One Public, Two Health Systems: Hong Kong and China, Integration without Convergence*

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Abstract

This paper will explore the political dimensions of public health between the Hong Kong Special Administrative Region (HKSAR) and China under the “one country, two systems” concept. Enshrined in the Basic Law which came into effect on 1 July 1997, it is the modus vivendi for Hong Kong’s reintegration with the mainland ensuring that Hong Kong will retain its capitalist system and lifestyle, including its health care system for fifty years. In effect, it is the legal framework defining the relationship between the HKSAR (the city) and the Chinese state. In the past decade this modus vivendi has been challenged by cross-border public health crises with global impact such as HIV/AIDS, the newly emerging H5N1 (“bird flu”) virus and SARS, as well as escalating crises

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in food safety of pork, fish, vegetables and other products imported from the mainland. The concentration here will be on south China, considering its human and ecological interdependence with Hong Kong. Other issues focus on divergent health care governance including financing and health care delivery as well as questions of equity or “right to health,” all of which have precipitated a perceived need to re-evaluate the principle. Since the “one country, two systems” concept was originally formulated with Taiwan in mind, the Hong Kong experience will have a far-reaching impact on an important aspect in the future of the one-China policy of the People’s Republic of China (PRC).

**Convergence**

Beijing has stressed the need for “convergence” and a smooth transition to Chinese sovereignty for Hong Kong since the signing of the Sino-British Joint Declaration in 1984 to the handover and beyond. This notion dates back to the principle of “peaceful co-existence” first used in 1954 and again in 1979, based on the Leninist strategy to promote socialism with capitalism. The rationale for the “one country, two systems” formula as An-Chia Wu argued in the late 1980s, was reminiscent of Brzezinski and Huntington’s cold war “convergence theory” of the 1960s.¹ Jan Tinbergen, who developed the theory in 1961, argued that capitalist and socialist polities and their innate ideological contradictions would under reciprocal influences change and “converge” under the forces of industrialization, urbanization and economic growth (and we may add, the forces of globalization) which would give rise to a common culture.²

Although the theory has been roundly criticized by comparative economists for its lack of theoretical and empirical precision, what is important here, as Wu implied, is the perceived (and desired) direction of long-term change: for Marxists, capitalism, defeated by its own imperfections, will become socialist; for proponents of capitalism, the irrational (idealist) socialist planned system will revert to a rational market economy.³ Economists also recognize the distinction between the organic development of social institutions, a product of history, and the “pragmatic” purposive design of social institutions based on *a priori* ideological aims or goals.⁴ In that context convergence theory has also been used to explain the development of public health systems suggesting that social, political and economic organization and scientific technologies in developed countries are productive of similar outcomes in policies and health strategies.⁵ Critics have argued that the theory does not recognize