c]
None HD or PD	14,021.2	14,102.5	13,359.7	
HD only	14,830.5	14,823.9	14,887.5	
PD only	14,696.2	14,619.3	15,763.0	
HD + PD	16,463.3	15,811.3	24,255.5	
Kidney transplantation	55,779.8	55,779.8	\	
ICU admission	67,981.7	67,981.7	\	
Referral from other hospitals	19,655.6	20,103.1	14,136.7	
Readmission in 15 days	19,949.8	20,299.4	17,573.2	
Length of stay (days)	< 0.001[b]	< 0.001[b]	< 0.001[b]	< 0.001[c]
< 10	7,349.9	7,329.9	7,508.8	
10 ⩽ Days < 20	14,131.6	14,097.8	14,478.7	
⩾20	33,312.0	33,263.6	33,836.0	
Hospital level	< 0.001[b]	< 0.001[b]	< 0.001[b]	< 0.001[c]
Primary	8,154.7	7,898.9	9,274.1	
Secondary	10,651.4	10,488.7	11,771.8	
Tertiary	16,569.2	16,633.1	15,921.7	

Notes: UEBMI, Urban Employee-based Basic Medical Insurance scheme; URBMI, Urban Resident-based Basic Medical Insurance scheme; HD, haemodialysis; PD, peritoneal dialysis. [a]*p*-values are based on the Mann–Whitney test; [b]*p*-values are based on the Kruskal–Wallis test; [c]*p*-values are based on the Friedman's two-way non-parametric ANOVA test for the interaction terms between health insurance type and each characteristic

Table IV. Patients' characteristics associated with inpatient costs by insurance types

lower than that was found in the USA ($39,873, 2014 price) (Ozieh *et al.*, 2017) and European countries, €4,300 (2009 price) in Sweden (Eriksson *et al.*, 2016), €3,912.8 (2011 price) in Italy (Roggeri *et al.*, 2017), but much higher than that in other Asia countries, such as $386 in India (Ahlawat *et al.*, 2017). The international comparison of medical costs for CKD patients was limited by different data sources (survey data or claims data) and different health services (outpatient or inpatient care), but the variation in costs was mainly attributable to the varied healthcare systems across different countries.

Costs comparison with previous studies in China

The authors also compared the average hospitalization costs of CKD reported in this study with the previous China-based study. Liang et al. (2016) reported that the mean inpatient cost per capita was CNY21,760.0, which was higher than the finding of this study (CNY15,517.7). The study covered 108 samples from only one hospital in Taiyuan, and the hospitalization expenses of their patients included HD spending. But in Guangzhou, dialysis

	Overall $n = 5{,}803$			UEBMI $n = 5{,}242$			URBMI $n = 561$		
	Coef.	SE	Marginal effect	Coef.	SE	Marginal effect	Coef.	SE	Marginal effect
Male (reference: female)	0.013	0.014	194.4	0.011	0.014	154.6	0.022	0.016	339.4
Age (reference: 18–45)									
$45 \leqslant$ Age < 60	0.084***	0.020	1,257.7	0.088***	0.020	1,324.6	−0.000	0.026	−5.9
$60 \leqslant$ Age < 75	0.105***	0.020	1,569.4	0.111***	0.020	1,658.4	0.004	0.025	68.6
$\geqslant 75$	0.164***	0.023	2,494.2	0.167***	0.022	2,546.3	0.036	0.028	570.0
Insurance type (reference: URBMI)									
UEBMI	−0.067***	0.024	−1,004.4	\	\	\	\	\	\
Comorbidities (reference: none)									
Hypertension	−0.028	0.015	−410.1	−0.030	0.015	−436.1	−0.031	0.018	−486.0
Diabetes	0.053***	0.017	786.4	0.051***	0.017	757.7	0.057***	0.019	901.6
Coronary	0.017	0.026	258.8	0.015	0.026	221.4	0.018	0.029	278.0
Dialysis therapies (reference: none)									
HD only	0.116***	0.018	1,695.1	0.113***	0.018	1,660.1	−0.008	0.021	−128.1
PD only	0.024	0.023	353.3	0.020	0.023	301.1	−0.140***	0.028	−2,058.1
HD+PD	0.116***	0.033	1,779.4	0.113***	0.033	1,736.9	−0.044	0.037	−673.0
Kidney transplantation	1.194***	0.094	27,400.7	1.201***	0.095	27,332.6	\	\	\
ICU admission	1.282***	0.160	31,135.8	1.293***	0.163	31,137.0	\	\	\
Referral from other hospitals	0.210***	0.057	3,365.6	0.206***	0.057	3,282.6	0.170***	0.055	2,922.2
Readmission in 15 days	0.024	0.048	364.3	0.027	0.048	399.5	0.090	0.066	1,471.9
Length of stay (days) (reference: < 10)									
$10 \leqslant$ Days < 20	0.557***	0.029	8,782.0	0.552***	0.029	8,655.9	0.696***	0.039	13,848.7
Days $\geqslant 20$	1.394***	0.023	27,547.0	1.393***	0.023	27,350.1	1.496***	0.023	38,660.3
Hospital level (reference: primary)									
Secondary	0.303***	0.078	4,900.5	0.296***	0.078	4,761.0	0.410***	0.110	7,934.4
Tertiary	0.624***	0.082	7,846.8	0.613***	0.082	7,734.6	0.799***	0.113	9,491.5
λ	0.200**	0.088		0.214**	0.089		−0.144	0.104	
θ_1	0.296***	0.010		0.296***	0.010		0.351***	0.012	
θ_2	1.945***	0.053		1.946***	0.052		2.029***	0.051	

Table V.
Factors associated with total inpatient costs

Notes: EEE, extended generalized linear model; UEBMI, Urban Employee-based Basic Medical Insurance scheme; URBMI, Urban Resident-based Basic Medical Insurance scheme; HD, haemodialysis; PD, peritoneal dialysis. Standard errors are in parentheses. $^{**}p < 0.05$; $^{***}p < 0.01$

(HD and PD) expenditures of patients under the two urban health insurance schemes were often reimbursed in the outpatient sector, which could induce lower hospitalization costs in our study. Furthermore, the previous China-based study did not compare the differences in medical costs of CKD patients between the two urban health insurance schemes in China.

Differences in costs between two insurance schemes

This study investigated the differences in hospitalization costs for CKD patients between two health insurance schemes for the first time. The UEBMI enrolees with CKD had higher average inpatient costs than the URBMI enrolees but had a lower percentage of OOP spending. The regression analysis also showed that the type of health insurance schemes was a significant predictor of inpatient costs for CKD. There are some reasons for this finding. First, since the UEBMI and URBMI schemes covered different population with different funding sources and reimbursement policies (as shown in Table I), the disparities in health expenditures might exist among CKD patients under different types of insurance

schemes (Wang *et al.*, 2018). As a result, CKD patients enrolled in the UEBMI scheme, who have a higher benefit level with higher reimbursement rates and higher reimbursement ceiling (Meng *et al.*, 2015), might be more likely to incur higher hospitalization costs. Second, the URBMI scheme did not have adequate financial protection and service coverage for its enrolees, which could discourage the enrolled patients from spending more on healthcare (Pan *et al.*, 2016). Thus, the URBMI patients who have lower ability to pay and limited healthcare access might have lower inpatient costs. As suggested in our finding, CKD patients enrolled in the URBMI scheme had a higher proportion of OOP spending than those UEBMI enrolees. Therefore, the insurance policy in China needs to focus on reducing the gap in reimbursement rates among these two health insurance schemes. In order to narrow the disparities between these two different insurance schemes in financing and benefit packages, it is suggested that the UEBMI and URBMI schemes should be further consolidated to be an integrated health insurance program in China.

Influential factors of hospitalization costs

The following section will discuss the four influential factors of hospitalization costs.

Age

In the regression results, this study found that after controlling for other confounding factors, patients with CKD in the older age groups had higher hospitalization costs for the overall sample, which was consistent with previous studies (Su *et al.*, 2010; Wyld *et al.*, 2015). However, when it comes to different insurance scheme subgroups, the authors found that age was a significant impact factor only within the UEBMI subgroup. This suggested that the costs management for CKD patients may be implemented differently across different insurance schemes.

Comorbidities and severity of disease

Comorbidities (diabetes) in CKD patients were also found to have higher hospitalization costs in our study. Nowadays, China and other countries face the similar CKD risk factor, diabetes. It was reported that diabetes remained the most important cause for CKD patients (Kirkman, 2014; Zuo and Wang, 2010). In addition, CKD patients having kidney transplantation surgery during hospitalization incurred significantly higher medical costs, which was consistent with previous studies(Erek *et al.*, 2004; Kim *et al.*, 2017). The severity of disease was positively correlated with the inpatient costs, with the help of proxies (ICU admission and referral from other hospitals) used in this study to capture the patients' state of CKD. This result was in line with previous findings in China and other countries (Liang *et al.*, 2016; Ramachandran and Jha, 2013).

Dialysis therapies

Compared with those without any dialysis therapy in the outpatient sector, inpatient costs for CKD patients having HD only, both HD and PD, were significantly higher for all sample and the UEBMI patients, but CKD patients having PD only had significantly lower hospitalization costs for the URBMI patients. Previous studies have reported that the direct medical costs of HD patients were higher than PD patients (Kim *et al.*, 2017; Sun *et al.*, 2016; United States Renal Data System, 2016), thus it seems reasonable to have higher inpatient costs for those CKD patients having HD in the outpatient sector. Normally, patients undergone PD are younger (Eriksson *et al.*, 2016; Horl *et al.*, 1999) and have better physical conditions and fewer complications, thus they would incur less inpatient costs. Some studies reported that PD patients were more likely to suffer from peritonitis (Chaudhary, 2011; Mehrotra *et al.*, 2016), which might lead to higher hospitalization rates and higher

inpatient costs. But in our study, there was no evidence suggesting that PD patients would incur higher hospitalization costs, and the authors also found that PD patients had significantly lower hospitalization costs within the URBMI subgroup. Previous study has suggested that PD was a more cost-effective therapy than HD where the benefits were driven by cost savings of PD over HD (Rosner, 2013). The high prevalence of CKD coupled with limited health resources highlights the need for strategies to maximize the use of PD in China (Yu and Yang, 2015). Therefore, the Chinese Government might consider increasing PD penetration rates and reducing hospitalization costs, in order to reduce the economics burden of CKD patients and the financial burden of health insurance funds in China (Yu and Yang, 2015).

Hospital level and LOS

In this study, CKD patients in tertiary and secondary hospitals had significantly higher inpatient costs than those incurred in primary hospitals. Tertiary hospitals in China were often better equipped. They provided more precise diagnosis and better medical services but also charged more than secondary or primary hospitals due to advanced diagnostic and surgical medical facilities (Li and Ji, 2018). Consistent with the findings in previous studies (Liang *et al.*, 2016), LOS was a driver of hospitalization costs, with longer LOS considerably increased the hospitalization costs of CKD patients. It suggested that reducing LOS might be an effective method to contain the inpatient costs of CKD patients. This study found that the average LOS of CKD patients was 14.4 days, which was longer than that in the USA (10.3 days) (Blanchette *et al.*, 2015), in Sweden (6.2 days) (Eriksson *et al.*, 2016) and in Taiwan (8 days) (Yu *et al.*, 2014). But the mean LOS of this study was similar as that in another China-based study (14.6 days) (Liang *et al.*, 2016). The lengthy LOS in China might be due to that most CKD patients tend to stay in hospitals. Meanwhile, China has a limited number of community-based care centers or day care institutions available, which can hardly meet the increasing demand for those healthcare services among the aging population. The findings of this study suggested that strategies to reduce LOS such as building more community-based care facilities, day care centers and promoting home-based care might be effective methods to contain the hospitalization costs of CKD.

Conclusion

The costs of hospitalization for CKD were high and differed by types of insurance in China. The findings of this study could provide economic evidence for understanding the burden of CKD and evaluating different treatment of CKD (dialysis therapy) in China. Such useful information could also be used by policy makers in health insurance program evaluation and health resources allocation.

The findings of this study have important policy implications for reducing the costs of hospitalization for CKD patients and improving the health insurance system in China. First, given the differences in reimbursement rates and benefit packages between the UEBMI and URBMI schemes, the authors suggest that these two urban health insurance schemes should eventually be consolidated to be an integrated insurance program in China. Second, since the high prevalence of CKD coupled with limited economic resources, the Chinese Government can consider increasing PD penetration rates, which may reduce the hospitalization costs of CKD and the financial burden of China's health insurance funds. Third, in order to contain the inpatient costs of CKD and reduce the overuse of medical resources in the hospitals, establishing more community-based care facilities, day care centers and promoting home-based care might be feasible methods to reduce the lengthy hospital LOS in China.

Limitations

There were some limitations in this study. First, this study only examined the hospitalization costs. The costs of outpatient services and indirect costs were not analyzed. Thus, the authors likely underestimated the total medical costs of CKD in China. Second, clinical severity factors such as glomerular filtration rate, an important predictor of costs, were omitted from the analysis due to data unavailability. But the authors employed three severity proxies to measure the CKD severity in this study. Third, the study population was limited to urban enrolees under two insurance schemes in one city of China, which cannot represent the whole Chinese population. Further studies considering the whole Chinese population, outpatient expenditures and indirect costs are necessary to have a more comprehensive evaluation of CKD costs in China.

References

Ahlawat, R., Tiwari, P. and D'Cruz, S. (2017), "Direct cost for treating chronic kidney disease at an outpatient setting of a tertiary hospital: evidence from a cross-sectional study", *Value in Health Regional Issues*, Vol. 12, pp. 36-40.

Andersen, R.M. (1995), "Revisiting the behavioral model and access to medical care: does it matter?", *Journal of Health and Social Behavior*, Vol. 36 No. 1, pp. 1-10.

Basu, A. and Rathouz, P.J. (2005), "Estimating marginal and incremental effects on health outcomes using flexible link and variance function models", *Biostatistics*, Vol. 6 No. 1, pp. 93-109.

Blanchette, C.M., Craver, C., Belk, K.W., Lubeck, D.P., Rossetti, S. and Gutierrez, B. (2015), "Hospital-based inpatient resource utilization associated with autosomal dominant polycystic kidney disease in the US", *Journal of Medical Economics*, Vol. 18 No. 4, pp. 303-311.

Chaudhary, K. (2011), "Peritoneal dialysis drop-out: causes and prevention strategies", *International Journal of Nephrology*, Vol. 2011, pp. 1-7.

Chen, W., Chen, W., Wang, H., Dong, X., Liu, Q., Mao, H., Tian, J., Lin, J., Zhou, F., Luo, N., He, H., Johnson, R.J., Zhou, S.F. and Yu, X. (2009), "Prevalence and risk factors associated with chronic kidney disease in an adult population from southern China", *Nephrology Dialysis Transplantation*, Vol. 24 No. 4, pp. 1205-1212.

Erek, E., Sever, M.S., Akoglu, E., Sariyar, M., Bozfakioglu, S., Apaydin, S., Ataman, R., Sarsmaz, N., Altiparmak, M.R., Seyahi, N. and Serdengeçti, K. (2004), "Cost of renal replacement therapy in Turkey", *Nephrology*, Vol. 9 No. 1, pp. 33-38.

Eriksson, J.K., Neovius, M., Jacobson, S.H., Elinder, C.G. and Hylander, B. (2016), "Healthcare costs in chronic kidney disease and renal replacement therapy: a population-based cohort study in Sweden", *BMJ Open*, Vol. 6 No. 10, pp. 1-9.

Guangzhou Statistics Bureau (2012), "Guangzhou City Statistics Bulletin 2013" (in Chinese), available at: www.gzstats.gov.cn/gzstats/tjsj/list.shtmlDate (accessed October 1, 2018).

Horl, W.H., Alvaro, F.D. and Williams, P.F. (1999), "Healthcare systems and end-stage renal disease (ESRD) therapies – an international review: access to ESRD treatments", *Nephrology Dialysis Transplantation*, Vol. 14 No. S6, pp. 10-15.

Kim, S.H., Jo, M.W., Go, D.S., Ryu, D.R. and Park, J. (2017), "Economic burden of chronic kidney disease in Korea using national sample cohort", *Journal of Nephrology*, Vol. 30 No. 6, pp. 787-793.

Kirkman, M.S. (2014), "Chronic kidney disease in diabetes: progressing towards higher costs", *Journal of Diabetes and Its Complications*, Vol. 28 No. 1, pp. 6-7.

Li, Y.L. and Ji, H.Y. (2018), "Analysis of hospitalization costs of the same disease at different grades of hospitals", *China Health Industry*, Vol. 15 No. 21, pp. 99-101 (in Chinese).

Liang, L.F., Xu, J. and Duan, L.Z. (2016), "The analysis on hospitalization expenses of 108 in patients with chronic renal failure", *Proceeding of Clinical Medicine*, Vol. 25 No. 1, pp. 60-62 (in Chinese).

Liu, Z.H. (2013), "Nephrology in China", *Nature Reviews Nephrology*, Vol. 9 No. 9, pp. 523-528.

Lozano, R., Naghavi, M., Foreman, K., Lim, S., Shibuya, K., Aboyans, V. and Murray, C.J.L. (2012), "Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010", *The Lancet*, Vol. 380 No. 9859, pp. 2095-2128.

Mehrotra, R., Devuyst, O., Davies, S.J. and Johnson, D.W. (2016), "The current state of peritoneal dialysis", *Journal of the American Society of Nephrology*, Vol. 27 No. 11, pp. 3238-3252.

Meng, Q., Fang, H., Liu, X., Yuan, B. and Xu, J. (2015), "Consolidating the social health insurance schemes in China: towards an equitable and efficient health system", *Lancet*, Vol. 386 No. 10002, pp. 1484-1492.

Ozieh, M.N., Bishu, K.G., Dismuke, C.E. and Egede, L.E. (2017), "Trends in healthcare expenditure in United States adults with chronic kidney disease: 2002-2011", *BMC Health Services Research*, Vol. 17 No. 1, pp. 368-376.

Pan, Y., Chen, S., Chen, M., Zhang, P., Long, Q., Xiang, L. and Lucas, H. (2016), "Disparity in reimbursement for tuberculosis care among different health insurance schemes: evidence from three counties in central China", *Infectious Diseases of Poverty*, Vol. 5 No. 1, pp. 7-16.

Ramachandran, R. and Jha, V. (2013), "Kidney transplantation is associated with catastrophic out of pocket expenditure in India", *PLoS One*, Vol. 8 No. 7, pp. 1-6.

Roggeri, A., Roggeri, D.P., Zocchetti, C., Bersani, M. and Conte, F., ReNe (Renal Lombardy Network); Additional contributors from ReNe Network (2017), "Healthcare costs of the progression of chronic kidney disease and different dialysis techniques estimated through administrative database analysis", *Journal of Nephrology*, Vol. 30 No. 2, pp. 263-269.

Rosner, M.H. (2013), "Cost of renal replacement therapy", *Nephrology Dialysis Transplantation*, Vol. 28 No. 10, pp. 1399-2401.

Su, B.G., Tsai, K.L., Yeh, S.H., Ho, Y.Y., Liu, S.Y. and Rivers, P.A. (2010), "Risk factor and cost accounting analysis for dialysis patients in Taiwan", *Health Services Management Research*, Vol. 23 No. 2, pp. 84-93.

Sun, L., Zou, L.X., Han, Y.C., Huang, H.M., Tan, Z.M., Gao, M., Ma, K.L., Liu, H. and Liu, B.C. (2016), "Forecast of the incidence, prevalence and burden of end-stage renal disease in Nanjing, China to the Year 2025", *BMC Nephrology*, Vol. 17 No. 1, pp. 60-67.

United States Renal Data System (2016), "USRD 2016 Annual Data Report: atlas of chronic kidney disease and end-stage renal disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Chapter11: Medicare Expenditures for Persons with ESRD", available at: www.usrds.org/2016/download/v2_c11_CostsofESRD_16.pdf (accessed June 8, 2018).

Wang, Z., Li, X., Chen, M. and Si, L. (2018), "Social health insurance, healthcare utilization, and costs in middle-aged and elderly community-dwelling adults in China", *International Journal for Equity Health*, Vol. 17 No. 1, pp. 17-30.

World Kidney Day (2015), "Chronic kidney disease", available at: www.worldkidneyday.org/faqs/chronic-kidney-disease/ (accessed October 1, 2018).

Wyld, M.L., Lee, C.M., Zhuo, X., White, S., Shaw, J.E., Morton, R.L., Colagiuri, S. and Chadban, S.J. (2015), "Cost to government and society of chronic kidney disease stage 1-5: a national cohort study", *Internal Medicine Journal*, Vol. 45 No. 7, pp. 741-747.

Yu, X. and Yang, X. (2015), "Peritoneal dialysis in China: meeting the challenge of chronic kidney failure", *American Journal of Kidney Diseases*, Vol. 65 No. 1, pp. 147-151.

Yu, Y.J., Wu, I.W., Huang, C.Y., Hsu, K.H., Lee, C.C., Sun, C.Y., Hsu, H.J. and Wu, M.S. (2014), "Multidisciplinary predialysis education reduced the inpatient and total medical costs of the first 6 months of dialysis in incident hemodialysis patients", *PLoS One*, Vol. 9 No. 11, pp. 1-8.

Zhang, L., Wang, F., Wang, L., Wang, W., Liu, B., Liu, J., Chen, M., He, Q., Liao, Y., Yu, X., Chen, N., Zhang, J.E., Hu, Z., Liu, F., Hong, D., Ma, L., Liu, H., Zhou, X., Chen, J., Pan, L., Chen, W., Wang, W., Li, X. and Wang, H. (2012), "Prevalence of chronic kidney disease in China: a cross-sectional survey", *Lancet*, Vol. 379 No. 9818, pp. 815-822.

Zuo, L. and Wang, M. (2010), "Current burden and probable increasing incidence of ESRD in China", *Clinical Nephrology*, Vol. 74 No. S1, pp. S20-S22.

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Received 7 December 2018
Revised 18 July 2019
3 August 2019
Accepted 23 September 2019

Jamaica's development of women entrepreneurship: challenges and opportunities

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Abstract

Purpose – The purpose of this paper is to assess how far Jamaica has come regarding women economic empowerment, female entrepreneurship and its development policies in favour of women entrepreneurship development.

Design/methodology/approach – This exploratory study employs a mixed method approach to achieve its research objectives, consisting of literature review and corroboration with existing database and indices. Key insights of research on female entrepreneurship are used to reflect on published data to assess progress of female entrepreneurship development in Jamaica. The 2017 editions of the Global Entrepreneurship Monitor and Gender Entrepreneurship and Development Index were examined to gain a better understanding of how the Jamaican business environment has progressed or regressed over time and how the economic development and business environment impact female participation in Jamaica's labour force and entrepreneurial initiatives.

Findings – The economic conditions in Jamaica and the role of females as domestic caregiver have made it difficult for women to enter the labour force even though Jamaican women are relatively better educated than men. Women remain at a disadvantage in the labour force. Jamaica's legislation and budget allocations in favour of female entrepreneurship are analysed to identify where and how Jamaica is investing its efforts to improve women's participation in the labour force. The authors conclude with suggestions on how the Jamaican government could facilitate further women entrepreneurship development to reach a more gender balanced inclusive socio-economic development.

Originality/value – While global policy has been promoting women empowerment through entrepreneurial development, little is known on the actual outcome of such human capital investment strategy and the critical vectors that contribute to such outcome. This scarcity of knowledge is also applicable to Jamaica. This paper attempts to contribute to women entrepreneurship research by reaching beyond the output-oriented perspective of various skill development programmes and attempts to link policy choice with overall macro results of entrepreneurship development in general and women entrepreneurship development in specific. The study thus provides a rare glimpse of the entrepreneurship ecosystem in Jamaica.

Keywords Jamaica, Women entrepreneurship, Entrepreneurship ecosystem,
Female labour force participation, Gender and work

Paper type Research paper

Introduction

The OECD report, "Enhancing Women's Economic Empowerment" emphasises that if women enjoy greater participation in education, it may provide females with more economic opportunities (Adema *et al.*, 2014, p. 9). This, however, is not the case in Jamaica. According to the National Policy for Gender Equality (NPGE) developed by The Bureau of Women's Affairs (Gender Affairs), Kingston, Jamaica and The Gender Advisory Committee (2010), women currently

The authors thank Ms Diandra Dillon, research assistant at CSEND, for her assistance in collecting data and information for this paper.

Public Administration and Policy
Vol. 22 No. 2, 2019
pp. 152-172
Emerald Publishing Limited
1727-2645
DOI 10.1108/PAP-09-2019-0023

outnumber and outperform men in schools especially in tertiary education at higher proportion with a ratio of 40.7 per cent women enroled and 20.3 per cent of men. On the other hand, they earn less money, have higher unemployment and hold less managerial positions than their male counterparts (The World Bank, 2019). As such, the typical solution for female economic empowerment and gender equality might not be as useful to Jamaica as in other countries with similar levels of development. What is needed is a more in-depth understanding of why higher educational achievement has not resulted in better gender balance in the labour force and not in innovative solutions to achieve gender parity and women economic empowerment in Jamaica. Jamaica has made important efforts to improve the situation during the 15 years of the millennium development goals (MDGs, 2000–2015). The subsequent sustainable development goals (SDGs, 2015–2030) offer an opportunity to further reduce the imbalance. The Jamaican government was working on issues aligned with the SDGs before 2015 through its strategic plan "Jamaica Vision 2030". The Jamaican female labour force participation rate as of 2017 was 64 per cent, while in other Latin American and Caribbean (LAC) countries, the female labour force participation rate of 2016 was only 40.6 per cent (The World Bank, 2017). Even though Jamaica exceeds other countries of the region in female labour participation, creating avenues for more productive and more substantial female entrepreneurship is one of the many ways by which women could become economically empowered and contribute to the transformation of the Jamaican economy and society. Creating these avenues will not only help women, but also society in general. High rates of entrepreneurship can create new jobs and boost a country's development (Adema *et al.*, 2014). Capacity building for female entrepreneurship development in this regard is thus considered key strategy in achieving the multifaceted development objectives in Jamaica.

Literature review: research on women entrepreneurship

Women's participation rate in the 63 out of 74 economies that participated in the bi-annual Global Entrepreneurship Monitor showed that overall female entrepreneurial activities increased by 10 per cent comparing 2016/2017 with 2014/2015 and the gender gap also narrowed (Kelley *et al.*, 2017). However, such progress varied significantly amongst the 74 economies monitored. The rates of Total Entrepreneurial Activity (TEA), the basic unit of analysis, ranged from 3 per cent in Germany, Jordan, Italy and France to 37 per cent in Senegal. Out of 74 economies, 5 were found with equal or higher women participation rate, namely, Indonesia, the Philippines, Vienam, Mexico and Brazil. Kelley *et al.* (2017) also found that although women in general exhibit a 20 per cent or greater likelihood of citing necessity motives than men, opportunity motives account for the majority of women entrepreneurs (p. 8). This suggests that if enabling environment exists and is equally available to women, the gender gap regarding entrepreneurship and success rates would narrow even more and faster.

An early assessment of the literature regarding presumed differences in regard to gender and organisational performance of small business by Kalleberg and Leicht (1991) came to the conclusion that businesses headed by women were not more likely to go out of business, nor less successful, than those owned by men (p. 136).

However, a subsequent study by Cliff (1998) added new insights about potential differences between female and male entrepreneurs observing that for female entrepreneurs, personal considerations appear to override economic considerations when women entrepreneurs are faced with the possibility of business expansion. Cliff states:

> For policy-makers, the finding that female entrepreneurs appear to be particularly concerned about growing in a controlled fashion that does not exceed their maximum business-size threshold suggests that a smaller-sized firm with a slower growth rate may be a deliberately chosen, desirable state for many women business owners. As a result, government programmes designed to increase the size and/or growth rate of female-owned firms may not achieve the expected level of demand; moreover, these programmes may be considered unsatisfactory by participants if they do not explicitly address women's expansion concerns. (p. 524)

Cliff's study pointing at women's hesitation to expand business beyond their control can also be linked to perceived risk tolerance and willingness to incur risks. Watson and Robinson (2003) studied risk taking and whether or not a difference exists between female and male risk taking. They found that while profits are significantly higher for male controlled SMEs, so is the variation in profits (risk). After adjusting for risk, they however found no significant difference between the performances of males and female controlled SMEs.

Risk taking by female and male SME owners being equal, this does not disqualify the findings of Jennifer Cliff (1998) in regard to female SME owner's preference not to embark on an expansion of business that they might not think they could control. Business expansion is not the same thing as taking conventional business risks which was shown by Watson and Robertson to be non-gender specific.

Jennings and Brush (2013) documented the development of women's entrepreneurship research and assessed their contribution *vis-à-vis* the broad entrepreneurship literature. One of their findings was that the proportion of women's entrepreneurship research published within top-tier journals has steadily declined since the mid-1990s and the number of leading-edge articles in the pipeline is relatively low (p. 698). Their conclusion highlights research findings that are also relevant for this study, namely:

> Another (finding) is that even though much women's entrepreneurship research has ostensibly focused on topics similar to those studied by general entrepreneurship scholars, the collected work on female entrepreneurs challenges the dominant imagery within mainstream theory and research in several ways; notably, by demonstrating that entrepreneurship is a gendered phenomenon, that entrepreneurial activity is embedded in families and can result from necessity as well as opportunity, and that entrepreneurs often pursue goals beyond economic gain.

In a more recent study, Aidis and Weeks (2016) looking at ways to measure high impact female entrepreneur development came to conclusions which addressed the question regarding policy and development strategies for women entrepreneurship development stating:

> Public policy programmes can play a key role in creating a supportive environment – indeed, they are critically important as women-owned businesses move up the growth continuum. Policies focused solely on getting more women to start businesses (many of them microenterprises or cooperative-based initiatives), but not designed to aid in their growth into new markets, will not increase the number or impact of "potential" or "promising" entrepreneurs – the two groups impacted most by an enabling (or dis-enabling) business environment.

In other words, they warn against policies which only focus on attempts to create new female start-ups considering such policies ineffective in creating high performing female entrepreneurship without giving them support to enter new markets either domestically or abroad.

In conclusion of this review of research literature, Cesaroni *et al.* (2017) highlight the important factor of social media and women's ability in developing countries who use social media to create new business and networks much more effectively than male entrepreneurs especially since in many developing countries, cultural factors can make it difficult for women to be entrepreneurial due to women's subordination, marginalisation and lack of inclusion (p. 324). Digital forms of communication are more gender-neutral than face-to-face or other forms of communication making it easier for women to engage in communications with unfamiliar persons, especially if the latter are males.

The following sections narrate the current business environment for women in Jamaica and discuss steps undertaken by the government to support women entrepreneurship development. In the concluding section, the above findings of the literature will be used to reflect on the current state of women entrepreneurship development in Jamaica.

Methodology

This study includes secondary data covering all female entrepreneurs, not just the ones that are considered high growth oriented. However, a note of caution is called for. Secondary data often do not make accurate distinctions between the different types of female entrepreneurs. There is also insufficient disaggregated data between males and females (Budhu and Watson-Williams, 2014). Entrepreneurship will be looked at from a macro-perspective. This study will map how the Jamaican business environment has changed over time in order to see if that has also had positive effect on the employment of Jamaicans in general with a specific emphasis on Jamaican women. By putting a stronger focus on the kind of current prevalent female entrepreneurship, a broader understanding is possible whether Jamaica is progressing or regression in regard to female labour force participation in Jamaica.

The study will achieve this in three parts. The first part discusses the Jamaican economy and business environment in regard to women's participation in the workforce and ability to be entrepreneurs. A second part will use entrepreneurial development data to reflect on how the current situation in Jamaica confirms or disconfirms the existing literature and a third part suggests recommendations how the Jamaican government can further improve women entrepreneurship development.

Understanding the background of Jamaica

Jamaica is the third largest island in the Caribbean with a total size of 10.991 km^2 and a total population of 2.7m, with 1.34m men and 1.36m women (Statistical Institute of Jamaica, n.d.). It is the largest English-speaking Island in the West Indies. The country gained its independence from the UK in August 1962. However, like other previous colonies, Jamaica still lags regarding economic prosperity. After independence, Jamaica has undergone several structural reforms intended to stimulate its economy. However, for the last few decades, Jamaica has been experiencing high unemployment (The World Bank, 2017). The country is also heavily dependent on remittances and tourism which accounts for another 14 per cent of the GDP in addition to the revenues generated from services (Central Intelligence Agency, 2018). In the last three decades, the country has experienced a growth rate of less than 1 per cent. Table I lists the operational context that Jamaican entrepreneurs have to face and cope with.

Size of population, GDP per capita, unemployment and economic growth rate appear quite consistent over the period of 2013–2017. The figure that is striking is the high public debt which has receded from 141 per cent of GDP in 2013 to 104 per cent in 2017, but still remained high resulting in high interest payments. Economic growth peaked in 2016 then declined.

Economic environment

In recent years Jamaica has shifted from being a goods-producing economy to a service economy. The service industry accounts for 72.0 per cent of the GDP (Central Intelligence Agency, 2018). For the past 40 years, Jamaica has experienced cycles of unemployment, low economic growth and a high fiscal deficit (Williams, 2014). The overall unemployment rate in

Category	2013	2014	2015	2016	2017
Population (million)	2.8	2.8	2.8	2.8	2.8
GDP per capita (USD)	5,128	4,965	5,042	4,969	5,178
Unemployment rate	15.3	13.7	13.5	13.2	13.0
Public debt (% of GDP)	141	141	121	114	104
Economic growth	0.5	0.7	0.9	1.4	0.5

Source: Adopted from Focus Economics (2018) at www.focus-economics.com/countries/jamaica

Table I. Change in Jamaica's population, GDP per capita, public debt and economic growth of Jamaica between 2013 and 2017

2010 stood at 12.36 per cent, youth unemployment at 30 per cent, female unemployment was 16.2 per cent, whereas male unemployment stood at 9.2 per cent (The World Bank, 2010). The overall unemployment rate in 2018 remains was at 12.4. However, slight improvement is shown with youth unemployment at 28.3 per cent and female unemployment at 15.6 per cent (The World Bank, 2018a). This trend in unemployment shows that the economic dynamism has not been picked up in any significant ways over the last eight years. This persistent high unemployment has led to a significant migration of Jamaicans particularly skilled females, leaving the country for better economic opportunities in countries abroad (Jamaica Vision, 2030). Another problem for Jamaica is the high debt that the state has accumulated. Jamaica holds still a gross public debt of 117.8 per cent of its GDP (Central Intelligence Agency, 2018) as well as a debt related interest burden of 13 per cent of its GDP (The World Bank, 2018a). In the 2009/2010 fiscal year, 45 per cent of the government spending was interest payment on its public debt (Weisbrot, 2011) leaving not much room for funding activities to promote the social development of the country. Although the debt burden has since fallen below 100 per cent of GDP in 2018/2019, the employment rate in October 2018 was 8.7 per cent, a reduction of 1.8 per cent compared to 12 months ago in October 2017 and almost half of the rate compared to the start of the last reform programme (The World Bank, 2018b). Jamaica must find an effective sustainable solution to manage its debt burden while investing in social programmes and other employment generation measures.

Business environment

According to The World Bank's Doing Business Survey, Jamaica is currently ranked 70 which is above average compared to other countries in the LAC region in terms of ease of doing business, but it is still not performing at its best (The World Bank, 2018b). Some of the constraints which make it more difficult for all firms to do business are: tax rates, electricity, practices of the informal sector, crime theft and disorder and access to finance (The World Bank and International Finance Corporation, 2011).

While many enterprises face similar issues, however different sizes of the enterprises are faced with different challenges that impede on their productivity. In all sizes of the enterprises, tax rates are one of the most significant constraints that are faced by all. However, small firms are more affected by informal practices and access to finances to medium and large firms, while medium and large firms are more affected by access to electricity (The World Bank, 2018b). According to the Global Entrepreneurship Monitor (GEM), Micro, Small and Medium Enterprises (MSME) account for 90 per cent of employment. Throughout Jamaica, there are initiatives in support of entrepreneurship development. The government is also supporting many of these initiatives and has made significant steps to make entrepreneurship easier for Jamaicans (Boodraj *et al.*, 2017).

For example, the government is trying to create a business environment where entrepreneurs are encouraged to take risks while reducing the risk impediments for MSME. Despite the challenges that Jamaican entrepreneurs face, they are reported to be some of the world's most entrepreneurial people (Boodraj *et al.*, 2017). In the World Bank Opinion survey of 2016, 56 per cent of the respondents indicated that job creation/employment, innovation and entrepreneurship were some of the most important developmental priorities in Jamaica (Public Opinion Research Group, 2017).

The report also showed that as of 2018, Jamaica had implemented a series of reforms that made it easier to do business. For example, Jamaica reinstated the next-day service for company incorporation which made it faster to start a business. Jamaica also invested in distribution networks which made electricity supply more reliable since reliable electricity is essential to the operation of most businesses. In addition, Jamaica implemented a web-based custom data management platform which made importing foreign goods more efficient (The World Bank, 2018b).

Women entrepreneurship, decent work and links to SDG 5 (gender equality) and SDG 8 (employment and decent work)

In September 2015, as a follow-up to its Millennium Development Goals, the United Nations General Assembly (2015) adopted Resolution 70/1, entitled Transforming Our World: the 2030 Agenda for Sustainable Development. Resolution 70/1 introduced the 17 SDGs, created with the aim to "end poverty, protect the planet, and ensure prosperity for all". The 17 goals encompass all aspects of sustainable development, including ending poverty and hunger, ensuring quality education and gender equality, reducing inequalities and ensuring sustainable business practices and taking care of the environment. Two of the 17 goals are of particular relevance for women entrepreneurship development namely SDG 5 and SDG 8 defined as:

> Goal 5: Achieve gender equality and empower all women and girls.
>
> Goal 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all. (UNGA, 2015)

Improving women's economic empowerment is the domain of SDG 5 which focuses on gender equality and promoting decent work for all rests with SDG 8. These SDG goals will play a pivotal role for the achievement of the national strategic plan called Jamaica Vision 2030. Jamaica presented its SDG implementation plan during the United Nations High Level Political Forum in New York in 2018 and gave detailed information as to how the Jamaican government plans in the coming years to implement the SDGs including targets relating to SDG 5 and 8 (Planning Institute of Jamaica, 2019).

According to a UN Women's thematic brief, women's economic empowerment can be seen as a direct path towards gender equality, poverty eradication and inclusive economic growth (UN Women, 2013). Although work and care provided by women domestically is not counted nor included in official GDP statistics, women play a tremendous role in the economy, in that they invest in health, education and nutrition. If women are empowered globally by 2025, Global GDP could increase by $28 trillion (Abney and Laya, 2018). But despite their significant contributions, women often face numerous barriers which inhibit them from fully or equally taking part in the economy.

Women's empowerment implies that women have equal opportunities to participate on the same footing as men in the economy and also in the society as a whole be this in social, culture and political decision making. Female economic empowerment, decent work and women entrepreneurship play a complementary role to each other. Active women economic empowerment in the Caribbean could help increase female entrepreneurship which could have a positive effect on the economy and sustainable development. According to UN Women, women do 2.6 times more unpaid care and domestic work such as caring for children, elderly and housework, which also prevents many women from fully taking part in the economy in general (UN Women, 2013).

As the World Bank stated in its 2012 World Development Report, "Gender Equality Is Smart Economics". Yet, the study of women's economic empowerment and entrepreneurship is limited in the Caribbean as many of the indicators and data sets which measure the outcome of gender parity, and female empowerment are unavailable or aggregated with male data (Budhu and Watson-Williams, 2014). This data gap however tends to be a global phenomenon. Study found female-led businesses at global level tend to be 30–40 per cent less profitable than male-led businesses because of such barriers like lack of training, limited access to finance, networks and being primarily responsible for domestic care (Adema *et al.*, 2014). Nevertheless, women entrepreneurs in the Caribbean play a crucial role in supporting the Caribbean economy (Pounder, 2016).

When interviewed, many women expressed that their race and class background are larger obstacles compared to their gender to participate in economic opportunities. As for Hossein's (2013) study on comparing bias against female entrepreneurs, she argues that

"microfinance is misused as a tool to reinforce exclusionary practices of large segments of the very people it was designed to help." (p. 52) Individuals granting loans often use discriminatory and prejudice practices to decide who receives loans. In Jamaica, educated females make up a sizable part of the lending officers in banks (Hossein, 2013). In selecting who they lend money to, they are more likely to favour wealthy over poor or female clients. These discriminatory practices reinforce not only the barriers to female entrepreneurship but also have a negative impact on the economy at large because it increases intersectional inequalities instead of decreasing it (Hossein, 2013, pp. 51-65). Therefore, effective programmes and legislation aiming at women's economic empowerment through entrepreneurship and the promotion of decent work are essential for Jamaica's development.

Many women entrepreneurs turn to the informal sector because of lack of opportunities in the formal sector. Women in developing countries face more difficulties in entering the formal economic areas because of a lack of skills and experience. This claim was also supported by Kaushal *et al.* (2014) who argued that female entrepreneurs are driven to entrepreneurship for survival and necessity because of the lack of job opportunities in the formal sectors.

Counter to this trend, women in the Caribbean have higher rates of female entrepreneurship in this region than in other regions (Seguino, 2003). In the Caribbean, self-employed women are roughly 30 per cent of the entrepreneurship in the region but entrepreneurship among women is significantly lower than entrepreneurship amongst men accounting for 8 and 19 per cent, respectively (Lashley and Smith, 2015, p. 60). There are 1.2m employed women in the Caribbean, of those only 228,000 were self-employed. Of all the self-employed women, 204,000 had no employees, 21,000 had between one and four employees while only 3,000 had more than five employees (p. 12). Currently, women-owned businesses are less successful than male entrepreneurship endeavours due to the lack of entrepreneurship support and access to resources. The primary constraints which prevent women entrepreneurs from succeeding are socio-cultural factors, cost and a lack of proper skills in the labour force.

Gender issues of Jamaica's workforce participation

Unequal access to employment

The issue of women economic empowerment is a difficult topic for many middle-income countries. In Jamaica, issue of women economic empowerment is very unique. Although Jamaica has made strong efforts to fulfil its developmental agenda (The Bureau of Women's Affairs (Gender Affairs), Kingston, Jamaica and The Gender Advisory Committee, 2010), the country's economic growth policies have so far had limited success. Without economic growth, the state is more susceptible to poverty which has a more debilitating effect on women. There are areas where women are at an advantage, primarily in enrolment in the tertiary education. Despite the higher academic achievement of women, their employment rate is meagre. Consequently, Jamaican young women are the most economically disempowered group and have the highest rates of unemployment, making them more vulnerable to exploitation (Williams, 2014). Although males are statistically better off in the employment and economic area, they also bear their share of society's ills. For example, men underperforming in the educational systems are more often at risk of violence (The Bureau of Women's Affairs (Gender Affairs), Kingston, Jamaica and The Gender Advisory Committee, 2010).

Gender pay gap

The educational statistics of males and females should be reflected in the employment rate and income in the labour force. However, this is often not true. For instance, males with lower education attainment have higher employment rates and wages (The Bureau of

Women's Affairs (Gender Affairs), Kingston, Jamaica and The Gender Advisory Committee, 2010). A 2010 IDB study also revealed that on average women in Jamaica at all levels earn approximately 12.5 per cent less than males for the same jobs. Even though Jamaica has the highest percentage of female executives in the region, 60 per cent according to a 2015 report of the International Labour Organization (McCarthy, 2015), but in general earn less than the men "regardless of whether they are bosses or employees".

This is also in line with similar phenomenon in other countries of the region. In Latin America, women's labour income is between 64 and 90 per cent of that of men, according to the study, "The Effect of Women's Economic Power in Latin America and The Caribbean" (The World Bank, 2012). For the few women in top positions, they receive lower pay relative to men in similar positions. And this indicates that the gender pay gap also exists at the top management levels.

Gender segregation of jobs

When compared with other regions, there is the recognition that women have a strong presence in the labour market in the Caribbean. However, this strength is weakened by the fact that their entrepreneurial potential is not being realized. The trend is for women in the Caribbean to be overrepresented at the lower end of the labour market, and under-represented at the high end:

> According to the UN ECLAC report on "Advancing the economic empowerment and autonomy of women in the Caribbean through the 2030 Agenda for Sustainable Development (Stuart *et al.*, 2018), women tend to "concentrate in menial low paying jobs, often without access to social protection, and to predominate as providers of unpaid labour associated with domestic and caring roles." The report continued to suggest that, "The unequal gender division of unpaid household work "has displayed a remarkable resilience and continues to shape the terms on which women are able to take up paid work". It also serves to limit the "transformative potential of employment for enhancing and improving the situation and status of women in the private sphere of the home as well as the public sphere in the wider society". (Stuart *et al.*, 2018, p. 22)

Figure 1 captures the distribution of employed labour force by industry groups and gender. Women are shown to have a much higher participation rate in the service sector reflecting similar trends in other Caribbean countries.

Female participation and representation in Jamaica's state functions

As such, issues of empowerment in Jamaica should be looked at from the standpoint of achieving equality and prosperity for both genders. Currently, the legal environment has a tremendous impact on how both male and females are viewed in society. The political system in Jamaica is unequal and is also reflective of the broader social norms and values of the justice system and institutions. In the national policy for equality, they state that Jamaica is changing its discriminatory laws against women. However the process is slow (Stuart *et al.*, 2018). The Jamaica national gender policy (The Bureau of Women's Affairs (Gender Affairs) & The Gender Advisory Committee, 2010) stipulates that it would be desirable to have 30 per cent women representation in the decision making. However, women still make up only a fraction of the desired representation. Women hold a quarter of seats in the Jamaican Senate and 12.7 per cent of House of Representatives. However, when it comes to the more competence-based roles and functions women make up 43 per cent of high court appointees.

Jamaica is progressive in the sense that they elected a female prime minister in 2006–2007 and again in 2012–2016, who appointed more female ministers than previous government (United Nations Development Programme, 2015). Nonetheless, it appears that still there is more rhetoric than actions to enhance women empowerment. Various political

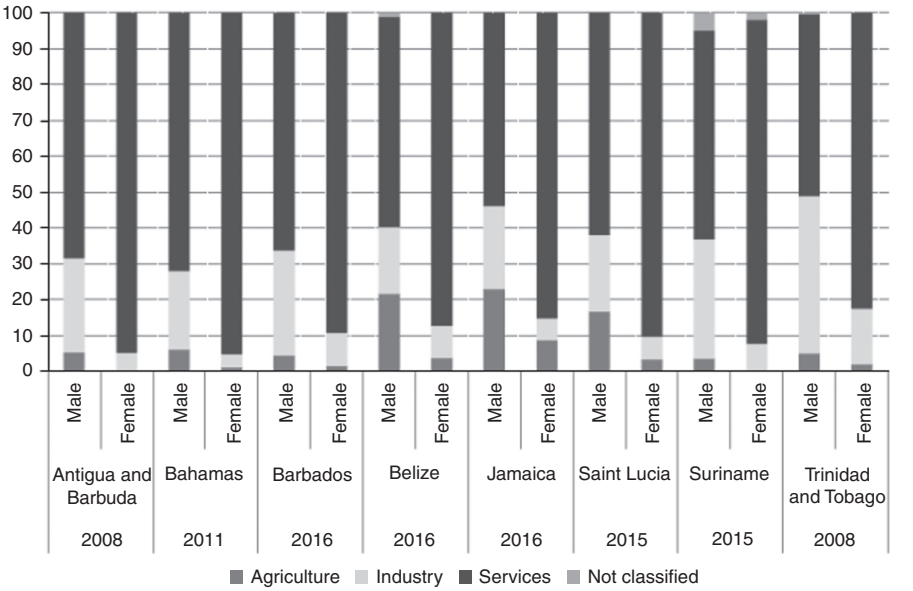


Figure 1.
Distribution of employed labour force by industry groups and sex (Percentage and latest year available)

Source: Stuart *et al.* (2018, p. 32)

parties have talked and discussed the gender equality. However, they have done little to tackle the real issues of gender inequality (Williams, 2014, p. 80).

The most significant improvement is women's participation in the judiciary amounting to 50 per cent in 2011 and 42.9 per cent in 2014 while the other form of women's political representation in the Jamaican state system appear to be stagnant (See Table II).

Women play a pivotal role in the Jamaican economy. Women head approximately 42 per cent of Jamaican households (Leo-Rhynie, 1993). Approximately 38.2 per cent of firms in Jamaica have female participation in ownership. In view of the fact that approximately 61 per cent of Jamaican women firms are competing in the informal sector or are unregistered formalization, business support to help these female-led business grow could be a feasible policy option (Lashley and Smith, 2015, p. 31).

	1993 (%)	1997 (%)	2002 (%)	2007 (%)	2011 (%)	2014 (%)
Cabinet ministers	6.2–18.7[b]	11.1–22.2[c]	18.7–25[d]	13.3[e]	20–25[f]	20–25[g]
Senate	14.3	23.8	19.0	14.3	23.8	28.6
House of representatives	11.7	13.6	11.7	13.3	12.7	12.7
Local councils[a]	12.8	25.6	11.9	19.8	18.9	18.9
Judiciary[h]	na	na	na	25.9	50.0	42.9

Notes: [a]Local Council elections were in 1990, 1998, 2003, 2007 and 2012. The results were placed in the nearest reference year in the table above; [b]18.7 per cent if ministers of state included, 6.2 per cent if excluded; [c]22.2 per cent if ministers of state included, 11.1 per cent if excluded; [d]25 per cent if ministers of state included, 18.7 per cent if excluded; [e]2 of a total of 15 ministers, incl. Prime Minister, and state ministers not included. www.jaconsulatecayman.orgdocs7JaCabinetMinistersSept2007.pdf; [f]25 per cent if ministers of state included; 20 per cent if excluded; [g]25 per cent if ministers of state included; [h]Refers to judges appointed in high courts
Sources: Office of the Prime Minister, IPU database, ECLAC Gender Observatory, Jamaica Gleaner, 16 September, 2007, www.jamaica-gleaner.com; reprinted in United Nations Development Programme (2015, p. 11)

Table II.
Jamaica's women in executive, legislative and judiciary powers (between 1993 and November 2014)

Jamaica's achievements during the MDGs and the remaining entrepreneurial gaps

The MDGs preceded the SDGs and lasted from 2000–2015. The MDGs agreed by all member states consisted of eight goals ranging from halving extreme poverty rates to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015 (United Nations, 2015).

The Jamaican summative report of its implementation of the MDGs does not explicitly mention female economic empowerment, entrepreneurship nor decent work. The majority of the goals that were covered in MDG 3, Gender equality are about improving girl's access and enrolment to education, increasing women who hold seats in parliament and improving the number and share of women in wage employment (Commonwealth Foundation, 2013). In the MDGs, the Jamaican government emphasised employment as a method of eliminating poverty. To implement that, the Ministry of Labour and Social Security instituted the "Steps to Work Programme" in 2013. This programme was established to benefit individuals who are part of the PATH programme (Programme of Advancement through Health and Education), which helped to maintain the subsistence level of poor Jamaicans while increasing access to education. The Steps to Work Programme targeted individuals who were 15 years and older and provided them with remedial education, skills and competency building and business development. Progress in regard to achieving the MDG 3 is described by the government as having reached a participation rate of 50 per cent of women labourers in the agricultural sector and being able to show that girls outperform boys at primary, secondary and tertirary educational levels but no indications are given in regard to participation of women entrepreneurs in the national economy.

Jamaica has promoted gender equality and women empowerment for the past decades. The history of gender relations in Jamaica is however somewhat complicated. Jamaica has been forward thinking in the past. In 1974, a women's desk was established and later in 1975, the Bureau of Women's Affair was established. The MDGs comprehensive assessment states that women have always taken part in the labour market. However, their participation is more limited compared to male counterparts despite the fact that males are less qualified as elaborated before (Williams, 2014). To address the issue of gender inequality and to help empower women, the Government of Jamaica adopted the NPGE in 2011. Although there was no direct mentioning of decent work and female entrepreneurship, Jamaica has plans to work on improving the situation in this regard.

The MDGs provided the basis for the 2030 Agenda and its SDGs. Although Jamaica has made strides, there is still a significant amount of progress to be made for the country to live up to the five principles of the SDGs, namely, people, planet, prosperity, peace and partnership. The Jamaica SDG roadmap outlines the steps that Jamaica will take to achieve the 2030 agenda by aligning the SDGs with the existing national priorities. The SDG roadmap for 2030, states that Jamaica faces many challenges in implementing policies that will have an immediate impact on the countries progress towards the SDGs. For Jamaica, to achieve alignment of the SDG goals with Jamaica's vision 2030, Jamaica will need to focus on the social protection programmes such as children and elderly care services, strengthening of the judiciary and police system, enhancing education and community development while supporting MSMEs "by establishing inclusive procurement process, strengthening supply chain and announcing inclusive financing" (Williams, 2014). This will help the overall development of Jamaica while relieving some of the burdens that women and MSMEs face.

The Jamaica Vision 2030, National Development Plan, prepared by the Planning Institute of Jamaica (2009) is a development plan elaborated by the government, private sector and civil society to create a future in which the country will have the ability to reach developed country status by 2030. This strategy suggests that Jamaica wants to be "Jamaica, the place

of choice to live, work, raise families, and do business" (p. xi). The authors of this vision confessed that it is not in their realm to solve all developmental problems of Jamaica. However, this plan gives a framework, or roadmap with which the country can advance. The ending goal is to develop equally and sustainably while maximising institutions and capitals. The six components of the Jamaican growth strategy that was implemented in 2012 have set the groundwork and may have a positive impact on Jamaica' implementation of SDG 5 and SDG 8. Jamaica's vision for 2030 and the NPGE produce a more comprehensive set of goals that are aligned with SDG 5 and SDG 8. The goal of the NPGE is to reduce all forms of gender inequality, strengthen institutional mechanisms, develop the skills and tools to mainstream gender in cultural, social and political institutions, and lastly, to promote sustainable behaviour. To achieve some of these goals, the NPGE proposed several acts that are now crucial to accelerating SDG 5 and SDG 8.

Achieving the gender equity in the context of 2030 Agenda for Sustainable Development will have multiple spillover effect at the whole of system level. Mainstreaming gender equity will contribute explicitly towards the fulfilment of 48 of the 169 SDG targets, representing 28 per cent of the total SDG indicators (details of these 48 targets can be seen in the Figure 2). Diminishing the gender disparity and gender-based discrimination around the world will have a visible impact to the sustainable future of our world. An inclusive approach for women's participation in the labour force and existing economic opportunities will accelerate the attainment of poverty reduction, reducing hunger, improving family health and well-being just to name a few of the SDGs for obvious reason.

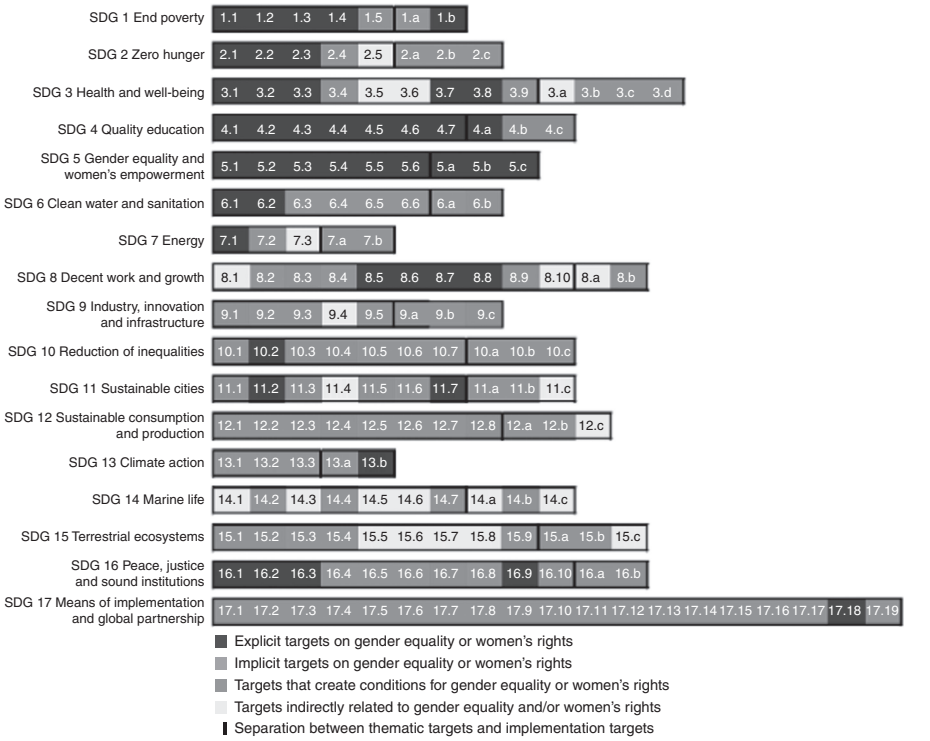


Figure 2.
Proposal for mainstreaming gender equality in the sustainable development goals (SDGs) in the language agreed upon in the 2030 Agenda for Sustainable Development

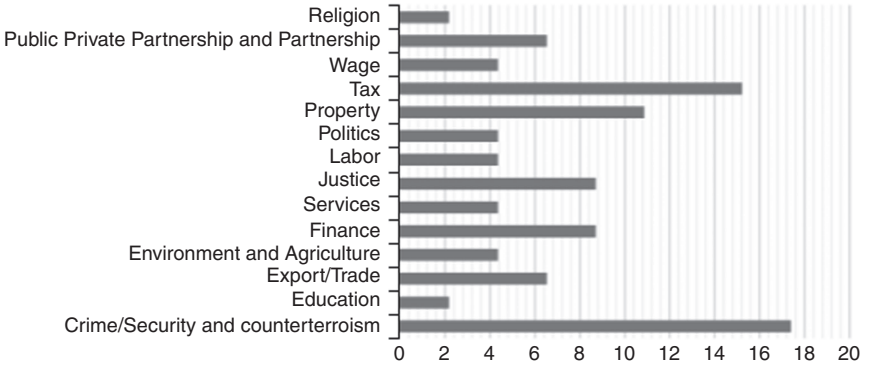
Source: ECLAC (2016, Figure 1.1, p. 30)

Jamaican government's legislation and budget regarding entrepreneurship

By reviewing the legislation passed between 2013 and 2017 on the Jamaican Ministry of Justice Website, one can see that the Jamaican government passed a series of laws that will have an impact on the overall business environment. But of all the legislation that was passed between 2013 and 2017, only one law mentions gender in general terms such as in regard to women, female, girl, mother, maternal and wife. This does not necessarily mean that the Jamaican government is not prioritising gender inclusion and equity. However, it does appear that most of the actions that the Jamaican government has taken to combat gender inequality and promote female empowerment are mostly window dressing. When reviewing the type of laws that were passed during 2013–2017 (Figure 3), it shows that most of the laws passed are focused on combating crime and on strengthening security. Although the Jamaican government is not working directly to combat gender inequality, the psycho-social dynamics of male identity in Jamaica due to various skewed relationship. The male violence is one of the major social issues affecting Jamaicans today. The high levels of crime impede economic development and the attractiveness in doing business. As such, these laws not only reflect Jamaica's immediate priorities and indirectly support a more stable and secure business environment for entrepreneur to prosper (Planning Institute of Jamaica, 2009).

The second type of laws are tax laws. Most of Jamaica's developmental plans mention that there is a need to improve tax collection as a way of increasing revenues. Of all the laws, passed between 2013 and 2017, none mentioned gender or women economic empowerment explicitly through preferential tax exemption or holidays. This may be because a high proportion of the Jamaica's government budget is spent on servicing its debt. As such, the government needs improving its tax collection process to gain more revenues which in turn could be reinvested in society to stimulate and promote good economic development.

The budget for the 2016/2017 fiscal year is listed on the official website of Jamaican Ministry of Finance (Jamaica Ministry of Finance, 2017). Of the total spending for all of the departments, only 0.046 per cent was spent on the Ministry of culture, entertainment and sports and gender. This department undertakes lot of activities responding to the social needs of the citizenry on behalf of the Jamaican government. However the financial amount made available for this department is very small and the lion share of the small budget was used to pay for administrative costs and other fixed costs such as rentals and running cost of the department resulting in very low investment in programmes to fund women. Actual funds for programmes to combat the plight of women are non-existent. This means that most of the funding and programming to help fight the barriers against women



Source: Jamaica Ministry of Justice (2019)

Figure 3.
Percentage of laws passed in 2013–2017

empowerment are mostly dependent on grants offered by international organisations (IOs), foreign donor countries and foreign and local NGOs. Such funding mechanisms create challenges of their own in terms of policy continuity and programme sustainability coupled with other frequently seen pitfalls in international development cooperation, e.g. crowd pleasing and other opportunistic behaviour.

Mapping Jamaica's entrepreneurial environment with Global Entrepreneurship Monitor (GEM) in 2016/2017

A team of researchers and faculty members of the Joan Duncan School of Entrepreneurship, Ethics and Leadership at the Jamaican University of Technology completed a study on entrepreneurship in Jamaica in 2016 led by Prof G. Boodraj and five other members of the Jamaican research team. GEM came about through an initial partnership of the US based Babson College and the London Business School in 1999 and has since grown to a network of 100 plus universities. GEM data are being collected on an annual basis and country team publishes national reports on a regular basis. In the case of Jamaica, the first report went back to 2005.

The GEM methodology consists of an adult population survey (18–64 years) and a survey of national experts in entrepreneurship (NES). Following the GEM sampling standard set for all participating country studies, the Jamaica team collected data from 2020 adults of whom 14 per cent were involved in entrepreneurship and 36 experts as part of the (NES) study sample.

The report does not provide detailed information on the individuals who participated in the study nor orientation as to what questions were asked and how the team analysed the data collected. The final report then narrates the key findings which are of relevance for this study.

GEM distinguishes between two forms of new entrepreneurial activity, namely, the Early-Stage Entrepreneurial Activity and the stage of owning-managing an established business beyond 3.5 years old. The principal indicator of GEM is the Total Early-Stage Entrepreneurial Activity (TEA) rate, which measures the percentage of the 18–64 age group who are either a nascent entrepreneur or owner-manager of a new business. Nascent entrepreneurs are individuals who are actively involved in setting up a business they will own or co-own but the business should not have paid salaries, wages or any other form of remuneration for more than three months. A new business, on the other hand, is one in which the owner-manager has paid wages, salaries or other forms of payments for more than three months but not more than 42 months. The TEA rate for Jamaica in 2016/17 was 9.9 per cent which is considered a good percentage indicating that jobs are being created by the mainstream economy reducing thereby unemployment and the need to start a new enterprise out of need for survival but not because of perceived new market opportunities. Nascent entrepreneurs accounted for 59 per cent of TEA, whereas the remaining 41 per cent was attributed to new businesses (Boodraj *et al.*, 2017).

Based on the persons interviewed, it emerged that the most prevalent types of new entrepreneurship occurred in the retail trade, hotels and restaurant category (59.2 per cent) followed by Agriculture, Forestry and Fishing (20.4 per cent) and few percentages in other sectors. The dominant type of new entrepreneurship initiatives fits with the strong tourism sector of the country.

In regard to reported gender differences, a majority of males (55 per cent) were involved in early stages of entrepreneurship compared to females (45 per cent) however no information is provided in regard to age of males and females engaging in new entrepreneurial activities.

Citing members of the research team, the following statements highlight important aspects of their study's findings. For instance, Professor Paul Golding referring to previous reports sees the following trend that needs attention of the policy makers:

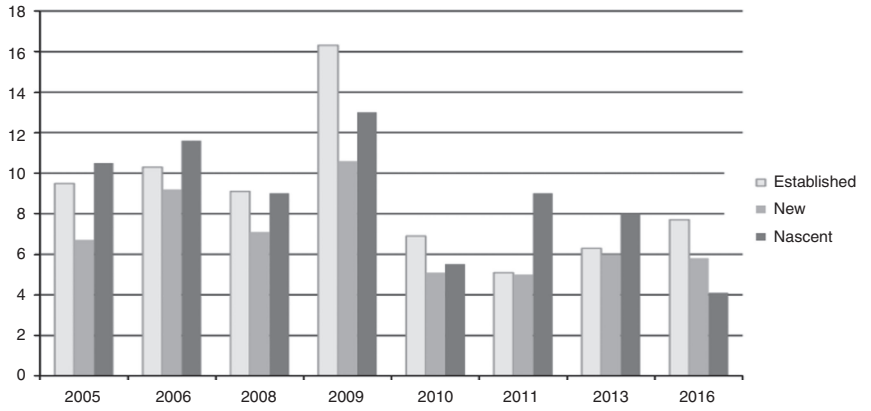
> The Report also evaluates the level of innovation in entrepreneurial activity measured in terms of the novelty of products or services and the application of new technology. A summary of

> previous reports indicates the following characteristics: low level of technical skills, lack of financing, low levels of operational and marketing capacity, low capacity for innovation and utilization of technology, limited product differentiation, weak linkages to supply chains and insufficient promotion of entrepreneurship (Paul Golding, GEM 2016/2017 Jamaica Report). (Boodraj *et al.*, 2017, p. 11)

Seen from a longitudinal perspective, the financial crisis of 2008 resulted in peak of new entrepreneurial initiatives (22.7 per cent) which declined to a more stable rate of 9.9 per cent in 2016 indicating that the economy became more stable with growth orientation. As a consequence of stabilisation, Jamaica was again classified in 2013 by the World Economic Forum as an "efficiency economy" up from being a "factor driven economy" subsequent to the financial crisis in 2008–2009. Still, efforts have to be made to stabilise the regained level of "efficiency driven economy" and to aim for growth towards the next level of economic development which would be based on innovation be this in regard to creating new products, or new services or new business models. However, according to the GEM 2018 report, innovation is lagging behind and technology is not effectively used by the new and old entrepreneurs in Jamaica.

Comparing the development of entrepreneurial development from 2005 to 2016, it appears that established enterprises are benefitting from more growth than new and nascent enterprises (Figure 4). No new data is available for 2017 and 2018. Should this trend continue, a study would be useful to find out what leads to the strengthening of established enterprises? Is it a good sign – e.g. more innovative trends – or is it a form of market capture that makes it very difficult for new enterprises to enter the market. Two most relevant questions for this study are: One, whether the economic stabilisation has equally benefited female-owned or managed companies in terms of growth? Two, whether the growth of the economy has impacted the wage and types of employment of women?

Based on the findings of the interviews conducted with the expert group (NES), the GEM 2016/2017 Jamaica Report provides a very useful list of suggestions for improvement covering financial support, government policies, commercial and service infrastructure and concerning the physical infrastructure. The report closes with 13 recommendations on how Jamaica could improve its entrepreneurial development. The recommendations appear very valid and useful but do not address the gender aspect of entrepreneurship development which is the purpose of this paper.



Source: "Global Entrepreneurship Monitor 2016/2017 Jamaica Report" by Boodraj *et al.* (2017, p. 34)

Figure 4.
Established, new and nascent business rates (percentages) in Jamaica

Discussion

As previous studies have indicated, economic development in Jamaica has been relatively stagnant over the past decade. The result shows that there has not been much progress regarding improvement of gender equality, women employment, women entrepreneurship as well as of the labour force in general. This stagnant condition of the Jamaican economy may be indicative of the high percentage of its budget dedicated yearly to make interest payments and pay off public debt instead of investing in programs that would help to improve socio-economic conditions. Looking at the results of the GEM, it is evident that there are some positive changes in the business and entrepreneurial environment of Jamaica. However, it is unclear what caused the slight improvements. Are they a result of policies and projects initiated by the Jamaican government or results of the IMF loans extended to Jamaica, or development support by external donors for instance in the form of budget support? Or is the stabilisation of the economy due to general cyclical movements of the global economy?

In response to the results of the MDG implementation, the Jamaican government implemented a series of programs that were intended to improve the conditions of women, however, the government's assessments of the MDG achievements are not publicly available making it difficult to see what has been learnt from the MDG process and to what extent the subsequent SDGs are intending to complete the parts of the MDGs that could not be fully achieved. However, after looking at the Jamaican budget provided by the Ministry of Finance and the legislation available from the Ministry of Justice, it is evident that a lot remains to be done by the Jamaican government in order to achieve the SDGs. Nonetheless, since such a significant proportion of its budget is dedicated to servicing its debt and keeping the country out of the risk of insolvency, Jamaica may not be able to do much without the assistance from external partners. In the long run, and focusing on the topic of this study, Jamaica may create a positive impact on SDG 5 C, "adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels" by strengthening policies and legislation and by disaggregating and tracking the progress of women in the country. However, given the limited data currently available regarding gender inclusion and women development, the programs that the government funds as well as the pro-women legislation to be passed in parliament will show how much the current government will be able to achieve SDG 5 C.

Jamaica, like other former colonies in the LAC region and Sub-Saharan Africa are performing poorly regarding income equality and women entrepreneurship development. This could be the result of the colonial legacy of unequal wealth distribution between colonisers and colonised and prioritising extracting resources over enterprise development (Frankema, 2006). Though these historical aspects might be part of the factor resulting in modest economic and social performance, countries that do not have concrete policy measures when it comes to mainstreaming the implementation of gender issues will not be able to substantially improve the conditions of its female population.

More targeted policies to promote effectively gender equality and women entrepreneurship will not be possible without sufficient data. One of the key findings of the High Level Political Forum, when 46 countries presented their Voluntary National Review in July 2018, was that the "sex-disaggregated data seem to be missing everywhere." As such, there needs to be a major effort to obtain this data to assess the progress of women empowerment accurately (United Nations, 2018).

Like men, female entrepreneurs are affected by an unstable and inefficient business environment (The Global Entrepreneurship and Development Institute, 2013, p. 6). The business environment needs to improve, so fewer individuals are driven to needs based entrepreneurship. Currently, 42 per cent of Jamaican households are single-headed female

households (Central Intelligence Agency, 2018). While at the same time, the unemployment for women stands at 15.4 per cent nearly twice that of men who are 8.4 per cent. The higher unemployment rate of women is related to the fact that women also have to fulfil their domestic responsibilites as mothers and often as head of single households and take care of the elderly and hence their unemployment is so high. This condition of having to take care for several other, young or older, makes women extremely vulnerable to exploitation. Jamaica's vision 2030 and its medium-term socio-economic policy framework and the growth inducement strategies aligned with the SDGs should set the stage for sustained and equitable economic growth and social development.

The Jamaican government has discussed the plight of Jamaican women while improving the business environment for more entrepreneurship in general. Though they address these issues in their policies, the funding by the Jamaican government seems limited and concrete implementation and monitoring strategies are lacking. To achieve the SDGs, the Jamaican government needs to communicate with its national and foreign partners and explore mutually beneficial forms of cooperation in order to find effective ways to make Jamaica's future prosperous, equitable and sustainable.

Recommendations

Very relevant recommendations have been tabled by the authors of the GEM 2016/2017 report (Boodraj *et al.*, 2017). What follows are recommendations pertaining to areas of economic and social development that were not included in the GEM document. Our recommendations are grouped along the themes of research papers introduced in the section on Literature review: research on women entrepreneurship:

(1) Cliff (1998), women's concern about business expansion beyond their control:

- Create women entrepreneur self-help groups, provide support and facilitate exchanges to help them discover other women with similar concerns about growth beyond control, also provide examples where growth was possible and how these women were able to cope with business growth while at the same time taking care of their families and dependent others.

(2) Jennings and Brush (2013), women entrepreneurs often pursue goals beyond economic gain:

- Help women create cultural associations or strengthen existing ones which focus on music, storytelling, dancing and help them link up with the many diaspora communities of Jamaicans living in the USA, Canada, UK and other countries. This could include offering the diaspora community bed and breakfast opportunities and short discovery trips of the island for second generation diaspora children.

(3) Aidis and Weeks (2016), policies focused solely on getting more women to start businesses but not designed to aid in their growth into new markets, will not increase the number or impact of "potential" or "promising" entrepreneurs:

- Explore new markets of services such as providing homes and care facilities for retired people from abroad. Help women form care cooperatives that can use the often part-time only availability of local women to provide care services to retirement and health care facilities. Find investors who provide funds and know-how to set up such facilities and bind foreign investors to local investors through public-private-social society partnerships, and provide training and coaching opportunities for women to enable them to join the caring for older people industry.

(4) Cesaroni *et al.* (2017), women using social media create new business and networks much more effectively than male entrepreneurs especially in developing countries due to cultural factors:

- Create learning opportunities and team self-help groups to introduce them into digital literacy, e.g. smart phones and other ICTs, including introducing them to e-based payment systems. Lots of suggestions are available in the UN report entitled The Age of Digital Interdependence.
- Invest in digital literacy among women entrepreneurs so that they can explore the digital commerce to promote their goods and services and provide cooperative platforms by the chamber of commerce or government to manage the online transactions and trade.

(5) World Bank's Ease of Doing Business (2018b), lack of access to affordable loans and credits:

- Set up small credit scheme for the MSMEs managed by women entrepreneurs with favourable terms for business transition from nascent entrepreneurial initiatives to business activities with growth potential for job creation.

Conclusion

When focusing on women participation in the economy and society, it is very useful to be reminded of some essential facts. UN Women informs us that "women perform 66 per cent of the world's work, produce 50 per cent of the food, but earn 10 per cent of the income and own 1 per cent of the property" (UNICEF, 2012).

Promoting a favourable environment for productive, efficient and profitable female entrepreneurship will have a positive impact on the Jamaican society. In the Jamaica roadmap for SDG implementations, the authors state that "being employed in the private sector, *vis-à-vis* self-employment, contributes to pushing people out of poverty" (Planning Institute of Jamaica *et al.*, 2017, p. 44). As such, if the Jamaican environment for entrepreneurship and services surrounding MSME were improved, Jamaicans could gain a lot. MSMEs account for 90 per cent of the enterprises within Jamaica while employing 86 per cent of the workforce. Since the Jamaican MSMEs make up such a sizable part of the enterprises and total workforce, policies and laws that strengthen the endeavours of Jamaican women enterprises might prove to be extremely helpful in achieving the Jamaica Vision 2030 aligned with SDG 5 and SDG 8.

Nevertheless, these achievements may not be possible if the Jamaican government and other IOs and international donors do not take steps to address the constraints that MSMEs are facing. MSMEs face significant constraints when it comes to accessing finance for their business. Approximately 47 per cent of the small enterprises considered access to finance as one of their most significant obstacles to doing business (Planning Institute of Jamaica *et al.*, 2017). In the SDG roadmap for 2030, the Planning Institute of Jamaica indicates that the vast diaspora of Jamaicans abroad could play a crucial role in producing the much-needed finance to Jamaican MSME through remittances which account for nearly 14 per cent of GDP (Central Intelligence Agency, 2018). This would be through a venture capitalist system, in which the Jamaican diaspora invests in Jamaican entrepreneur endeavours.

The GEM research consortium has analysed the situation of entrepreneurship in general and the authors of this paper have added recommendations to support integration of Jamaican women into the Jamaican workforce through women entrepreneurship. Implementation of the listed recommendations requires full and sustained support by the government and its many stakeholders. Achieving a more equitable gender balance in Jamaica could be instrumental not only for the well-being and development of women but also for achieving Jamaica's goals of sustained economic and social development in the long run.

References

Abney, D. and Laya, A.G. (2018), "This is why women must play a greater role in the global economy", available at: www.weforum.org/agenda/2018/01/this-is-why-women-must-play-a-greater-role-in-the-global-economy/ (accessed 28 August 2018).

Adema, W., Ali, N., Frey, V., Kim, H., Lunati, M., Piacentini, M. and Queisser, M. (2014), "Enhancing women's economic empowerment through entrepreneurship and business leadership in OECD countries", OECD Gender Initiative, available at: www.oecd.org/gender/EnhancingWomen EconomicEmpowerment_Fin_1_Oct_2014.pdf (accessed 28 August 2019).

Aidis, R. and Weeks, J. (2016), "Mapping the gendered ecosystem: the evolution of measurement tools for comparative high-impact female entrepreneur development", *International Journal of Gender and Entrepreneurship*, Vol. 8 No. 4, pp. 330-352.

Boodraj, G., Sinclair-Maragh, G., Skeete, V., Steele, M., Sutherland, A. and Williams-Myers, C. (2017), "Global entrepreneurship monitor 2016/2017", University of Technology, available at: www.gemconsortium.org/economy-profiles/jamaica (accessed 31 July 2017).

Budhu, C. and Watson-Williams, C. (2014), "A review of gender related challenges affecting local government and MSMEs in Jamaica", Country Study 2014, Caribbean Local Economic Development Project, available at: http://cariled.org/catalog-items/jamaica-gender-country-study-2014

Central Intelligence Agency (2018), "The World Factbook: Jamaica", Central Intelligence Agency, available at: www.cia.gov/library/publications/the-world-factbook/geos/jm.html (accessed 11 July 2017).

Cesaroni, F.M., Demartini, P. and Paolini, P. (2017), "Women in business and social media: implications for female entrepreneurship in emerging countries", *African Journal of Business Management*, Vol. 11 No. 14, pp. 316-326.

Cliff, J.E. (1998), "Does one size fit all? Exploring the relationship between attitudes towards growth, gender, and business size", *Journal of Business Venturing*, Vol. 13 No. 6, pp. 523-542.

Commonwealth Foundation (2013), "National report: Jamaica", A civil society review of progress towards the Millennium Development Goals in Commonwealth Countries, available at: http://commonwealthfoundation.com/wp-content/uploads/2013/10/MDG%20Reports%20Jamaica_FINAL_3.pdf (accessed 12 September 2017).

ECLAC (2016), "Equality and women's autonomy in the sustainable development agenda", Economic Commission for Latin American and the Caribbean, Santiago, available at: https://repositorio.cepal.org/bitstream/handle/11362/40675/S1601247_en.pdf?sequence=4&isAllowed=y (accessed 12 August 2018).

Focus Economics (2018), "Jamaica's population, GDP per capita, public debt and economic growth of Jamaica between 2013 and 2017", available at: www.focus-economics.com/countries/jamaica (accessed 31 July 2018).

Frankema, E.H.P. (2006), "The colonial origins of inequality: the causes and consequences of land distribution", Groningen Growth and Development Centre, University of Groningen, June, available at: http://siteresources.worldbank.org/INTDECINEQ/Resources/1149208-1147789289867/IIIWB_Conference_ColonialOrigins_of_InequalityREVISED.pdf

Hossein, C.S. (2013), "Using a Black feminist framework: a comparative study of bias against female entrepreneurs in Caribbean micro-banking", *Intersectionalities: A Global Journal of Social Work Analysis, Research, Policy, and Practice*, Vol. 2, pp. 51-79.

Jamaica Ministry of Finance (2017), "2016–2017 Jamaica budget", available at: https://mof.gov.jm/downloads/budgets/eoe/Estimates_of_Expenditure_2016-2017.pdf (accessed 30 December 2017).

Jamaica Ministry of Justice (2019), "Law of Jamaica", available at: http://laws.moj.gov.jm/ (accessed 12 September 2017).

Jennings, J. and Brush, C. (2013), "Research on Women Entrepreneurs: Challenges to (and from) the Broader Entrepreneurship Literature?", *The Academy of Management Annals*, Vol. 7 No. 1, pp. 663-715.

Kalleberg, A. and Leicht, K. (1991), "Gender and organizational performance: determinants of small business survival and success", *Academy of Management Journal*, Vol. 34 No. 1, pp. 136-161.

Kaushal, D., Negi, A. and Singhal, C. (2014), "The gender gap in entrepreneurship and how to overcome it? A study of women entrepreneurship promotion in Uttarakhand State", *Global Journal of Finance and Management*, Vol. 6 No. 3, pp. 157-164.

Kelley, D.J., Baumer, B.S., Brush, C., Greene, P.G., Mahdavi, M., Majbouri, M., Cole, M., Dean, M. and Heavlow, R. (2017), "Global entrepreneurship monitor 2016/2017 report on women's entrepreneurship", the Global Entrepreneurship Association (GERA), Babson College and Smith College, available at: www.babson.edu/media/babson/site-assets/content-assets/images/news/announcements/GEM-2016-2017-Womens-Report.pdf (accessed 1 December 2018).

Lashley, J. and Smith, K. (2015), "Profiling Caribbean women entrepreneurs: business environment, sectoral constraints and programming lessons", available at: http://documents.worldbank.org/curated/en/240461562141037955/pdf/Profiling-Caribbean-Women-Entrepreneurs-Business-Environment-Sectoral-Constraints-and-Programming-Lessons.pdf (accessed 10 October 2017).

Leo-Rhynie, E. (1993), "The Jamaican family, continuity and change", available at: www.gracekennedy.com/images/lecture/GKF1993Lecture.pdf (accessed 10 September 2017).

McCarthy, N. (2015), "Where are women most likely to be your boss?", available at: www.statista.com/chart/3132/where-are-women-most-likely-to-be-your-bos/ (accessed 10 October 2017).

Planning Institute of Jamaica (2009), "Vision 2030 Jamaica: national development plan", available at: https://observatorioplanificacion.cepal.org/sites/default/files/plan/files/Jamaica_Vision_2030_Jamaica_NDP_Full_No_Cover_web.pdf (accessed 10 March 2018).

Planning Institute of Jamaica, Ministry of Foreign Affairs and Foreign Trade, Statistical Institute of Jamaica and United Nations Development Programme (2017), "A road map for SDG implementation for Jamaica", available at: https://statinja.gov.jm/pdf/JamaicaSDGRoadmap.pdf (accessed 20 March 2017).

Pounder, P. (2016), "Entrepreneurship and gender disparity in the Caribbean", *Journal of Research on Women and Gender*, Vol. 6 No. 4, pp. 4-23.

Public Opinion Research Group (2017), "World Bank group country survey 2016 – Jamaica, 2016", World Bank, available at: http://microdata.worldbank.org/index.php/catalog/2819 (accessed 10 April 2018).

Seguino, S. (2003), "Why are women in the Caribbean so much more likely than men to be unemployed?", *Social and Economic Studies*, Vol. 52 No. 4, pp. 83-120, available at: https://mpra.ub.uni-mWatuenchen.de/6507/

Statistical Institute of Jamaica (n.d.), "Population statistics", available at: http://statinja.gov.jm/Demo_SocialStats/Newpopulation.aspx (accessed 10 April 2017).

Stuart, S., Geny, L.R. and Abdulkadri, A. (2018), "Advancing the economic empowerment and autonomy of women in the Caribbean through the 2030 agenda for sustainable development", ECLAC Studies and Perspectives Series No. 60, United Nations Publication, available at: https://repositorio.cepal.org/bitstream/handle/11362/43232/1/S1701028_en.pdf (accessed 15 September 2018).

The Bureau of Women's Affairs (Gender Affairs), Kingston, Jamaica and The Gender Advisory Committee (2010), "National policy for gender equality (NPGE): Jamaica", available at: https://sta.uwi.edu/igds/documents/JamaicaNPGE-JA-FINALwCover21311.pdf (accessed 19 May 2017).

The Global Entrepreneurship and Development Institute (2013), "The gender global entrepreneurship and development index (GEDI): a 17 country pilot analysis of the conditions that foster high-potential female entrepreneurship", available at: http://i.dell.com/sites/doccontent/corporate/secure/en/Documents/Gender_GEDI_Executive_Report.pdf (accessed 12 October 2017).

The World Bank (2010), "Unemployment, youth total (% of total labor force ages 15–24) (national estimate)", available at: https://data.worldbank.org/indicator/SL.UEM.1524.NE.ZS?locations=JM (accessed 12 August 2017).

The World Bank (2012), "The effect of women's economic power in Latin America and the Caribbean", available at: https://openknowledge.worldbank.org/bitstream/handle/10986/11867/9780821397701.pdf (accessed 1 August 2017).

The World Bank (2017), "Unemployment, total (% of total labor force) (modeled ILO estimate)", ILOSTAT Database, available at: https://data.worldbank.org/indicator/SL.UEM.TOTL.ZS (accessed 2 September 2017).

The World Bank (2018a), "The World Bank in middle income countries", available at: www.worldbank.org/en/country/mic/overview (accessed 11 August 2017).

The World Bank (2018b), "Ease of doing business in Jamaica", Doing Business, available at: www.doingbusiness.org/data/exploreeconomies/jamaica (accessed 8 August 2017).

The World Bank (2019), "Labor force participation rate, female (% of female population ages 15–64) (modeled ILO estimate)", ILOSTAT Database, available at: https://data.worldbank.org/indicator/SL.TLF.ACTI.FE.ZS?locations=JM (accessed 23 July 2017).

The World Bank and International Finance Corporation (2011), "Enterprise surveys: Jamaica country Profile 2010", available at: www.enterprisesurveys.org/~/media/GIAWB/EnterpriseSurveys/Documents/Profiles/English/Jamaica-2010.pdf

UNICEF (2012), "International women's day: the way forward – true gender equality", available at: www.unicef.org.tr/basinmerkezidetay.aspx?id=2180&dil=en&d=1 (accessed 11 August 2017).

United Nations (2015), "We can end poverty: millennium development goals and beyond 2015", available at: www.un.org/millenniumgoals/ (accessed 3 August 2017).

United Nations (2018), "Are women meaningfully involved in implementing SDG 6+ in the national plans?", Sustainable Development Goals Knowledge Platform, available at: https://sustainabledevelopment.un.org/index.php?page=view&type=20000&nr=4361&menu=2993 (accessed 14 August 2017).

United Nations Development Programme (2015), "Where are the women? A study of women, politics, parliaments and equality in the CARICOM countries – Jamaica case study", available at: www.undp.org/content/dam/jamaica/docs/gender/JM%20Where%20Are%20The%20Women%20Jamaica%20%20(1).pdf (accessed 2 May 2017).

United Nations General Assembly (2015), "Transforming our world: the 2030 agenda for sustainable development", available at: https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf (accessed 11 November 2017).

UN Women (2013), "Economic empowerment of women", available at: www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2013/12/unwomen_ee-thematic-brief_us-webpdf.pdf?la=en (accessed 9 November 2017).

Watson, J. and Robinson, S. (2003), "Adjusting for risk in comparing the performances of male-and female-controlled SMEs", *Journal of Business Venturing*, Vol. 18 No. 6, pp. 773-788.

Weisbrot, M. (2011), "Jamaica's crippling debt crisis serves as a warning to Greece", *The Guardian*, 22 July, available at: www.theguardian.com/commentisfree/cifamerica/2011/jul/22/jamaica-debt-crisis (accessed 12 December 2017).

Williams, C.W. (2014), "Comprehensive assessment of Jamaica's progress towards the MDGs a review of policies and programmes", available at: www.pioj.gov.jm/Portals/0/Social_Sector/Comprehensive%20Assessment%20of%20Progress%20Towards%20MDGs%20-%20FINAL%20Dec%202016.pdf (accessed 13 October 2017).

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An international review of arts inclusion policies: lessons for Hong Kong

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Received 11 July 2019
Revised 16 September 2019
Accepted 26 September 2019

Abstract

Purpose – The purpose of this paper is to review and compare the implementation of "arts inclusion" policies (AIPs) by 14 different public administrative systems around the world. It aims to provide a consolidated source which informs further studies in this field, and to develop a framework to compare AIPs at a global level.

Design/methodology/approach – Using "arts inclusion policy" as the search term, academic journals from a wide spectrum of fields were reviewed. A data set was extracted from the Compendium of Cultural Policies and Trends' online database which provided real-time information of national cultural policies. Another data set is from the United Nations' Inequality-adjusted Human Development Index, as the geographic scope of the review – largely focussing on UK, US, Australian, Scandinavian and Asian contexts. Using existing policy-making literature as benchmark, the authors designed and applied a comparative framework dedicated to AIPs which focussed on "policy-making structures" as the main ground of comparison.

Findings – An important finding is that the policy development and implementation of AIPs often underscore inter-sectoral involvement in many public administrations in this study. With policy leadership and financial incentives pivotal to effective AIPs, central governments should take a more concerted leadership role to include AIPs in national inter-sectoral policies, encourage evidence-based research, expand funding and advocate the recognition of the impacts of arts inclusion. It is concluded that AIPs in western countries remain more developed in targeted scopes and programme diversity compared to those of Asian countries and regions. Continued studies in this field are encouraged.

Originality/value – This review is the first of its kind to include a number of Asian and western countries within its research scope, allowing it to offer a more holistic outlook on the development and implementation of AIPs in different countries and regions. A common critique with all relevant existing literature was usually their lack of concrete comparative grounds, and the present study's all-encompassing review of literature from across different levels and sectors of respective public administrative systems contribute to a unique and comprehensive perspective in the arts and health discourse.

Keywords Arts and social inclusion, Inter-sectoral policies, Policy comparison, Policy-making structures

Paper type Research paper

Introduction

The arts can strengthen communities and engender social benefits for marginalised groups including the elderly and those living with mental illness and functional impairments (Raglio *et al.*, 2008; Gold *et al.*, 2013; Gooding, 2011; Mers *et al.*, 2009; Howells and Zelnik, 2009). Disparities affecting socially disadvantaged groups limit their mobility and ability to access social networks, services and the labour market; this further intensifies health disparities linked to their low-socioeconomic status.

These biases can be ameliorated by policies enacted by governments which redress social exclusion and pursue health equity, by encouraging social empowerment through various means of the arts. Countries and regions are increasingly turning to the arts to

Public Administration and Policy
Vol. 22 No. 2, 2019
pp. 173-191
Emerald Publishing Limited
1727-2645
DOI 10.1108/PAP-09-2019-0019

encourage social empowerment and achieve social inclusion. The strategies, objectives and rationales developed from distinct approaches are worth examining.

Defining "the arts" and "social inclusion"

"The arts" is defined in its broadest meaning for the purposes of this study. It encompasses and is not limited to different types of creative and cultural engagement in visual, photographic, musical, kinaesthetic, theatrical and literary forms. Arts participation varies from joining a master class, opening studio workshops to attending arts events. Francois Matarasso (1997) parses the wide-ranging social impacts of the arts into five areas: personal development; social cohesion; community empowerment and self-determination; local image and identity; and imagination and vision. Arts-based initiatives improve physical functionality and provide symptom relief for elderly patients suffering from severe mental disorders (Gold *et al.*, 2009). These activities help regulate emotions among people with depressive disorders (Nan and Ho, 2017) and play an essential role in fostering social inclusion through the arts' non-verbal and non-discriminatory reach (Fisher, 2002; Matarasso, 1997). Although these respective groups are commonly associated as socially excluded due to their health statuses, their physical, communication, social and relationship skills can still be improved through arts therapy (Got and Cheng, 2008). There is a growing body of evidence that participatory arts alleviate health disparities and bring benefits to personal health and well-being as well as social inclusion.

Social inclusion is a multi-faceted concept with a cross-dimensional disposition. In policy discourse, social inclusion has come about in reaction to social exclusion. There is noticeably less literature dedicated to just inclusion without presupposing a state of exclusion. Social inclusion literature often advocates removing "structural barriers" so excluded groups can better participate in society. Promoting inclusion also requires radical changes in societal attitudes beyond simply enabling excluded groups to fit into unwelcoming societies (Bates, 2005; Bates and Davis, 2004; Dunn, 1999; Gordon *et al.*, 2000; Jermyn, 2001, 2004). It is a more deliberate process of encompassing and welcoming all persons and embracing greater equality and tolerance (United Nations, 2016). Social inclusion is more than remedial steps to remove barriers to participation and also involves encouraging participation. The main focus of the research is to review how barrier-free and active policy tools improve social inclusion through the arts.

Policy making in arts inclusion

The mobilisation of the arts as a policy tool to redress social exclusion was first deployed at the turn of the twenty-first century by then UK Prime Minister Tony Blair's administration through the Social Exclusion Unit. The programme was part of a national strategy to eradicate exclusion through joint-departmental collaborations (Sandell, 1998). International awareness grew and today, there are more arts and cultural policies that address issues of diversity by building stronger and healthier communities across countries and regions. These policies include wide-ranging programmes as well as research and development into longer-term plans and strategies. The goal is social inclusion through the arts executed by two means: removing structural barriers to the arts and facilitating excluded groups' participation in society; and using therapeutic arts interventions to improve marginalised groups' well-being and further facilitate social engagement.

This study reviews the policy-making process through the lens of administrative structures – which differ significantly across governments: some adopt an inter-sectoral approach while others prefer tasking one dedicated ministry or department.

The following two cases are real-life examples showing how different countries utilise arts inclusion policies (AIPs) to foster social inclusion and how AIPs involve inter-sectoral efforts.

Case 1 – DaDaFest, UK. DaDaFest is an innovative disability-focussed arts organisation that receives recurrent annual funding from ACE as a National Partner Organisation.

They deliver the internationally renowned DaDaFest disability arts festival and other arts events to promote high-quality "disability and deaf" arts from unique cultural perspectives. It also creates ways for the disabled and the deaf to access the arts. A bi-annual event, DaDaFest International 2016, was the 13th of its kind since its inception in 2001, funded by Art Council England and Liverpool City Council amongst other trusts, charitable foundations and academic institutions in the UK (DaDaFest, n.d.)

Case 2 – The Norwegian Resource Centre for Arts and Health, Norway. The Norwegian Resource Centre for Arts and Health, established in July 2014 is a collaboration amongst Nord University, Trøndelag County, Levanger Municipality, Helse Nord-Trøndelag HF and HUNT Research Centre. The centre's primary mandate is to synergise the efforts made in research, education and practice in the fields of arts and health. Publicly funded by the Norwegian Directorate of Health, the centre ensures good use of arts resources in the health-related sectors, and encourages arts-based strategies in the training of care providers. Its target groups include children, people with mental health problems, elders and people with dementia (Norwegian Resource Centre for Arts and Health, n.d.).

The need of AIPs' comparative review due to insufficient studies

The field of AIPs is relatively new, and thus studies remain few and narrow in scope. There is a lack of comparative grounds in the reviews or papers on arts inclusion: there is no similar literature by official institutions, independent agencies or academia, with unique focus on AIPs as a theme. Even where there are, they often place specific focus on a particular geographical location. And institutional reports from the United Nations (UN) and European Union, for instance, tend to be descriptive but dogmatic and lacking comparability. A comparison of AIPs in different governmental structures is therefore necessary.

This paper aims to inform continued study in this field by: developing a framework to compare policy-making structures on AIPs at an international level; and providing a comparison of AIPs in 14 countries and regions, particularly in the field of policy-making structures.

Research methodology on comparing AIPs

This study constructs a framework to compare policy-making structures on AIPs at a global level for empirical purposes. Despite challenges in applying metrics to AIPs, this paper begins with a qualitative approach for insights on AIPs' modes by comparing case studies and decisive factors. An initial review of academic journals was conducted to map existing trends and to identify gaps which this study is to fill, focussing on geographical coverage of policies as well as policy-making considerations. Journals from a wide spectrum of fields including health, arts therapy and cultural policy were reviewed. Existing literature largely focusses on UK, US, Australian, Norwegian and Swedish experiences.

A review of academic journals ran parallel with online-resource mining with "arts inclusion policy" as the search term. The documents fell mainly into three categories: official and non-governmental arts institution reports and papers; academic papers by universities; and institutional reports on global trends. An additional data set was extracted from the Compendium of Cultural Policies and Trends' online database which provides real-time information and monitoring of national cultural policies. This review studied the geographic scopes and theoretical frameworks of these data sets to determine a value-added research structure in order to complement the existing literature meaningfully.

Defining a geographical scope for comparison

Western countries are featured prominently in cultural and inclusion policy desk research with the UK, the USA, France, Sweden, Norway, Finland, Australia, Canada and Ireland as reoccurring parties. To bring better balance and provide a more comprehensive basis for

understanding differing external and cultural contexts to policy making, this study especially included data from non-western countries, which was extrapolated from the Inequality-adjusted Human Development Index (IHDI) developed by the UN.

The Human Development Index (HDI) captures long-term trends through human development indicators across multiple dimensions including people's health, education and income for every nation and region (United Nations, 2018). It emphasises that national development should also be measured by health and education achievements, and not only the income per capita as long been the practice. To offset inequality in health, education and income distribution, the IHDI is actually less than the aggregate HDI. This is to incorporate inequality into HDI metrics and reflect its influence on a country or region's longevity, education and income (United Nations, 2018).

AIPs predominantly focus on human development rather than pure economic goals, because its major objective is to boost social equality through arts-based strategies. All countries identified from desk research were within the top 25th percentile in terms of IHDI (as shown in Table AI). It is affirmative that countries and regions with higher IHDI tend to have a better awareness on social inclusion and be more sophisticated in deploying respective instruments including AIPs. A further study on the remaining top IHDI countries and regions with existing AIPs at the ministerial level added the Netherlands, Singapore, Hong Kong, Japan and Taiwan to the list of research.

This study covers 14 countries including the UK, the USA, Australia, Canada, France, Ireland, Sweden, Finland, Norway, the Netherlands, Hong Kong, Singapore, Taiwan and Japan, which collectively provide the most pertinent comparative grounds for policymakers and researchers. The information collected from various governments' online portals, websites, academic journals, reports and literature formed the basis of the analysis of this study, to be cross-compared using an original comparative framework.

Frameworks for policy comparison

In this section, the authors discuss existing policy comparison frameworks from which applicable elements were derived to develop the own grounds of comparison (Wyszomirski *et al.*, 2003; Zuiderwijk and Janssen, 2014) (Figure 1).

From literature, a framework adopted by Zuiderwijk and Janssen (2014) that compared open data policies at different government levels is examined. It follows the six-stage policy-making cycle first suggested by Stewart *et al.* (2008), and re-categorises them into four main types, namely, policy environment and context (related to agenda setting); policy content (related to policy formulations and implementation); performance indicators (related to policy evaluation); and realising public values (related to policy change or termination) (Zuiderwijk and Janssen, 2014).

More relevant to the context of AIPs in the scope of discussion, a second framework examined is developed by Wyszomirski *et al.* (2003) that compared policies of cultural diplomacy across countries. The study identified five "major" comparative dimensions covering: terminology and role; goals and priorities; structure; programme tools; and indications of scale and support (Wyszomirski *et al.*, 2003) (Table I).

The two frameworks above offer plentiful insights on relevant comparative grounds and largely resonate with other existing frameworks. While acknowledging that a comprehensive policy analysis should follow the full course of the policy-making cycle and its related parameters, but due to the pioneering nature of this research, the metric adopted for this study shall be precise, which is why the foremost dimension of "structure" is selected.

Drawing from the studies above, and applying those to the context of AIPs, "structures" would refer to the organisational structures behind AIP development. Key questions include: how AIPs are managed administratively? Which departments/ministries or agencies are involved in AIPs development, and managing its implementation? It also

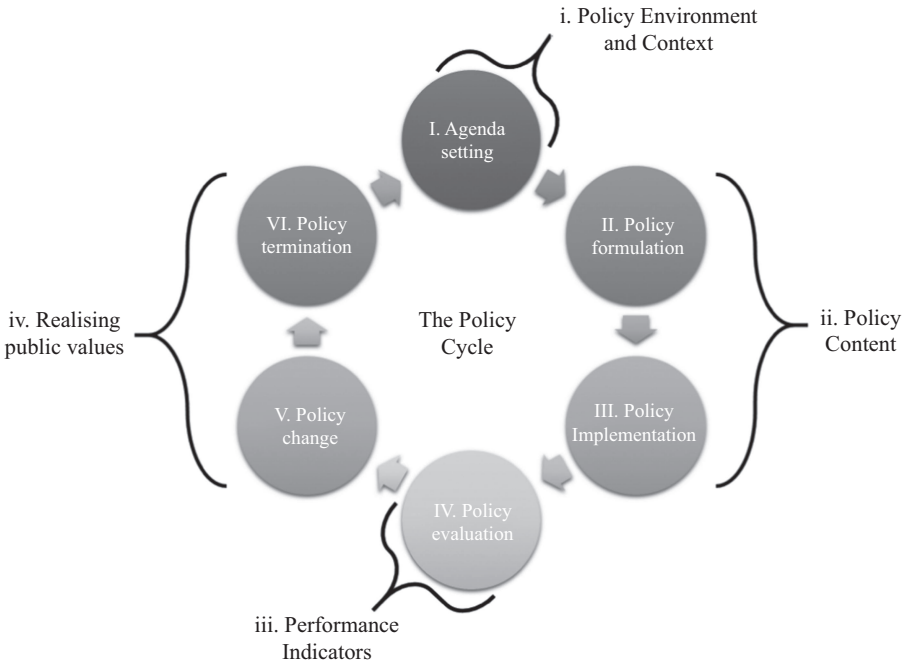


Figure 1. Frameworks used to compare open data policies

Sources: Zuiderwijk and Janssen (2014), Stewart *et al*. (2008)

Dimensions	Description
Terminology	How does each country refer to and regard what we call "cultural diplomacy"?
Goals and priorities	What are the stated goals and purposes of cultural diplomacy? Are there any explicit regional priorities?
Structure	How is cultural diplomacy managed? Which departments/ministries or agencies are involved in policy development and programme administration?
Programme tools	What are the programme tools employed in each country's cultural diplomacy efforts? A preliminary examination of cultural diplomacy programmes in a number of countries revealed a fairly common repertoire of nine kinds of programme activities. Few countries employ all nine types, but most countries do have a varied repertoire of programmatic activities
Indication of scale and support	How much does each country spend to support cultural diplomacy activities and how many activities are involved?

Table I. Five major comparative dimensions

happens that these considerations come under "policy environment and context" as coined by Zuiderwijk and Janssen (2014).

There is much literature that reify the symbiotic relationship between "organisational structures" and a policy's "environment and context". Scholars pointed to how organisational structures contribute to policy implementation effectiveness, and that "the choice for implementing officials" is "the correspondence of policy outputs" (Knill, 2005; Sabatier and Mazmanian, 1979).

This is why the authors have adopted the dimension of "organisational structure" as the first parameter of comparison in this study. In the following sections, how different

organisational structures develop AIPs, how AIPS are managed and which departments/ministries had been involved in policy development and programme administration will be examined. As institutional structures of government support for the arts become increasingly complex, focus was placed at the ministerial level for the analysis at the echelon most directly linked to policy implementation.

Results and discussion: government structure in policy implementation

In this section, a comparison of AIPs' policy-making structures is discussed. Government organisations responsible for advocating AIPs across countries and regions are reviewed and differences in targeted beneficiaries and areas of leadership explained.

Involvement of different ministries at strategic level

Ministries and government departments for arts and culture usually take responsibility for formulating AIPS as illustrated in Table II. In countries like USA, Singapore and Finland, AIPs are developed and implemented solely by the cultural sectors to foster social inclusion through the arts. Ministry involvement towards arts and culture is key to arts inclusion promotion, which is often steered top-down by virtue of national strategic plans, well-supported programmes and summits, etc.

Table II also shows a prevalence for cross-departmental structures though, mainly between separate authorities for health and culture. "Arts for inclusion" is embedded in healthcare policies in UK, Australia and Norway, featuring arts-based strategies targeting people with mental health problems, the elderly and those suffering from dementia. Often cited health benefits include enhanced motivation, improved social connection, a positive mindset, reduced isolation, increased confidence and enhanced self-esteem which constitute the "building blocks"

Country/Region	Structure	Main responsible ministry/department
UK	Cross-department	Department for Digital, Culture, Media and Sport Department of Health and Social Care
USA	Single department	National Endowment for the Arts[a]
Australia	Cross-department	Department of Communications and Arts Department of Health
Singapore	Single ministry	Ministry of Culture, Community and Youth
Canada	Single ministry	Department of Canadian Heritage
Ireland	Cross-department	Department of Culture, Heritage and Gaeltacht Department of Health
France	Cross-ministry	Ministry of Culture Ministry of Health
Japan	Cross-ministry	Ministry of Education, Culture, Sports, Science and Technology Ministry of Health, Labour and Welfare
Taiwan	Single ministry	Ministry of Culture
Hong Kong	Cross-bureau	Home Affairs Bureau Labour and Welfare Bureau
Finland	Single ministry	Ministry of Education and Culture
Norway	Cross-ministry	Ministry of Health and Care Services Ministry of Culture
Sweden	Cross-ministry	Ministry of Culture Ministry of Health and Social Affairs
The Netherlands	Cross-ministry	Ministry of Education, Culture and Science Ministry of Health, Welfare and Sport

Table II. Overview of governmental departments involved in the development of AIPs

Note: [a]The National Endowment for the Arts (NEA) is an independent agency of the United States federal government, the only funder – public or private – that supports the arts in all 50 States in the United States through grants and national initiatives

of social capital (Health Development Agency, 2000). These gains are the result of top-tier involvement by health authorities in AIPs-making processes. A primary principle behind these initiatives is to achieve the first step of health equity by reducing disparities among different groups in a prelude to tackling economic and social disadvantage (Braveman, 2014).

Objectives of "arts for inclusion" go beyond simply reconnecting people in an individual and collective capacity (Fisher, 2002; Matarasso, 1997) and include improving well-being to redress health disparities. The involvement of top health organisations contributes directly to this goal, as set out in Table I. Health policymakers promote arts-based strategies targeting people with mental health problems, the elderly and those suffering from dementia. Programmes initiated by health departments focus on clinical perspectives of arts-related processes as a means to achieve better health outcomes. Top-tier health organisations in countries including the UK, Norway and Sweden offer Arts on Prescription schemes through offering standard participatory arts programmes which encourage cultural engagement with its clinical intervention kit. For example, the UK's National Health Service highlights the role of the Arts on Prescription scheme which allows general practitioners to refer patients to an activity involving the arts or an arts-based therapy service. Arts therapy builds upon the therapeutic process of artistic participation and is delivered by professional and accredited arts therapists who closely interact with patients.

AIPs are mainly the remit of either the health or culture ministry in all countries examined, with the former focussing on mental illness through therapeutic arts interventions emphasising health outcomes, while the latter tends towards more participatory functions to foster social inclusion.

Inter-sectoral policy is key

Bettering health and equity through arts-based activities remains a prominent objective for AIPs and should form the basis for moving forward in developing inter-sectoral policies. Cultural heads usually focussed purely on inclusiveness and health tsars more concerned about therapeutic processes and will miss the indisputable potentials for synergy. In fact, most countries and regions have already been developing and implementing AIPs across several sectors. Despite differences in purposes and measures, policymakers should enhance inter-sectoral integration to maximise reach, efficiency and gains.

Many health determinants lie outside the formal health system according to the WHO and consist of social, physical and economic factors which have a critical influence upon health outcomes. The determinants' distribution remains imbalanced and is perceived to be unfair and unjust (World Health Organisation, 2008). In response, European countries developed the Health in All Policies policy approach in 2013 to reduce health inequities. The approach is founded on the understanding that health problems and inequities are created outside the health sectors (Shankardass *et al.*, 2018). It is a strategy to integrate health concerns related to the division of roles and responsibilities in different sectors and at different levels and scales (Hofstad, 2016).

The involvement of different ministries in the development of AIPs is a strong reminder that the responsibility for population health and health equity is inter-sectoral. There are wide-ranging factors which cause health disparities and a lack of coordination by health authorities limits AIPs' potential influence outside the health domain (Storm *et al.*, 2011). Implementation of AIPs does not have to remain siloed to health and cultural fields. Multi-sectoral policy making based on an integrated perspective can amplify efforts to reduce health disparity well beyond the healthcare sphere.

Rethinking the organisational structure for cross-sectoral policies

AIPs often involve inter-sectoral governance during development and implementation stages, and the difficulties in coordinating this type of inter-sectoral policy are the foci of many political science and public policy studies (Cann, 2017; Hofstad, 2016; Greer and Lillvis, 2014; Sabatier and Mazmanian, 1979). Two common difficulties afflicting inter-sectoral governance

are coordination and durability. Missions and goals vary across sectors, making relevant organisations reluctant to adopt integrated objectives. The resources spent by any other ministry promoting arts inclusion may be seen as money wasted on what should be the cultural authority's remit and financial responsibility. Different bureaucracies may also have difficulty efficiently collaborating and co-financing specific programmes (Cann, 2017).

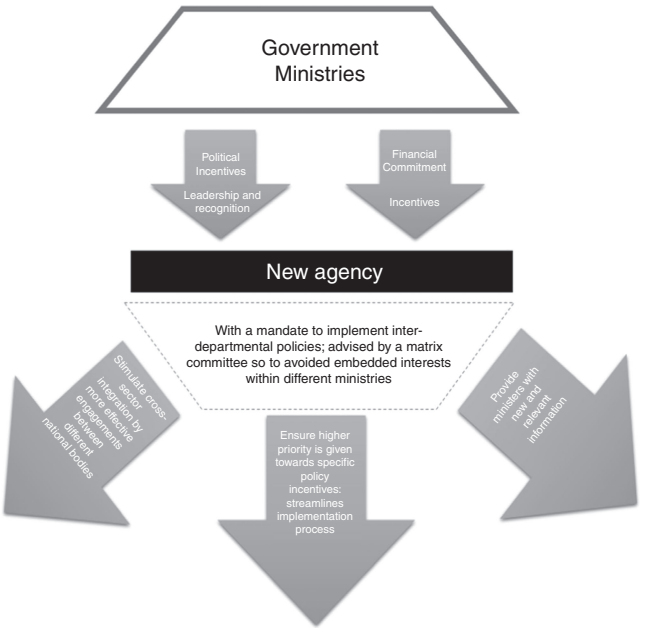
Facilitating collaboration across sectors is one approach to induce bureaucratic changes for better inter-departmental collaboration (Hofstad, 2016; Greer and Lillvis, 2014). Countries such as the UK and Norway have publicly funded organisations to bring cultural engagement into policies for health and well-being improvement. The Culture, Health and Wellbeing Alliance is one such newly formed example which provides a clear, focussed voice to articulate the role arts and culture play in health and well-being. Sabatier and Mazmanian (1979) pinpoint the essential conditions for effective policy implementation, beginning with assigning implementation to agencies which give the new programme a high priority. The appointment of new committees and officials disconnects inter-sectoral policy from embedded interests within different ministries (Hofstad, 2016). Such fresh start gives the new structure freedom to develop a special focus on health and culture, energising committees which provide ministers with new and relevant information (Greer and Lillvis, 2014). This renewed vigour will stimulate cross-sector integration of health and culture by engaging different national bodies such as the NHS to develop programmes such as Arts on Prescription. Only these dedicated agencies can accord higher or the highest priority to AIPS while coordinating and streamlining cross-departmental implementation.

Two key roles of governmental leadership

Jensen *et al.* (2017) argued that political incentives and financial commitments are essential in developing arts and health projects. These major roles taken up by respective ministries are discussed below.

Political leadership drives policy stimulation and recognition. Government organisations are the political anchor which fixes AIPs, social inclusion and health equity at the national strategic level. Political leadership can change agendas, create or redirect networks and directly make inter-sectoral policy (Greer and Lillvis, 2014). A commonality of techniques observed was the early formation of strategic plans and targets. These targets and plans are representative of a government's commitment and directly shape the agendas of subordinate ministries and organisations. A detailed plan also clarifies roles and responsibilities of different actors which is important in inter-sector policy implementation. Officials from ministries for health and culture develop strategic plans and development frameworks while commissioning research related to AIPs, as shown in Figure 2.

Australia's Ministers for Health and Culture jointly developed a 2014 National Arts and Health Framework to enhance the profile of arts and health in Australia. The framework promotes greater integration of arts and health practice as well as health promotion, services, settings and facilities (Department of Communications and the Arts, 2014). The framework's basis rests on the benefits and importance of arts and health practices. It also encourages the inclusion of the arts in health initiatives by suggesting approaches across sectors and areas through research and facility building. UK's Department of Health and Department of Culture, Media and Sport separately published white papers highlighting the crucial role of arts and culture in promoting social prescription, social contacts and social inclusion (Department for Culture, Media and Sport, 2016; Department of Health and Social Care, 2006). Sabatier and Mazmanian (1979) emphasised that policy objectives should be precise and clearly ranked for implementing agencies. UK and Australian experiences serve as excellent examples of directives to actors and supporters both inside and outside for effective implementation.



Sources: Adapted from Jensen *et al*. (2017), Sabatier and Mazmanian (1979), Ran (2013), Pressman and Wildavsky (1984)

Figure 2.
Governmental structure for effective implementation of cross-sectoral policies

Policymakers can also openly recognise arts inclusion initiatives by publicly endorsing the benefits of arts-based activities. Singapore has long recognised the relationship between the arts and inclusion; its Ministry of Information, Communications and the Arts regards arts and culture as the most socially inclusive platform for strengthening community bonding in the implementation of its Renaissance City Plan. The Japanese Government also places a strong emphasis on the arts for, and by the disabled. The Agency for Cultural Affairs, a special body under the Ministry of Education, Culture, Sports, Science and Technology, focussed on the significance of disability arts in its 44th Directions for Developing Arts and Culture. Bureaucracies are influenced by advocacy for arts inclusion by ministers and top policymakers (Greer and Lillvis, 2014). The endorsements from these policymakers serve as public commitments and stimulate policy implementation (Sabatier and Mazmanian, 1979).

Financial commitment incentivises AIPs development. The success of policy implementation requires not only political stimulation but also sufficient financial incentives (Ran, 2013; Pressman and Wildavsky, 1984). In countries such as Australia and Norway, the success of policy implementation largely depends on whether local governments and officials receive enough financial incentives from their respective central governments (Ran, 2013; Jensen *et al.*, 2017). In most countries and regions, AIPs are delivered through publicly funded organisations. Grants have long been the primary funding means for state arts agencies; similarly, grants and funding are in parity central to effective arts policies (National Research Center of the Arts, Inc., 1976; Lowell, 2004).

Funding from authorities can be divided into programmes and research domains. The Finnish Government granted €2m to the implementing agency, Arts Promotions Centre Finland to fund arts projects related to the health and social care sector (Tamm, 2008). A similar grant was made in Singapore through the WeCare Arts Fund as part of the Arts

for All Initiative which supports arts organisations and access for social service sector beneficiaries (National Arts Council, 2017). These grants expand supply, promote access and cultivate demand for AIPs. They broaden arts participation and also increase public awareness (Lowell and Zakaras, 2008).

Governments bear a significant role in funding research in culture and health. One barrier in the further development of AIPS is the scarcity of research. This is especially the case where AIPs is totally subordinate to the healthcare system. Policymakers may lack evidence to push for greater arts and cultural initiatives in relation to the healthcare system. Insufficient research restricts the scope of public service agencies to invest in new ways of increasing well-being through the arts (Cann, 2017). Ministries should take the initiative to strengthen the body of evidence detailing the impact of arts and cultural activities for health and care practices. US's National Endowment for the Arts supports research on the value and impact of the arts, and currently focusses on arts and aging. Arts Council of England also funds research and development of cultural work in the health and criminal justice sectors. The publicly funded Norwegian Resource Centre for Arts and Health was established in 2014, and its primary mandate is to bring a greater interaction between research and practice in the fields of arts and health (Jensen *et al.*, 2017).

The importance of stable and sufficient financial resources for better policy implementation has long been emphasised. Government funding is vital for implementing agencies to hire staff, administer, conduct research, develop activities and regulations, manage programme delivery, and monitor and evaluate impacts. Public funding is a necessary precondition to achieving statutory objectives in policy implementation (Sabatier and Mazmanian, 1979) (Table III).

Learning from the west: facilitating policy implementation

The in-depth inquiry into the policy-making structures of the 14 countries has one important finding: AIPs in western countries are more developed in terms of target scope and diversity of programmes when compared to those of Asian countries and regions. This section especially highlights two distinct parameters which serve as valuable testimonies for Asian policymakers to consider when designing their local-centric programmes.

More evidence-based studies on the impact of arts inclusion

The arts are long recognised as important tools for fostering health and well-being in western countries. In the UK, Arts on Prescription has existed in one form or another for about two decades (Jensen *et al.*, 2017), while arts and health policies only started emerging in Asia in the late 2000s, in countries such as Taiwan, Singapore and Japan. One possible reason for this discrepancy is that western countries have long invested in building evidence of the positive impacts of arts on health and well-being. Different countries in the west have set up research centres on arts and well-being. There are plentiful testimonies of how participation in arts activities is highly valued by the elderly, the disabled and those in rehabilitation. Leading research in the arts, health and well-being fields is mainly produced in the UK and Scandinavia, where ample research centres specialise in the field (Jensen *et al.*, 2017). The evidence gathered subsequently contributes to a robust base for sustaining investment in the arts and cultural activities. Therefore, it is of paramount importance for Asian countries to establish a localised evidence base so that public service commissioners and funders can access and acknowledge the benefits of the arts on health, and move towards mobilising the arts for social inclusion and healthcare in their own geographical contexts.

Higher public and professional recognition of the role of the arts

Public perception of the arts in enhancing health and well-being can also be cultivated by actively incorporating the arts into health and social welfare systems. In western countries

Country/ Region	Major responsible ministry/ department	Target groups: The disabled	Elderly	Children and the young	People with mental problems/ the sick	Other underserved community (e. g. ethnic minority)	Key roles: Funding	Proposing initiatives	Initiating programmes	Conducting research	Developing strategic framework	Promoting art-based strategies and programmes
UK	Department for Digital, Culture, Media and Sport Department of Health and Social Care	✓	✓		✓		✓		✓			✓
USA	National Endowment for the Arts	✓	✓						✓	✓		
Australia	Department of Communications and Arts	✓	✓	✓		✓					✓	
	Department of Health and Department of Communications and Arts[a]	✓	✓	✓	✓						✓	
Singapore	Ministry of Culture, Community and Youth	✓				✓	✓		✓		✓	
Canada	Department of Canadian Heritage	✓			✓	✓	✓		✓	✓	✓	
Ireland	Department of Culture, Heritage and Gaeltacht	✓		✓		✓	✓		✓	✓	✓	

(*continued*)

Table III.
Overview of the policy options and target groups of AIPs

Table III.

Country/ Region	Major responsible ministry/ department	Target groups					Key roles					
		The disabled	Elderly	Children and the young	People with mental problems/ the sick	Other underserved community (e. g. ethnic minority)	Funding	Proposing initiatives	Initiating programmes	Conducting research	Developing strategic framework	Promoting art-based strategies and programmes
	Department of Health		✓		✓				✓		✓	
	Department of Culture, Heritage and Gaeltacht			✓		✓				✓		
	Department of Health[a]											
France	Ministry of Culture											
	Ministry of Culture				✓				✓	✓		
	Ministry of Health[a]											
Japan	Ministry of Education, Culture, Sports, Science and Technology	✓	✓		✓			✓				
	Ministry of Health, Labour and Welfare	✓					✓					
Taiwan	Ministry of Culture		✓			✓	✓		✓			✓
Norway	Ministry of Health and Care Services		✓	✓	✓				✓	✓		✓
	Ministry of Culture			✓	✓	✓	✓	✓	✓	✓		✓

(*continued*)

Country/ Region	Major responsible ministry/ department	Target groups					Key roles					Promoting art-based strategies and programmes
		The disabled	Elderly	Children and the young	People with mental problems/ the sick	Other underserved community (e. g. ethnic minority)	Funding	Proposing initiatives	Initiating programmes	Conducting research	Developing strategic framework	
Finland	Ministry of Health and Care Services Ministry of Culture[a]		✓						✓			
	Ministry of Education and Culture		✓	✓	✓			✓				
Sweden	Ministry of Culture		✓				✓					✓
	Ministry of Culture Ministry of Health and Social Affairs[a]				✓		✓					✓
The Netherlands	Ministry of Education, Culture and Science Ministry of Health, Welfare and Sport	✓	✓	✓		✓			✓		✓	
Hong Kong	Home Affairs Bureau	✓			✓	✓	✓					✓
	Labour and Welfare Bureau	✓					✓					

Note: [a]Joint-ministry effort

Table III.

including the USA, the UK and Australia, arts therapists are recognised under associations of allied health professions as legitimate members of the healthcare sector. This professional recognition enhances public trust of the role of the arts within health and well-being discourses. The increase in credibility of qualified arts therapists and professionals will facilitate the development of AIPs such as Arts on Prescription schemes. According to Gustavsson *et al.* (2018), moreover, successful implementation of a new healthcare practice depends on the healthcare providers' attitude and users' perceptions towards the new treatment. Sweden stands out as an exemplar of having an encouraging social context for the introduction of Arts on Prescription, as prior to which social prescribing had already existed locally. The Swedish Physical Activity on Prescription was launched in 2001 to promote physical activity for prevention and treatment of lifestyle-related health disorders (Gustavsson *et al.*, 2018). It was introduced in Sweden over a sustainable period and as an existing social prescription programme, helped increase public confidence and acceptance of non-clinical means for health treatment. The precursor role positively impacted public perceptions and eased the introduction of Arts on Prescription in 2009 (Jensen *et al.*, 2017).

Conclusion: policy-making structures are vital to AIPs development

Administrative structures across different countries and regions take on varied approaches to fostering social inclusion through the arts – wherein a majority deploy their cultural ministries to take the lead on AIPs development, although there are certain circumstances where health ministries also bear major responsibilities to AIPs. These inter-sectoral structures allow inclusive outcomes to manifest through participatory and therapeutic approaches to the arts. The policies ushered in by the cultural ministries are often more general and targeted towards a wide spectrum of socially disadvantaged groups via participatory arts initiatives. The policies under the health ministry are observed to be more clinically based which target patients especially with mental illness primarily via arts interventions of a "therapeutic" function. Of those, medium- to long-term benefits would include reduction or elimination of social disadvantages brought by bettering overall health (Braveman, 2014). Taken together, inter-sectoral approaches lead to more comprehensive policy development.

While tracing and evaluating the funding sources behind each policy is a necessary step for comparative analysis, the ideal role of governmental ministries should not only be limited to the remit of funding programmes. Mobilising art and culture for socially inclusive outcomes is a recent development and it is important for ministries to take a leading role in policy formation. Some ministries are independently collecting data to gauge the impacts of art activities for developing strategic plans and frameworks. The involvement of top politicians also provides incentives to policymakers to further invest, and is essential to seed and inject AIPs in areas where local research and practice remains relatively new.

AIPs in western countries remain more developed in target scope and programme diversity compared to Asian countries and regions. Learning from western models, there is ample potential to engage further in the arts to drive out public health benefits, while achieving social inclusion. Before popularising the efficacy of arts in health and social inclusion, more localised research is needed to understand the impact and value of the arts on health when applied in an Asian context.

The framework developed for this study is a useful guide for understanding how policy-making structures shape and define AIPs, particularly through studying the differences and similarities among 14 selected governments in the world. Yet it is not the scope of this study to include all the set parameters for comparison, so the authors fully acknowledge the limitations that remain, and future studies to be devoted in this area. First, the term "arts inclusion policy" is not widely adopted, thus research remains largely focussed on cultural and health policies across a small, albeit wealthy, subset of countries and regions. Second, "arts inclusion" remains a relatively new concept globally speaking, and most AIPs

are still evolving hence the evaluation of impacts across countries and regions remains scattershot and has yet to provide mature results for empirical evaluation. Third, a comprehensive policy review requires a complete investigation along the policy-making cycle, while this study has only embarked on one out of the five parameters explained in our recommended comparative framework. Nevertheless, existing programmes, more represented by the west, will continue to yield results and develop the know-how to further development of "arts for inclusion" policies. As the impacts of AIPs become increasingly visible over time, locally specific research and development corresponding to the metrics suggested in this paper for further evaluation is recommended.

References

Bates, P. (2005), *Reviewing Measures of Social Inclusion*, National Development Team, Nottingham.

Bates, P. and Davis, F.A. (2004), "Social capital, social inclusion and services for people with learning disabilities", *Disability and Society*, Vol. 19 No. 3, pp. 195-207.

Braveman, P. (2014), "What are health disparities and health equity? We need to be clear", *Public Health Reports*, Vol. 129, pp. 5-8, available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC3863701

Cann, P.L. (2017), "Arts and cultural activity: a vital part of the health and care system", *Australasian Journal of Ageing*, No. 2, pp. 89-95, available at: www.ncbi.nlm.nih.gov/pubmed/28635088

DaDaFest (n.d.), "DaDaFest International", available at: www.dadafest.co.uk/what-we-do/festivals-and-events/ (accessed 24 September 2019).

del Mers, C.L., Tincani, M., van Norman, R.K. and Higgins, K. (2009), "Effects of music therapy on young children's challenging behaviors: a case study", *Music Therapy Perspectives*, Vol. 27 No. 2, pp. 88-96, available at: https://doi.org/10.1093/mtp/27.2.88

Department of Communications and the Arts (2014), "National arts and health framework", available at: www.arts.gov.au/sites/g/files/net1761/f/National%20Arts%20and%20Health%20Framework%20May%202014.pdf (accessed 18 November 2019).

Department for Culture, Media and Sport (2016), "The Culture White Paper", available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/510798/DCMS_The_Culture_White_Paper__3_.pdf (accessed 24 September 2019).

Department of Health and Social Care (2006), "Our health, our care, our say: a new direction for community services", available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf (accessed 24 September 2019).

Dunn, S. (1999), "Creating accepting communities: report of the MIND inquiry into social exclusion and mental health problems", MIND, London.

Fisher, R. (2002), "Social Cohesion in the United Kingdom: a case report", *Canadian Journal of Communication*, Vol. 27 No. 2, pp. 161-166, available at: www.cjc-online.ca/index.php/journal/article/view/1291

Gold, C., Mössler, K., Grocke, D., Heldal, T.O., Tjemsland, L., Aarre, T. and Rolvsjord, R. (2013), "Individual music therapy for mental health care clients with low therapy motivation: multicentre randomised controlled trial", *Psychotherapy and Psychosomatics*, Vol. 82 No. 5, pp. 319-331, available at: https://doi.org/10.1159/000348452

Gold, C., Solli, H.P., Krüger, V. and Lie, S.A. (2009), "Dose–response relationship in music therapy for people with serious mental disorders: systematic review and meta-analysis", *Clinical Psychology Review*, Vol. 29 No. 3, pp. 193-207, available at: https://doi.org/10.1016/j.cpr.2009.01.001

Gooding, L.F. (2011), "The effect of a music therapy social skills training program on improving social competence in children and adolescents with social skills deficits", *Journal of Music Therapy*, Vol. 48 No. 4, pp. 440-462, available at: https://doi.org/10.1093/jmt/48.4.440

Gordon, D., Adelman, L., Ashworth, K., Bradshaw, J., Levitas, R., Middleton, S. and Townsend, P. (2000), *Poverty and Social Exclusion in Britain*, Joseph Rowntree Foundation, York.

Got, I.L.S. and Cheng, S.-T. (2008), "The effects of art facilitation on the social functioning of people with developmental disability", *Art Therapy*, Vol. 25 No. 1, pp. 32-37, available at: https://doi.org/10.1080/07421656.2008.10129347

Greer, S. and Lillvis, D. (2014), "Beyond leadership: political strategies for coordination in health policies", *Health Policy*, Vol. 116 No. 1, pp. 12-17, available at: www.ncbi.nlm.nih.gov/pubmed/24576497

Gustavsson, C., Nordqvist, M., Bröms, K., Jerdén, L., Kallings, L.V. and Wallin, L. (2018), "What is required to facilitate implementation of Swedish Physical Activity on Prescription? – interview study with primary healthcare staff and management", *BMC Health Services Research*, Vol. 18 No. 1, pp. 1-10, available at: https://doi.org/10.1186/s12913-018-3021-1

Health Development Agency (2000), "Art for health: a review of good practice in community-based arts projects and initiatives which impact on health and wellbeing", available at: www.artshealthresources.org.uk/docs/art-for-health-a-review-of-good-practice-in-community-based-arts-projects-and-initiatives-which-impact-on-health-and-wellbeing (accessed 18 November 2019).

Hofstad, H. (2016), "The ambition of Health in All Policies in Norway: the role of political leadership and bureaucratic change", *Health Policy*, Vol. 120 No. 5, pp. 567-575, available at: https://doi.org/10.1016/j.healthpol.2016.03.001

Howells, V. and Zelnik, T. (2009), "Making art: a qualitative study of personal and group transformation in a community arts studio", *Psychiatric Rehabilitation Journal*, Vol. 32 No. 3, pp. 215-222, available at: https://doi.org/10.2975/32.3.2009.215.222

Jensen, A., Stickley, J., Torrissen, W. and Stigmer, K. (2017), "Arts on prescription in Scandinavia: a review of current practice and future possibilities", *Perspectives in Public Health*, Vol. 137 No. 5, pp. 268-274.

Jermyn, H. (2001), "The arts and social exclusion: a review prepared for the Arts Council of England", Arts Council of England, London, available at: https://webarchive.nationalarchives.gov.uk/20090104082907/http://www.artscouncil.org.uk/publications/publication_detail.php?sid=21&id=134 (accessed 24 September 2019).

Jermyn, H. (2004), "The art of inclusion (Vol. 35)", Arts Council of England, London, available at: https://webarchive.nationalarchives.gov.uk/20160204123854/; www.artscouncil.org.uk/advice-and-guidance/browse-advice-and-guidance/the-art-of-inclusion (accessed 24 September 2019).

Knill, C. (2005), "Introduction: cross-national policy convergence: concepts, approaches and explanatory factors", *Journal of European Public Policy*, Vol. 12 No. 5, pp. 764-774, available at: https://doi.org/10.1080/13501760500161332

Lowell, J. (2004), "State arts agencies, 1965-2003: whose interests to serve?", RAND, Santa Monica, CA, available at: www.rand.org/dam/rand/pubs/monographs/2004/RAND_MG121.pdf (accessed 18 November 2019).

Lowell, J. and Zakaras, L. (2008), "Cultivating demand for the arts: arts learning, arts engagement and state arts policy", RAND, Santa Monica, CA, available at: www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG640.pdf (accessed 18 November 2019).

Matarasso, F. (1997), "Use or ornament? The social impact of participation in the arts", available at: www.artshealthresources.org.uk/wp-content/uploads/2017/01/1997-Matarasso-Use-or-Ornament-The-Social-Impact-of-Participation-in-the-Arts-1.pdf (accessed 24 September 2019).

Nan, J.K.M. and Ho, R.T.H. (2017), "Effects of clay art therapy on adults outpatients with major depressive disorder: A randomized controlled trial", *Journal of Affective Disorders*, Vol. 217, pp. 237-245, available at: https://doi.org/10.1016/j.jad.2017.04.013; www.sciencedirect.com/journal/journal-of-affective-disorders/issues

National Arts Council (2017), "National Arts Council Annual Report FY 2017/2018, making marks", available at: www.nac.gov.sg/dam/jcr:43193822-71e2-4482-b595-c3eafc26d8a0 (accessed 24 September 2019).

National Research Center of the Arts (1976), *Americans and the Arts: A Survey of the Attitude Toward and Participation in the Arts and Culture of the United States Public*, National Research Center of the Arts, New York, NY.

Norwegian Resource Centre for Arts and Health (n.d.), "Arts and health: promoting well-being through creativity", available at: https://kulturoghelse.no/2019/04/artshealth-promoting-well-being-through-creativity/ (accessed 24 September 2019).

Pressman, J. and Wildavsky, A. (1984), *Implementation*, University of California Press, Berkeley, CA.

Raglio, A., Bellelli, G., Traficante, D., Gianotti, M., Ubezio, M.C., Villani, D. and Trabucchi, M. (2008), "Efficacy of music therapy in the treatment of behavioral and psychiatric symptoms of Dementia", *Alzheimer Disease and Associated Disorders*, Vol. 22 No. 2, pp. 158, available at: https://doi.org/10.1097/WAD.0b013e3181630b6f

Ran, R. (2013), "Perverse incentive structure and policy implementation gap in China's local environmental politics", *Journal of Environmental Policy and Planning*, Vol. 15 No. 1, pp. 17-39.

Sabatier, P. and Mazmanian, D. (1979), "The implementation of public policy: a framework of analysis", *Policy Studies Journal*, Vol. 8 No. 4, pp. 538-560, available at: https://doi.org/10.1111/j.1541-0072.1980.tb01266.x

Sandell, R. (1998), "Museums as agents of social inclusion", *Museum Management and Curatorship*, Vol. 17 No. 4, pp. 401-418, available at: https://doi.org/10.1080/09647779800401704

Shankardass, K., Muntaner, C., Kokkinen, L., Shahidi, F.V., Freiler, A., Oneka, G., … O'Campo, P. (2018), "The implementation of health in all Policies initiatives: a systems framework for government action", *Health Research Policy and Systems*, Vol. 16 No. 1, available at: https://doi:10.1186/s12961-018-0295-z

Stewart, J., Hedge, D. and Lester, J.P. (2008), *Public Policy: An Evolutionary Approach*, Wadsworth-Thomson, Boston, MA.

Storm, B.C., Angello, G. and Bjork, E.L. (2011), "Thinking can cause forgetting: memory dynamics in creative problem solving", *Journal of Experimental Psychology: Learning, Memory, and Cognition*, Vol. 37 No. 5, pp. 1287-1293, available at: https://doi:10.1037/a0023921

Tamm, K. (2008), "Managing art projects with societal impact", Executive Agency, Education, Audiovisual and Culture, European Union, Helsinki, available at: www.mapsi.eu/mapsi/wp-content/uploads/2016/05/MAPSI_Final-Report.pdf (accessed 18 November 2019).

UNDP (2017), "Human Development Reports – Table 3: Inequality-adjusted Human Development Index", available at: http://hdr.undp.org/en/composite/IHDI (accessed 24 September 2019).

United Nations (2016), "Leaving no one behind: the imperative of inclusive development, report on the World Social Situation 2016", available at: www.un.org/esa/socdev/rwss/2016/full-report.pdf (accessed 24 September 2019).

United Nations (2018), "Human Development Indices and Indicators, 2018 Statistical Update", available at: http://hdr.undp.org/sites/default/files/2018_human_development_statistical_update.pdf (accessed 24 September 2019).

World Health Organisation (2008), "The world health report 2008 – primary health care: now more than ever", available at: www.who.int/whr/2008/whr08_en.pdf; https://www.who.int/whr/2008/whr08_en.pdf (accessed 18 November 2019).

Wyszomirski, M.J., Burgess, C. and Peila, C. (2003), "International cultural relations: a multi-country comparison", *Cultural Diplomacy Research Series*, The Ohio State University, available at: http://culturalpolicy.org/pdf/mjwpaper.pdf (accessed 18 November 2019).

Zuiderwijk, A. and Janssen, M. (2014), "Open data policies, their implementation and impact: a framework for comparison", *Government Information Quarterly*, Vol. 31 No. 1, pp. 17-29, available at: https://doi.org/10.1016/j.giq.2013.04.003

Appendix

IHDI Rank (2017)	Country/Region	2017
1	Iceland	0.879
2	Japan[a]	0.876
3	Norway[a]	0.876
4	Switzerland[a]	0.871
5	Finland[a]	0.868
6	Sweden[a]	0.864
7	Australia[a]	0.861
8	Germany	0.861
9	Denmark[a]	0.86
10	The Netherlands[a]	0.857
11	Ireland[a]	0.854
12	Canada[a]	0.852
13	New Zealand	0.846
14	Slovenia	0.846
15	Czechia	0.84
16	Belgium	0.836
17	Austria	0.835
18	UK[a]	0.835
19	Singapore[a]	0.816
20	Luxembourg	0.811
21	Hong Kong, China (SAR)[a]	0.809
22	France[a]	0.808
23	Malta	0.805
24	Slovakia	0.797
25	USA[a]	0.797

Note: [a]Regions included in our comparison
Source: UNDP (2017)

Table AI.
Inequality-adjusted HDI (IHDI)

About the authors

Alvin Cheung's research focus is on environmental, social and governance (ESG) reporting, social impact assessment (SIA) and arts innovation. He is one of the authors of Arts Inclusion Policy Research Report, Policy Review on ESG Reporting, the Social Innovation Research Report, Green Bond Study and Pay-for-Success Study published by Our Hong Kong Foundation. He has engaged different local stakeholders, including government officers, business leaders and social innovators, to promote applications of arts inclusion and facilitate communication between government and social sectors. He obtained his MPhil in Economics from The Chinese University of Hong Kong and BSc in Economics and Finance, with First Class Honors, from The Hong Kong University of Science and Technology.

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Public Administration and Policy
Indexed and abstracted by:
The British Library

ISSN 1727-2645
Volume 22 Number 2
2019

Public Administration and Policy

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