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**Explaining Health Policy Change in China between 2003 and  
2009: Actors, Contexts and Institutionalisation**

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(Politics)

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## Abstract

The health policy change in China between 2003 and 2009 was profound. In 2003, the Chinese government changed its response to the Severe Acute Respiratory Syndrome (SARS) outbreak from initial passivity to proactivity. Following the SARS outbreak, in 2005 the Chinese government started major healthcare reforms. During this process, the health policy direction then changed from marketisation towards being more government-led. Previous research has explained health policy change mainly from bureaucratic perspectives that considered the government playing the main role. This thesis explains how and why health policy changed by focusing on three actors outside the political system. I argue that, after the SARS outbreak, experts, the media, and international organisations influenced the health policies as a ‘Policy Entrepreneurial Coalition’ (PEC), the result of which was a combination of normal and paradigmatic policy changes between 2003 and 2009.

This is a qualitative study. I conducted fieldwork in China involving semi-structured interviews of policy insiders and outsiders. The policy insiders are government officials in the Ministry of Health. The policy outsiders are: domestic Chinese experts in social science, health economics, and health; external (foreign) experts who were involved in China’s health policymaking; journalists in national media and other commercialised traditional media; and representatives of international organisations in China. I also did content analysis of both policy documents and media reports. I identified three cases: the health policy change during the SARS outbreak, the initiation of the healthcare reform, and the health policy change during the healthcare reform policymaking.

This thesis makes three major contributions. First, it documents the health policy change between 2003 and 2009. Second, previous studies focused on bureaucratic bargaining during policymaking in China, but I examine roles of policy outsiders, who have conventionally been neglected in China’s policy process. Third, to explain the influence of the outsiders, I examine the policymaking process within the central government and how the policy outsiders interacted with the policy insiders. In doing so, this thesis contributes to the understanding of China’s politics and policy processes.

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I dedicate this thesis to my family.

## Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature \_\_\_\_\_

Printed name \_Aofei Lv\_\_\_\_\_

## Main Abbreviations

CASS	Chinese Academy of Social Science
CCP	Chinese Communist Party
CCTV	China Central Television
China CDC	Chinese Centre for Disease Control and prevention
CPPCC	Chinese People's Political Consultative Conference
CYD	China Youth Daily
DFID	UK Department for International Development
DRC	Development Research Center of the State Council
GIRD	Guangzhou Institute of Respiratory Disease
MOF	Ministry of Finance
MOH	Ministry of Health
MOLSS	Ministry of Labour and Social Security <sup>1</sup>
NDRC	National Development and Reform Commission
NPC	National People's Congress
PEC	Policy Entrepreneurial Coalition
RCG	Research Coordination Group
SARS	Severe Acute Respiratory Syndrome
SC	State Council
TCM	Traditional Chinese Medicine
WHO	World Health Organisation

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<sup>1</sup> Due to administrative reform within the central government, the MOH is called National Health and Family Planning Commission since 2013, and the MOLSS is called Ministry of Human Resources and Social Security since 2008. But in this thesis, I will still use the MOH and the MOLSS.

# 1 Introduction

In November 2002, an unknown but highly communicable and fatal disease suddenly swept through China's Guangdong province, eventually causing 8,096 cases and 774 deaths worldwide (WHO, 2004).<sup>2</sup> On 12 March 2003, the World Health Organisation (WHO) issued the first global alert in history (Braden et al., 2013). On 15 March 2003, 'the WHO named this disease Severe Acute Respiratory Syndrome (SARS)' (Abraham, 2005 p.148).

As the worst-hit country, as well as the presumed origin of SARS at the beginning of the SARS outbreak, China was at the centre of international criticism because of its initial response of covering up the disease – discouraging the press from reporting on SARS, and delaying the reporting of the disease situation to the WHO. However, the Chinese government showed dramatically different responses after the Minister of Health and Beijing's mayor were both fired for downplaying SARS on 20 April 2003 (Wong and Zheng, 2004, Kleinman and Watson, 2005). 'This marks a turning point in control efforts in China' (Whaley and Mansoor, 2006 p. 32). 'Once the public health implications were recognised, however, the subsequent response to SARS by China was among the most aggressive and effective worldwide and included substantial improvements' (Braden et al., 2013 p.865).

Health policies in China continued to change significantly after SARS was controlled. For instance, from 2003 to 2009, fourteen relevant laws and regulations were issued and amended to improve the public health emergency system based on the experience dealing with SARS (Zhang, 2011). Furthermore, the policy change extended from disease prevention and control to the whole health system. In 2005, the Chinese government started a new healthcare reform (Huang, 2013). After the policymaking process between 2005 and 2009, the healthcare reform restored the government's role and realigned the roles of both government and the market in the re-distribution of medical resources (Kornreich et al., 2012). The health policy direction then changed towards being more government-led (Zhang, 2011).

Scholars have explained the health policy change from different perspectives. Thornton (2009) argued that the sudden change in the central government's response to SARS could

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<sup>2</sup> According to the WHO, China (mainland) had 5,327 cases and 349 deaths, while Hong Kong had 1,755 cases and 299 deaths.

be attributed to the centralisation of political power of the Chinese Communist Party (CCP) along with military force, local state agencies, and mobilised social groups. Some others explained it from a crisis management perspective (Wong and Zheng 2004). The SARS crisis challenged the political stability and legitimacy of the Chinese government with its new leaders, Hu Jintao and Wen Jiabao. Therefore, the Chinese government had to change their response from passive to active. Some scholars explained that the policy change that followed the healthcare reform resulted from social learning. ‘The SARS epidemic in 2003 sparked the process to review and reform China’s health care system. The cascade of failures in multiple systems, both political and medical, at the outbreak of SARS highlighted the problems facing China’s highly marketised health system, prompting official introspection into the issue. Subsequently, government attention to the health system increased’ (Thompson, 2009 p.75). The Chinese government realised that, although a ‘political campaign and social mobilisation’ were effective in controlling SARS temporarily, these measures could not work all the time (Gu, 2004). To prevent similar crises, the Chinese government had to improve the healthcare system. Therefore, the Chinese government learnt lessons from the SARS crisis and reconfigured the healthcare system.

Despite their insights, these scholars considered policy change a political process in which the government played the main role, and they neglected the roles of other actors in health policy change. In fact, some actors outside the government were also involved in the health policy process. For instance, Cao (2004b) stated that science researchers in China influenced the SARS treatment policies; some scholars have examined the media campaign that provided SARS information (e.g. Fewsmith, 2003, Tai and Sun, 2007, Yu, 2009); some scholars considered the roles of the WHO in assisting the Chinese government’s defeat of SARS (Balasegaram and Schnur, 2006, Schnur, 2005); and other scholars have discussed the influence of experts, media, and international organisations in the healthcare reform policymaking based on bureaucratic bargaining (e.g. Huang, 2013, Kornreich et al., 2012, Wang and Fan, 2013).

The previous research of explaining the health policy change had limitations. First, it focused more on the political process rather than the policy process. Although China is an authoritarian state with one ruling party (Lieberthal and Oksenberg, 1988), the CCP does not set every detail of policy. Seeing the policy change as a result of CCP decision-making simplified the policymaking process in China. In fact, the Chinese government, especially

the State Council system,<sup>3</sup> has a whole set of policymaking processes (Saich, 2011). Second, although scholars saw the SARS outbreak as a significant moment for the government to review the healthcare system critically (e.g., Xin, 2004, Wong and Zheng, 2004, Wang, 2004, Liu, 2004, Cao, 2004a, Kaufman, 2005, Abraham, 2005, Meng et al., 2004), few researchers focused on the consistent health policy change since the SARS outbreak. Instead, the existing research examined the health policy change as a one-off case during the 2003 SARS outbreak (Ahmad et al., 2009, Davis and Siu, 2007) and single cases that occurred during the healthcare reform between 2005 and 2009 (e.g. Kornreich et al., 2012, Thompson, 2009, Balla, 2014). Therefore, the research overlooked the consistency of the policy change that occurred after the SARS outbreak, when the Chinese government started to provide some health services for free as public goods,<sup>4</sup> which was conducive for the government to consider bringing back the government's role of promoting public welfare. Third, the research did not explain how exactly the policy changed and why it changed in the way it did rather than in other ways.

Based on these limitations, before going further to discuss my research questions and arguments, I need to clarify some concepts. First, the difference between decision-making and policymaking in China is that the decision-making lies with the CCP, while policymaking is left to the government. The top CCP leaders make decisions – for example, Political Bureau members decide on a broad development principle for the CCP and state – while the government make policies; ministries and divisions within the ministries formulate specific policies based on the decisions made by the CCP.<sup>5</sup> Second, within the policymaking area, there are two different types of actors, policy insiders and policy outsiders. The insiders are those within the government, and they can make or formulate policies, so they can incorporate their opinions into the policies directly. Therefore, the policy insiders have decisive roles in setting policy. The outsiders are those who do not make or formulate policies and thus lack direct access to convey their opinions. The policy outsiders can merely influence the policies.

Drawing upon theories of policy change, policy entrepreneurship, and fragmented authoritarianism, in this thesis, I explain how and why health policy changed after the SARS outbreak between 2003 and 2009 and the extent to which policy outsiders influenced the change. I argue that, after the SARS outbreak, experts, the media, and

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<sup>3</sup> The State Council is like a cabinet.

<sup>4</sup> For instance, the SARS patients did not pay the fees for treatment and drugs.

<sup>5</sup> I will further discuss the difference in Chapter 2.

international organisations influenced the health policies as a ‘Policy Entrepreneurial Coalition’ (PEC), the result of which was a combination of normal and paradigmatic policy changes between 2003 and 2009. The PEC is an informal and loose collective of actors, via which policy outsiders exert an influence on policy. The PEC does not have a fixed membership, and it has used various methods and strategies to influence policy change.

This thesis makes four major contributions. First, it documents the health policy change between 2003 and 2009, on which little research has been done. Following Lampton (1977), who studied health policy between 1949 and 1977 and Duckett (2010a) studied health policy between 1978 and 2003, I address health policy between 2003 and 2009. Second, previous studies focused on bureaucratic bargaining during policymaking in China (Aitchison, 1997, Lieberthal and Lampton, 1992), but I examine roles of policy outsiders, who have conventionally been neglected in China’s policy process. Third, to explain the influence of the outsiders, I examine the policymaking process within the central government and how the policy outsiders interacted with the policy insiders. In doing so, this thesis contributes to the understanding of China’s politics and policy process.

This chapter first reviews in detail the current approaches – the process approach and the actors approach – to the explanations of policy change. The second section discusses China’s authoritarian political system, specifically its fragmented authoritarianism and the outsider’s influence in China. The third section explains my argument: what I mean by ‘outsiders,’ ‘coalition’, and influence. The fourth section draws a four-layer analytical framework of the thesis: contexts, outsiders’ influence, multiple streams framework, and institutionalisation. The fifth section explains the methodology of this research. The last section offers an overview of the thesis.

## **1.1 Approaches to the explanation of policy change**

Scholars explain the reasons for policy change differently. Some study policy change by analysing policy processes, while others focus on various actors in policy change. This section reviews those approaches – the process approach and the actors approach.

### **1.1.1 Process approach to policy change**

Kingdon (1995) made his primary contribution by introducing the multiple streams framework (MSF) to explain policy change. In the framework, the policy process is



composed of three streams: the problem stream, the policy stream, and the political stream. The problem stream is associated with issues that may require governmental action. The policy stream represents the policy alternatives, possible solutions to a problem, and their proponents. The political stream consists of public officials and elections and concerns the 'national mood', ideology, or attitudes of policymakers and the public. These streams flow independently, but when they converge, a window of opportunity opens to start making policy changes. The framework explains how policies are made by governments under conditions of ambiguity (Zachariadis, 2007). However, policy windows close in a flash and are not easy to predict. Thus, it is difficult for actors to recognise the appropriate moments when windows of opportunity open and then act swiftly to promote policy change (Zachariadis, 2007).

However, a single issue can often be identified as different problems from various angles, which in turn influences the policy chosen. For instance, SARS could have been identified as a public health emergency requiring crisis management to deal with, so the policy change might have stopped when the emergency ended; it could also have been identified as a health system problem that needed fundamental policy change to handle, in which case the policy change could persist even after the crisis ended. Different problem identifications necessitate different policy solutions and thus exclude policies that do not fit into the problem stream. When an issue arises, various policy alternatives and possible solutions crowd the 'policy pool', but which policy will be chosen by the government largely depends on who is able to influence the problem identification of the decision-makers. In other words, only when the problem is identified in a way that matches the policy alternatives and possible solutions can the problem stream and policy stream converge. In this circumstance, the policy that fits the problem identification can be set on the agenda. Therefore, when policy outsiders propose ideas and try to influence policy change, they must offer a set of problem identification and policy solutions that are compatible.

Kingdon adapted the MSF into the policy cycle model. Kingdon (1995b) divided the policy process into three key stages before implementation: agenda-setting, considering alternatives and specifications, and decision-making. The process of agenda-setting indicates the movement of an issue from its recognition as a problem to being seriously considered by the government on its political agenda. The key question to address in this stage is why, among many issues, some are moved to the political agenda while others are not. After an issue is put on the government agenda, the next step is policy formulation. At

this stage, the key question is why some policy proposals are adopted as viable solutions to the issues while others are discarded. When it comes to the stage of making decisions on policy proposals, government sectors retain the decisive role, though various actors through their own networks can have some input in the decision-making stage. Feedback on the policy implementation will be taken to the next policy cycle and trigger policy change.

The policy cycle theory is widely applied to explain the policy process because it divides a complicated process into stages and explains what happens during those stages, which makes it easy to understand the policy change throughout the process. However, the policy process cannot be always clearly separated into different stages. Some policymaking involves pilot projects before the final decisions are made (Heilmann, 2008). The government conducts pilots in some areas first and then evaluates and scales up the pilots with the necessary changes following an evaluation. For example, public hospital reform in China was initially piloted in 16 cities to determine the effectiveness of the reform, and then it was eventually rolled out elsewhere based on the summaries of evidence from the evaluation of the results in the pilot cities (WHO, 2012). Therefore, unlike Kingdon's policy cycle, which sees policy change as a result of going through the four stages, policy change could happen between stages within one cycle, before the final decision is made. This thesis focuses on policy change during the policymaking process before the final policy is set and implemented and explains how and why policies change within one policy cycle.

The advocacy coalition framework (ACF) is useful in understanding the role that technical information plays in the policy process (Sabatier, 1988). The ACF explained how policy formation and change happened through the function of competing advocacy coalitions within a policy subsystem. A policy subsystem consists of 'actors from public and private organisations who are actively concerned with a policy problem' (Sabatier, 1988 p.131). The actors within a policy subsystem form a number of advocacy coalitions based on sharing a particular belief system, such as a set of basic values, causal assumptions, and problem perceptions (Sabatier, 1988). Advocacy coalitions attempt to realise a set of shared policy beliefs 'by influencing the behaviour of multiple government situations over time' (Sabatier and Jenkins-Smith, 1993 p.212). The ACF is a system-based model that 'operates in complex, interdependent political environments where hundreds of participants interact in the context of nested institutional arrangements, uneven power

relations, and uncertain scientific and technical information about problems and alternatives' (Weible et al., 2009 p.121).

Although both the ACF and the PEC concern problems and try to influence policy change with technical information, they are different. The ACF mainly focuses on technical information; while the PEC focuses on policies in general, including policies relating to techniques and policies of social and state development. The ACF values advocacy of the policy outsiders, while the PEC values not only advocacy but also how those policy outsiders getting through institutional barriers and allying with the stakeholders. Even the policy outsiders that the ACF and the PEC look at are different. Media are not studied as part of the ACF. While the ACF describes policy change as a result of the learning process among and across coalitions, it focuses mainly on the structure of advocacy coalitions without considering how actors with similar policy beliefs coordinate their behaviours into coalitions or how to develop, maintain, or make lasting actions within the coalitions. However, in this thesis, I will explain how policy outsiders coalesce their action via the PEC regardless of whether they share similar beliefs or not. Moreover, compared to the ACF, the PEC is a loose collective action rather than a patterned framework. The PEC members do not necessarily compete with each other or behave in a firm, advocating way, as the ACF does.

The aforementioned theories study policy change through a dynamic process. However, there is one missing key factor in this process, which has been addressed only in the ACF – the role of actors in the process. More specifically, we cannot neglect the role and importance of policy entrepreneurs, which we now turn to.

### **1.1.2 Actors approach to policy entrepreneurship**

When scholars have studied different stages of the policy process, they have identified some actors who were essential and contributed to the process of policymaking (e.g. Polsby, 1985, Eyestone, 1978, Kingdon, 2003). These actors have been referred to as 'public entrepreneurs', 'political entrepreneurs', and 'policy entrepreneurs' (Kingdon, 2003, Cobb, 1983). Roberts and King (1991) described policy entrepreneurs as people from outside formal government positions who introduce, translate, and help implement innovative ideas into public practice or a formal explicit statement. Those innovative ideas could be technological ideas (e.g., new technologies and products) or administrative ideas (new policies and procedures) (Daft and Becker, 1978). Policy entrepreneurship is, then, a

process of introducing those innovative ideas into the public sector or into policies. The concept of policy entrepreneurs has been widely used and tested in several policy areas, such as education, environment, foreign affairs, and health care (e.g. Crow, 2010, Mintrom, 2000, Carter and Scott, 2004, Oliver and Paul-Shaheen, 1997) in many countries (e.g. Howard, 2001, Bundgaard and Vrangbaek, 2004, Zhu, 2008).

Policy entrepreneurs are able to influence policy change for several reasons. First, taking advantage of windows of opportunity, policy entrepreneurs link problems, policy ideas, and politics to draw attention to issues and put ideas on the agenda (Mintrom and Norman, 2009, Kingdon, 1995b). Second, both institutionalism and new institutionalism leave space for policy entrepreneurs to instigate change (Mintrom and Norman, 2009). Because major change happens often as a result of the insiders' sensibilities, policy entrepreneurs can promote policy change easily when they make good use of networks that include both 'insiders' and 'outsiders' (e.g. Brandl, 1998, Roberts and King, 1996, Mintrom and Vergari, 1998). Third, policy entrepreneurs can destabilise policy with their expertise and influence policy discourse by bringing policy issues into the public arena and trying to raise public interest and attention to change policy (Baumgartner and Jones, 1991).

Policy entrepreneurs are widely used in Western democratic countries to explain policy change. Rabe (2004) highlighted how policy entrepreneurs have framed the issue of climate change and supported certain approaches to environmental policy at the state level in the United States. To set the issues on state legislative agendas, environmental policy entrepreneurs made full use of expertise in the energy or environmental sector to place themselves in the relevant policy venues. During periods of stability, environmental policy entrepreneurs established a strong network with elected officials, industry, and interest groups, through which they were able to recognise windows of opportunity when they opened and act rapidly to promote the agenda-setting. Oborn and his colleagues (2011) analysed the role of policy entrepreneurs in the health policy process in London by studying a particular entrepreneur who works as a clinical leader. This study went beyond the general model, which considered policy entrepreneurs to have a single role at each stage. In the research, the policy entrepreneur set up institutional networks and linked them with health problems by 're-defining problems, forging alliances across interest groups (and mediating between them), and developing (or refining) policy proposals' (Oborn et al., 2011 p.342). Crow (2010) pointed out that policy entrepreneurs and media worked together to initiate change in the environmental policy process in a US state. The policy entrepreneurs did not work alone but were good at making an alliance with people, groups,

or media sharing the same aims and interests. They worked together as ‘comrades-in-arms’. The alliance members took advantage of each other’s specialties to influence policy.

Some scholars have adapted policy entrepreneurship in studying China, an authoritarian country. In a new trend in the policy process, elites and people with professional knowledge and expertise are increasingly becoming involved in the policy process with policy entrepreneurship skills and experience. Tanner (1995) identified the role played by an policy entrepreneur in developing Chinese bankruptcy law. This policy entrepreneur seized an opportunity when the Chinese government were finding ways to reform state-owned enterprises, which led to lots of bankruptcies. He ‘married’ his legislative proposals regarding bankruptcy law to a think-tank’s research report on methods for promoting state-owned enterprises using his idea to conduct bankruptcy procedures. As a result, the government accepted his legislative proposals for bankruptcy law and changed the old law accordingly. In this process, he ‘carefully packaged policy proposals, promoted and lobbied, used publications and mass media, and aggressively built support coalitions from both inside and outside the Beijing bureaucracy’ (Tanner, 1995 p.50). Zhu (2008) discussed a case study on how Chinese legal scholars, as policy entrepreneurs, used a ‘technically infeasible’ strategy to influence policy change involving Chinese urban vagrants. The scholars not only used mass media to spread propaganda and publicise their policy proposal but also wrote public letters directly to the National People’s Congress so that the issue could not be ignored. To put the issue on the agenda and influence the government to change the policy as they suggested, as a comparison, the scholars also suggested another direction in which the policy change could go, which was, however, technically impossible to implement for policymakers at the time. As a result, the policymakers chose the feasible suggestion to change the policy in the exact way that the scholars desired.

Based on the definition of policy entrepreneurship, Hammond (2009) further developed a new concept in the context of China, ‘policy sponsors’, who not only set the agenda, sponsor, and develop ideas as policy entrepreneurs but also ‘sustain active interest in a policy into the decision making and implementation stages of a policy and beyond’ (Hammond, 2009 p.36). Other scholars have focused on the role of policy entrepreneurs in creating space for policy ‘outsiders’, making policy proposals, agenda-setting, and introducing policy innovation (e.g. Ding, 2003, Zhang, 2005, Liu, 2010, Han, 2008, Li and Zhang, 2008).

In this thesis, I use policy entrepreneurship to describe activities that are comprehensive and collective and taken by actors or organisations to transform their innovative ideas into policies, such as defining problems and generating solutions, disseminating ideas, formulating strategies, and collaborating with bureaucratic insiders (Roberts and King, 1991). The PEC is, then, a loose collective action of individuals and groups that take entrepreneurial policy actions. The PEC consists of a ‘joint-work’ of the experts, media, and international organisations. The experts and professionals in interest groups or research institutions can influence policies as policy entrepreneurs (William, 1986, Spill et al., 2001). The media can facilitate the entrepreneurial policy functions of other actors (Zhu, 2013, Zhu, 2012c, Mertha, 2009a). International organisations can shape domestic policy preferences by developing the expertise of researchers from scientific and epistemic communities (Economy, 2001).

## **1.2 Understanding China’s political system: an authoritarian state**

Theories of policy change cannot be considered independently of the political system. To better adapt the theory of policy change and policy entrepreneurship established in Western democratic countries to the Chinese context, I use the theories of fragmented authoritarianism to explain China’s political system. I then review literature of outsiders’ influence in China.

### **1.2.1 Fragmented authoritarianism**

Since the 1980s, scholars (e.g. Lampton, 1987, Lieberthal and Oksenberg, 1988) have used fragmented authoritarianism to describe the policy process in China. First, China is an authoritarian state. Although other democratic parties are participatory parties that are consulted in the policymaking process, only the CCP holds the ruling power. The political system and administrative hierarchy has a pyramidal structure within which the power of policymaking is monopolised by the limited number of top officials and party leaders. Therefore, power and authority are centralised by a small group of elites, and the policy process is more or less within a closed ‘black box’ that is technically cut off from actors outside the political system. Second, the authoritarian state is fragmented and disjointed in that, although the political structure is driven from the top down, it is also partitioned into vertical and horizontal governments and institutions. The horizontal partition in different regions and the vertical partition in the functional division of various bureaucracies create

spaces in the closed political structures. As a result, ‘although the central government remains at the peak of the power hierarchy, opportunities for competition and bargaining between governments and institutions became possible’ (Zhang et al., 2012 p.166).

The concept of fragmented authoritarianism is useful in understanding fissures within vertical and horizontal political systems, which leave spaces for policy outsiders to enter the policy process. However, it is an institutional model that mainly involves ‘insiders’ and is often used to explain the relationship between the governments within a pyramidal structure. Therefore, it easily overlooks actors that are outside the political system. However, China has undergone major governmental changes since the 1990s; for instance ‘(there is) an altered policy process that involves more consultation with the affected agencies and some solicitation of expert advice’ (Oksenberg, 2001 p.25). Thus, as a ‘static description of core state apparatus’, the original fragmented authoritarianism model cannot capture the essence of the system. The ongoing changes of the state and society need ‘an intellectually satisfying depiction to capture the forces producing change in the system... which requires us to include state-society interactions in any comprehensive model of the Chinese system’ (Oksenberg, 2001 p.28).

Mertha (2009c) further developed the concept of fragmented authoritarianism by demonstrating a more complex policy process involving ‘outsiders’. He found that in the environmental policy arena, officials, media, and NGOs that shared similar interests acted as policy entrepreneurs and ‘successfully entered the political process’ (Mertha, 2009c p.996), which created a new, pluralised political phenomenon. Although the government officials and party leaders still hold the power of policymaking within the spaces created ‘between equal level governments or governmental institutions, and even between local and central governments’ (Zhang et al., 2012), the previously excluded outsiders are able to influence policymaking and change in various ways. For instance, they ally with each other to frame issues and mobilise the public to get attention from the government and society and then affect policy change in favour of their preferences.

### **1.2.2 Outsiders’ influence on the policy process in China**

Previous studies have found that before ‘Reform and Opening-up’, policy in China was made exclusively by leaders within the political system. Chang (1978) argued that policy making in China was a complicated, sometime conflictual, consensus-building process involving many CCP leaders. In this process, the conservative or radical orientations of

CCP's leaders, as well as central and local leaders' different understanding of policies, shaped the policies. Lampton (1977) examined and explained the evolution of specifically health policy processes between 1949 and 1977. In the 1950s, there was a short period when the MOH was relatively independent from the CCP and health policy was 'pre-liberal' because health expertise and the military context of China at that time gave the MOH power to resist the CCP's orders. However, from the late 1950s, in order to centralize the policy making power of the CCP, the MOH experienced bureaucratic de-professionalization, in which the responsibilities of elite health professionals were removed from the MOH (Lampton, 1977). The subsequent Cultural Revolution then almost destroyed the health system. The media were entirely controlled by the government, whose function was propaganda rather than news reporting. As a result, between the late 1950s and the late 1970s, health policy relied significantly on the centralised political system and the influence of the outsiders was very limited.

Since 'Reform and Opening-up' began in 1979, the Chinese social and political structure has become more 'rational, systematic and pragmatic' (Harding, 1987 p. 213), and some societal actors with common interests and political appeals have become active. Since the 1990s, the Chinese government has not only expanded the space for consultation and participation by internal bureaucrats and think tanks within the political system, but it has also gradually opened to people and institutions outside the political system, such as non-party members, academia and business elites, stakeholders and NGOs (He, 1997; He & Warren, 2005).

Scholars have previously discussed the opening up of policy space for outsiders in different policy areas, particular in research on environmental policy. For instance, Zheng and his colleagues (2014) found that the public used the media to push urban mayors to protect the environment and deal with pollution – something that could be effective because bad news about failed environment protection could hinder mayors' promotion chances. Also, Xie (2011) argued that Chinese local environmental NGOs interacted with international NGOs and pushed the Chinese government to adhere to international environmental regulations, which improved China's environmental policies. Han and his colleagues (2014) found that governmental departments (both central and local), experts, the media and business companies with similar ideas and interests allied with each other to influence environmental policies regarding dam-building on the Nu River.



Scholars also discussed outsiders' influence on China's foreign policies. Wang and his colleague (2014) found that public opinion on the Internet could influence China's foreign policy towards Japan. Jakobson and Knox (2010) found that there were different actors both inside and outside the government influencing China's foreign policies, including the CCP, governmental departments, the army, energy enterprises, financial sectors, local governments, research institutions, the media and the netizens.

There was also limited research on the outsider's influence on health policies. For instance, Duckett (2010) found that the World Bank influenced the Chinese government's retreat from health by suggesting to the government ways of dampening demand without adopting pro-private policies. Similarly, Szlezak found that the Global Fund played a significant role in changing China's HIV policy from passivity to active control and treatment, which in turn led China to accept the global HIV policy paradigm (Szlezák, 2012).

Thus previous research has indicated that since Reform and Opening-up, outsiders' influence in China has existed in various policy areas. Including outsiders in the policy process was one way that China's authoritarian regime, responded to domestic interests and international norms (Nathan, 2015). As Boix and Svolik (2013) have argued, some authoritarian states agree to share some power with others, in order to stabilise authoritarian control and reduce conflict. In line with this, Yan (2011) has suggested that China's authoritarian resilience has benefitted from the inclusion of some outsiders, such as non-CCP elites, in politics.

To date, however, there has been little research on how exactly outsiders exert their influence. My argument focus on outsiders' influence on health policy change helps to fill this gap. Within the fragmented authoritarian state, where there are cracks between bureaucrats, there is space for experts, media, and international organisations to seize opportunities to influence policy change in an informal PEC via interactions with each other as well as with government officials. The institutionalisation of the PEC's influence has helped the government to absorb pressures and adapt to changing situations.

### **1.3 Explaining the argument**

Although I look at policy outsiders' influence, there are two kinds of policy outsiders: those who are inside public institutions (*shiye danwei*) and those who are outside public institutions. Neither can directly make policy decisions. The difference between the two is

in their relation to the political system. The first type of outsiders is ‘established outsiders’ who are partly within the political system, as those public institutions are branches of the governments and even belong to the political hierarchy. Examples of this type include established experts within governmental research institutions and official newspapers. These established outsiders can deliver their opinions within the political system. The second type of outsiders is ‘non-established outsiders’, who are completely outside public institutions and the political system, such as non-established experts within non-governmental research institutions and commercialised newspapers. They do not belong to any political hierarchy and have limited roles in the policymaking process.<sup>6</sup>

I chose to focus on experts, the media, and international organisations inductively for the following reasons. First, the Chinese government uses experts to enhance authoritarian control (Nathan, 2015). Experts are ‘given enough freedom to work productively in their areas of specialisation without violating the ban on criticizing the regime.... the governments have learned to listen respectfully to the experts and to take their advice on technical subjects’ (Nathan, 2015 p.159). Second, the Chinese government has continued to engage in censorship, but it has permitted the development of diverse media outlets, allowed some criticism, and even used information in the media to rein in local governments, for example in its anti-corruption efforts, so long as it did not generate public collective expression or ‘mass incidents’ (King et al., 2013). Woodman (2014) also suggested that there were spaces for public speech in authoritarian states depending on the institutional location of the utterance, the identity of the speaker, and the time of the event. Third, the Chinese government tried to shape international organisations to make them ‘regime type-neutral’ while cooperating with the various international organisations broadly to tackle domestic social issues, such as inequality (Nathan, 2015).

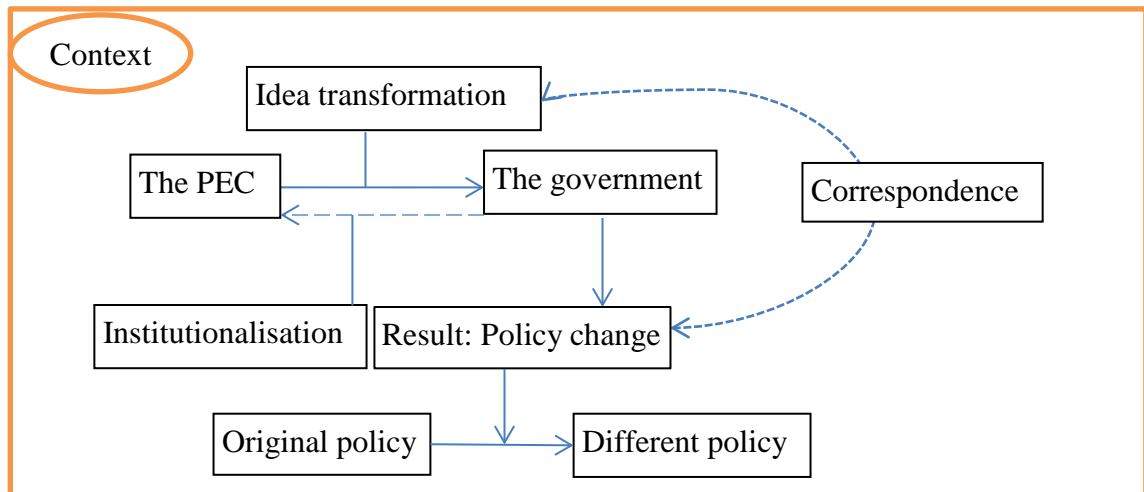
The three types of actors are able to coalesce because they make good use of each other’s strengths. The experts use the media to disseminate their ideas and draw the attention of the government and the public. The experts use international organisations for funding and obtaining advanced technologies. The media use technology and the expertise of the experts and the international organisations to back up their reports’ credibility and draw attention. However, forming a coalition does not necessarily mean that the three actors cooperate or collaborate deliberately. It only means that they promote policy change in the same direction regardless of whether they deliberately coordinate collective work among

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<sup>6</sup> I consider employees in China offices of the international offices as part of international organisations, even though some of them are Chinese.

them or not. Moreover, the actual experts, media, and international organisations involved in shaping policy can change, depending on the precise policy. This enables me in the analysis below to compare the differences and similarities of different actors' influence in three separate cases.

To identify influence, I look at two main indicators: the transformation of ideas as a result of the PEC's interaction with the government, and then the change in policy in accordance with the transformation of ideas. If the policy changes in a way similar to the outsiders' ideas, I argue that the outsiders have influenced the policy change. Figure 1-1 shows how I identify influence. Policy outsiders engage or interact with the government to deliver their ideas; the result is that the policies differ in a similar direction as the outsiders' ideas. I cannot prove the causality in the policy change but I show a strong correlation and argue that causal influence is plausible. I do not reject the influence of other possible actors in this process, as the precise communication and negotiation between the PEC and the decision-makers within decision-making circles in China's authoritarian political system is not completely clear.



**Figure 1-1 Identifying influence**

## 1.4 Analytical Framework

Based on the theories of policy change, policy entrepreneurship, and fragmented authoritarianism, I will analyse outsiders' influence in four layers. First, the foundation of the analysis is the context, which is significant in shaping the prospects of success for

advocates of policy change. Kingdon (1995b) argued that only within certain policymaking contexts can policy entrepreneurs take advantage of windows of opportunity to promote policy change. Subsequent studies have demonstrated that key contextual variables influence the possibility of policy change and the outcome of policy entrepreneurs' actions within those contexts (Mintrom, 2000, Mintrom and Vergari, 1998). I will use fragmented authoritarianism to analyse why there are spaces within the authoritarian political system for outsiders.

Second, above the context layer, I will use policy entrepreneurship theories to analyse how the outsiders deliver their ideas. I will trace when and what they did, whom they contacted, how they delivered their ideas, any strategies they used, what happened next, and in what way the types of three outsiders coalesced. In addition, I will analyse differences and similarities in the outsiders' influence and whether the policy changed in the way they desired. Given the government's decisive role in the policy process, I will include information on the governmental departments that the outsiders tried to influence directly and indirectly with their ideas.

Third, above the layer of the outsiders' influence, I will use the MSF to analyse how the policy changed after the outsiders' influence. According to the MSF, when the problem stream, policy stream, and political stream converge, windows of opportunity open for policy change. I will then examine how the three types of outsiders converged the three streams and influenced the policy change.

Fourth, regarding the last layer, I will discuss the aftermath of the outsiders' influence and focus on how the government institutionalised the influence. I use institutionalisation to explain how authoritarian states adapt to social and political change and respond to pressures. Therefore, after the policy change, I expect that the government would institutionalise the outsiders or their influence to sustain authoritarian control.

I use these four layers to analyse three cases of policy change in a chronology, namely, policy change during the SARS outbreak, initiation of the healthcare reforms, and the policy change during the healthcare reform policymaking process. I will show how different PEC members influenced policy change in each case. However, I do not intend to suggest that the health policy only started to change after the SARS outbreak began. In contrast, I mentioned research explaining previous health policy change that occurred between 1949 and 2003. This thesis offers one explanation of the health policy change that

occurred between 2003 and 2009 by examining the roles of the outsiders. Neither do I suggest that outsiders began to influence the policy only since the SARS outbreak began. Between 2003 and 2009, I observed that policy outsiders crowded into the health sector on two prominent occasions, the SARS outbreak and healthcare reform, and their influence seemed to change from being ad hoc toward becoming the norm. This phenomenon was addressed in only a limited way in the research on previous health policy change, although some scholars discussed the roles of outsiders in health policy (e.g. Oksenberg, 1975, Lampton, 1981, Lee and Mills, 1982).

## 1.5 Methodology

The purpose of this research is to understand how the PEC influenced China's health policy change by investigating the interaction between the PEC and the government in the policy process. Interviews with the PEC and stakeholders as well as content analysis of both policy documents and media reports serve this end. Thus, this study adopts a qualitative research approach.

Qualitative research is useful in explaining correlation (or causation) of a contemporary phenomenon that has yet been identified (Strauss 1990). Using qualitative research methods, I trace back the actors and their actions that were involved in the policy process. Therefore I am able to answer how they influenced the policy change. Moreover, the actors' influence could only work under certain political and historical contexts (Kingdon, 1995), which I also analyse in this thesis. Therefore, I use case studies, which facilitate the exploration of complex situations better than other methods, such as surveys that are limited in investigating relations between the phenomenon and the context (Yin, 2010).

I used semi-structured interview to conduct my empirical work. On the one hand, I had key questions related to my research questions. For instance, I asked both outsiders and insiders whether there was any difference in health policies before and after SARS, who were involved in a particular health policy process and how, what the policy process was, who played what role in the process, and what the government's reaction was. By using semi-structured interviews, I left space for my interviewees to come up with new ideas and reflections upon their own experiences. This information could fill in gaps in the existing literature and help me to draw a detailed picture. The semi-structured interviews not only enabled me to ask key questions, but also left space for new information that I might have overlooked or been unaware of (King, Keohane et al. 1994).

To obtain first-hand data, I travelled to Beijing twice for fieldwork purposes from September to October in 2011 and 2013. I used snowball sampling to identify and approach my interviewees. I started with a few scholars in social policy and journalists of health and social policy. At the end of each interview, I asked the interviewees politely and honestly to recommend to me any other people that they think might be relevant to my research. As a result, in total, I conducted 29 interviews with 26 interviewees.<sup>7</sup>

The interviewees are classified into two main categories, policy insiders and policy outsiders. The policy insiders are government officials in the MOH. The policy outsiders are: domestic Chinese experts in social science, health economics, and health; external (foreign) experts who were involved in China's health policymaking; journalists in national media and other commercialised traditional media; and representatives of international organisations in China.<sup>8</sup>

To maintain the validity and reliability of the information, I used triangular verification (King, Keohane et al. 1994), i.e., asking different interviewees the same questions; thus, I could draw a complete picture using evidence from different sources. By doing so, I was able to narrow down the cases of policy change since SARS and draw a complete picture of the policy change process and the interaction between the media, experts, international organisations, and the government.

The fieldwork strictly followed ethical regulations of the University of Glasgow. I applied for ethical approval to the relevant university ethics committee before conducting fieldwork. According to the ethical regulations, I explained my research and aims of the fieldwork to the interviewees orally and asked for their permission to take notes during the interview.<sup>9</sup>

I took notes during the interviews and kept a research diary during the fieldwork period. According to ethical regulations, I transcribed the interview notes and kept a research diary in which the interviewees were anonymised. The transcripts were the raw materials for analysis and coding after the fieldwork.

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<sup>7</sup> I did follow-up interviews with three interviewees. All the interviewees are strictly confidential.

<sup>8</sup> Some of the interviewees have more than one identification because of job shifts. Please see the appendix for a full list of the interviewees.

<sup>9</sup> Ideally, the University of Glasgow Ethic Committee asked for a signed consent form by the interviewees before the interview. However, based on Chinese culture, tradition and reality, it is very difficult to ask the interviewees to sign on the paper. Therefore, the Ethic Committee agreed me to do it orally.

I also paid attention to the self-reflection during the fieldwork. I mainly identified myself as a former student of Nankai University (my home university), one of the best universities in China. This identification had two privileges: first, the reputation of Nankai University made me a credible researcher in China, even though I have abroad education background. Second, it helped me to have a fair conversation with the senior interviewees. While approaching the interviewees, even though they were older or more senior than me, this identification helped me to stand with them at the same level and talk with them intellectually.<sup>10</sup>

Moreover, I used various techniques to encourage interviewees to talk. I usually opened the conversation with well-prepared information. I told the interviewee that he/she was significant to my research because he/she was part of and witnessed the history. If they were reluctant to talk, I also said that they were not the only ones there and I already interviewed some (not mentioning names), and I just wanted to verify the accounts offered by other interviewees. Usually after all these background information has been conveyed, they would start talking. After they started talking, I could then ask follow-up questions.

I also performed a content analysis of policy documents and media publications (King, Keohane et al. 1994). The period of my research is from 2003 to 2009, which is too long for the interviewees to remember details such as exact timing, names, and numbers. Therefore, I delved into governmental websites and written documents and found those missing details to evidence and remedy the limitations of human memory. I also conducted a content analysis of a large number of policy documents, including health policies, national development plans and blueprints, governmental reports and archives, and leaders' speech and actions. In doing so, I examined the original health policies and the subsequent different ones to show the trend of the policy change.

I analysed materials in traditional media (e.g., newspaper reports) and new media (e.g., the Internet). I compared national and local newspapers and state and commercial newspapers. In doing so, I examined the rules and leverage of media reports in China. I also analysed posts on one of the largest online forums, *Tianya*, to learn about public opinion and the role of the media in facilitating public opinion to influence the policies.

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<sup>10</sup> Under the Chinese culture, to initiate a conversation or arrange an interview, females are sometimes seen as more innocent and less intimidating than males. As a result, female researchers might be easy to accept for the interviews (but not always). However, during the interviews, the interviewees might respond simply with little useful information, especially when the female researchers are young and junior. Therefore, the female researchers need another professional identification to put themselves at the same with the interviewees in order to have a relative fair conversation.

After the fieldwork, I identified inductively three cases where experts, the media, and international organisations were involved in the policy change process during the period between 2003 and 2009. From 2003 to 2009, the PEC played an important role in the SARS policy change, the initiation of major healthcare reform, and policy change during the healthcare reform. First, the cases were selected across time and among different types of policies. Scholars of policy have mainly focused on a single health policy in China during this period (e.g. Huang, 2013, Zheng et al., 2010, Zhu, 2012a, Zhu and Liu, 2009), overlooking the continuation of the policy over time. According to path dependency theory, previous policy change will shape the trajectory of later policy change. Moreover, a new policy can also be formed by previous several policies. For example, in the current research, the setting and changing of SARS policies contributed to the making of disease prevention and control policy, which in turn affected the later health care reform. Thus, tracing a series of policies across time could identify the policy change trajectory and place the actors involved in a broader picture.

Second, policy change happens under different circumstances, such as in times of emergency and in normal times. According to the concept of punctuated equilibrium (Howlett, 2009, True et al., 2007), policy change is more likely to happen during times of emergency than in normal times. In this study, the first case was policy change that occurred during the SARS crisis. The other two cases were policy changes made during normal times. Applying Evera's (1997) argument, if the PEC influences health policy change in both crisis times and normal times, then we can claim that the PEC has influenced policy change and not simply crisis management.

## **1.6 Structure of the thesis**

Chapter two covers the context of the health policy change and addresses the extent to which the outsiders can influence health policy in China. I first analyse the historical, ideological, political, and institutional contexts. This chapter shows that the Chinese government has opened the policy process to outsiders. I then explain the rationale for choosing to focus on the three types of outsiders.

Chapter three explains the health policy change that occurred between 2003 and 2009. Applying Hall's policy change theory (1993), I argue that the health policy change in China that has been undertaken since the SARS outbreak began has involved both normal and paradigmatic changes. Not only did SARS treatment policies, control policies, and



media reporting policies change but the health policy direction also changed during the healthcare reforms. By analysing the CCP's communiqués and government working reports, I find that the overarching policy goals changed, which indicates a paradigmatic change in the health policies.

Chapter four discusses the first case: the PEC's influence on the SARS policy change in terms of SARS treatment policies, control policies, and media reporting policies. I separate the SARS period into three stages in a chronology and explain how the PEC influenced the policies in each stage. This chapter shows that, during the SARS outbreak, the PEC influenced the policy change by converging the problem, policy, and political streams. Moreover, the influence continued in two ways: disease prevention and control policies changed fundamentally after SARS, and the government institutionalised the outsiders' influence.

Chapter five addresses the second case: the PEC's influence on the initiation of the healthcare reforms. Existing studies suggest that it was the report of the Development Research Center of the State Council (DRC) regarding 'the failure of the previous health reform' that started the recent health reform. However, the report was delivered to the decision-makers before it was released by *China Youth News*, but there was no response from the decision-makers. However, since it was released by *China Youth Daily*, the government set the healthcare reform on the agenda. In this chapter, I look at how the PEC interacted with the governments and how the health report initiated the health reform. I find that direct contact with decision-makers does not necessarily lead to an impact on policy, but attracting the attention of the public might do so.

Chapter six concerns the third case: the PEC's influence on the health policy direction during the healthcare reform policymaking process. In this case, I discuss the healthcare reform policymaking by distinguishing two opposite leading factions, the pro-government and pro-market factions. I analyse how the PEC members of the two factions allied with governmental departments with similar interests and ideas. Unlike the previous cases, the PEC influenced the policy change directly by competing for their own reform proposals. I draw a clear frame of the policy flow between the different ideas of the factions. From this dynamic, procedure I show that the PEC influenced the change in the health policy direction.

Chapter seven is the conclusion. I first review the three cases and distinguish among the different actors of the PEC. I indicate my theoretical contribution to the theories of policy process. Empirical implications and future research directions are given at the end.

## **2 The context of the PEC's influence and the health policy change**

In this chapter, I will analyse the context in which China's health policy changes and look at why and to what extent outsiders can exert an influence on the change. I will discuss the context of historical, ideological, political, and institutional factors. Health policy change is not done from scratch but results from the history of health policy development. This historical background shapes the direction of current health policy. History also leaves marks on ideology. Ideology plays a crucial role in influencing China's social policies (Duckett, 2010a). The dominant ideology and ideological transitions shape perceptions of social policy. However, the ideology cannot function without a specific political system. China's political system is fragmented and highly influenced by its top leaders (Lieberthal and Oksenberg, 1988). The political system shapes bureaucratic politics and the flow of information and thus influences the policies developed within the system and the opportunities for outsiders to enter the system. Within this political system, the institutional design of the policymaking structure constrains the opportunity to exert an influence by determining bureaucratic interactions and how policy outsiders can influence policy. After analysing the four factors that give outsiders opportunities to influence policy change, I will explain the rationale for choosing the three actors within the Policy Entrepreneurial Coalition (PEC): experts, the media, and international organisations.

This chapter is organised as follows. In the first section, I use path dependency theory to explain historical factors that influence health policy and shape the positions of the bureaucracy, which in turn affects health policy change and the impact of policy outsiders. In the second section, I look at the influence of ideology in shaping health policy change and how ideological transformation could change the ability of policy outsiders to influence policy change successfully. The third section introduces China's political system, and I examine the role of leadership transition and the fragmented authoritarian system in opening the political environment to policy outsiders. The fourth section addresses institutional design; I discuss departments within the central government that are involved in health policy research, formulation, and development. After explaining the influence of the contextual factors, in the fifth section, I discuss the reason that I specifically chose the three types of outsiders for consideration: experts, the media, and international organisations.

## 2.1 Historical background

The history of China's health policy development has shaped the direction of current health policy and possibilities for outsiders to influence health policy change. During the planned economy period in Mao's era, health policy provided equal and basic medical care to citizens (especially people in rural areas); after the socialist market economy was implemented after the opening-up reform in the post-Mao era, the health policy changed to 'modernisation', focusing on high technology and efficiency in urban areas (Huang, 2013). The reason for this policy shift was the combined influence of economic policy, political institutions, ideology, and stakeholders (Duckett, 2010a).

According to path dependency theory, historical events can influence future policy in two ways. First, the inheritance of a previous policy will shape the current policy direction even if external environmental conditions change (Kay, 2005). Previous health policies result in different problems for future health policies to solve and thus shape the current health policy direction to address these problems. China's urban based health policy in the 1980s and 1990s resulted in increasing health inequality between rural and urban areas. The decline of governmental funding for rural and urban risk protection led to an underdeveloped medical insurance system (Duckett, 2010a). As a result, even though the Chinese government has tried to improve healthcare in many ways (e.g., by implementing the new rural cooperative medical system beginning in 2002), healthcare remained unaffordable and inaccessible. These problems became increasingly serious and were exposed during and after the SARS crisis, which spurred the Chinese government to change health policies to seek solutions.

Second, previous conditions leave an imprint on the political system and institutions, thus continuing to shape outcomes of the political system, such as policy, in the long run (Marquis and Tilcsik, 2013). As Mertha (2009c) indicated, when some issues are not usually on the agenda, some agencies may need policy outsiders to attract the attention of decision-makers. For instance, when environmental concerns are sacrificed for the sake of economic development, environmental agencies are unable to resist a policy that supports economic development even when it causes environmental disruption. Some environmental agencies will approach non-governmental organisations, the media, or international organisations to report on or even intervene in the issue with public participation to attract both government and public attention (Mertha, 2009c). This is

especially the case for social policy, such as health policy, that deals with intangible resources (Huang, 2013). The healthcare system's lack of fiscal support restrained the Ministry of Health (MOH) within the political system, where 'political and economic resources are scarce' (Lampton, 1977). Therefore, the MOH was financially and politically weak (Huang, 2013) in bargaining with bureaucracies and had to rely on help from policy outsiders to raise the significance of health issues and attract attention from the decision-makers and the public.

Furthermore, the financial constraints of the MOH imposed by the central government forced the MOH to seek additional funding and techniques from outside. This provided the opportunity for policy outsiders with funding and advanced techniques to cooperate with the MOH and even to become involved in the policy process. As a result, the lack of financial and political support made the MOH eager to recapture its position in the political system and set health on the agenda for national development.

## 2.2 Ideology

Like the historical background, ideological transformation in China has also shaped health policies and the extent of outsiders' influence on the policies. An ideology includes perceptions on public policy, so ideology influences the policy direction via change in perceptions (Grafton and Permaloff, 2005). In health, ideological interpretations influence perceptions of issues in the field of medicine, health, and health policy (Emanuel, 1982). In Western democracies, where different ideologies exist, ideological transformation influences the health policy direction (Duckett, 2010a). For instance, in the 1980s, when the Conservative Party governed the UK, the health budget was cut and the UK government tried to commercialise and privatise the National Health Service, using economic constraints as justification for ideological-driven policies.

Although China is an authoritarian state without party competition, contradictory ideologies do exist. Table 2-1 shows the typical views associated with leftist and rightist ideologies in China.<sup>11</sup> China's leftists stress strong state power and believe that a planned

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<sup>11</sup> There is no scholarly measurement of ideology. The information I list refers to a general norm. The boundaries between leftism and rightism are not always clear. Even in the West, the ideology varies in different countries. For instance, rightism in the US is different from its EU counterpart. The ideology in both China and Western democratic countries resulted from revolutions. Leftism in China supports the CCP, which succeeded in the 1949 Revolution, so it supports the hierarchy and tradition of the CCP control as the conservative faction, while rightism in Western democratic countries supports the monarchist Ancien Régime, so it supports hierarchy, tradition, and clericalism. I list only factors relevant

economy is a prerequisite for social equality. The economic marketisation and capital liberalisation that occurred after the opening-up reform led to increasing inequality. Therefore, China needs strong state power to redistribute wealth, support social care, and provide public goods. The interest of the state is more important than individual interest. Similar to nationalism, leftism also considers the West ‘hegemonic’ and opposes communication with, or learning from, the West. In contrast, China’s rightism is liberal. It considers that individual interests and freedom are more important than the interest of the state. The law should restrict state power, and state power should give way to the market in the economy. Government intervention is the reason for social inequality. Although inequality is inevitable, free market competition could solve most of the problems and maintain the social hierarchy. Rightists support opening up and learning from Western developed countries.

The dominant ideology in China changes over time and is sometimes a mixture of left and right. For instance, the dominant ideology changed from the radical left in Mao’s era toward the right after the Cultural Revolution (Zhu, 2000). Since the Tiananmen Square protests in 1989, the CCP’s ideology returned to the left in politics, maintaining strong CCP ruling power, but to the right in economics, deepening the market economy reform (Gan, 2007).

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to the economy and social policy here, and some factors are not included, e.g., views of democracy. The sources of the graph information are as follows: ZHU, X. 2000. The new left and liberalism (xinzuopai yu ziyou zhuyi zhizheng). *Asiaweek*. Hongkong: Time Warner , GAN, Y. 2007. The Origins of China’s new liberal-left (zhongguo ziyou zuopai de youlai). Available from: <http://www.aisixiang.com/data/12647.html> [Accessed 1.5 2015], HUI, W. & KARL, R. E. 1998. Contemporary Chinese thought and the question of modernity. *Social Text*, 9-44, DUAN, Q. 2011. The difference and status quo of extem-left, left, right and extrem-right (jizuo, zuopai, youpai he jiyou de qubie he xianzhuang). Available from: [http://blog.sina.com.cn/s/blog\\_56fc0caa0100sx87.html](http://blog.sina.com.cn/s/blog_56fc0caa0100sx87.html), XU, J. 2002a. Two kinds of freedom and democracy: rethinking of liberalism and new-left (liangzhong xiyou he minzhu: duiziyou zhuyi yu xinzuopai lunzhan de fansi). *Economy and Management Digest (jingji guanli wenzhai)*, 39-44, XIE, Y. 2002. The political debate between new-left and liberalism (xinzuopai yu ziyou zhuyide zhengzhixue zhizheng). *Tewny-First Century*, 5, LE, Y. & YANG, B. 2010. Polarization of Cyber Society (wangluo jihua xianxiang yanjiu). *Youth Studies (qingnian yanjiu)*, 2, MARCUSE, H. 2013. *One-dimensional man: Studies in the ideology of advanced industrial society*, Routledge, MARX, K. 2004. *Capital (Volume 1: A Critique of Political Economy): A Critique of Political Economy*, Digireads. com Publishing, GRAMSCI, A. 2011. *Prison Notebooks Volume 2*, Columbia University Press, HAYEK, F. A. 2014. *The Road to Serfdom: Text and Documents: The Definitive Edition*, Routledge, ROUSSEAU, J.-J. 2008. *A discourse upon the origin and the foundation of the inequality among mankind*, Cosimo, Inc, MILL, J. S. 1999. *On liberty*, Broadview Press, DE TOCQUEVILLE, A. 2003. *Democracy in America*, Regnery Publishing, LOCKE, J. 1965. *Two treatises of government*, Awnsham and John Churchill, FANG, K. 2012. China’s left and right (zhongguo de zuopai he youpai). Available from: <http://cnpolitics.org/2012/02/left-right/> [Accessed 3.2 2013], POLITICAL COMPASS. 2001. Ideology in authoritarian and libertarian Available from: <https://www.politicalcompass.org/analysis2>, PAN, J. & XU, Y. 2015. China’s Ideological Spectrum.

	Leftism	Rightism
Origins	Communism and state power centralisation; <b>conservative</b> (original revolutionaries)	Capitalism and balance & restricted state power; <b>liberalism</b>
Politics	State interest is superior to individual interest; rule of mandate under the CCP's control; the CCP holds unlimited state power	Individual rights are superior to state power; restricted government power through constitutional system and supervision through rule of law; limited government that safeguards individual freedom
Economic	Planned economy; market subject to government regulation and adjustment; state controls economy and enterprises	Free market; against government intervention; private property
Reasons for inequality	Economic marketisation and capital liberalisation	Government intervention in the market economy restrained free competition and led to rent seeking; insufficient market reform resulted in benefit concentration for those in power, causing wide wealth gap
Solution	Maintain state ownership of the property; strengthen state power; wealth redistribution	Deepen the opening-up reform; expand market economy; restrict government power and intervention
View of other countries	Nationalism; oppose Western 'hegemony'	Learn from Western developed countries; support globalisation

**Table 2-1 Leftism and Rightism in China**

Ideological transition can occur not only from one ideology to another but also among many ideologies. Between left and right, there are new and more detailed divisions, such as the neo-left and neo-liberal. Neo-leftism is similar to ‘democratic socialism’ and ‘humanistic Marxism’ (Zhang, 1998), which favours Mao’s political idea of socialism and strong state power while embracing the open markets of capitalism for economic development (Xu, 2002b). New-rightism is similar to neoliberalism in the West, which opposes government intervention in the economy but supports wealth redistribution to a certain level to maintain sustainable and stable development (Hui and Karl, 1998).

The influence of ideology in health policy is important. Grafton and Permaloff (2008) argued that different ideologies could play a major role in an effective policymaking process in the US. This is also the case in China. There are four consequences of ideological transformation. First, ideological transformation compelled the CCP to turn to social policy to maintain its governing legitimacy. Although, politically, top Chinese leaders base their legitimacy on leftism and use it in the main body of propaganda to control China, leftism did not bring equity or equality as it promised (Duckett and Langer, 2013). Chinese citizens gradually lost faith in the communist ideology (Zhao, 2004) and started to focus on the material incentives and efficiency proposed by rightists. Therefore, ‘the state was forced to increasingly rely on performance, especially economic performance, as the fundamental basis for its legitimacy’ (Yang and Zhao, 2015). However, every coin has two sides. Economic reform and the state’s retreat from social welfare proposed by the rightists brought social problems. Facing acute social problems, the fourth-generation leaders implemented a series of leftist social policies to redistribute wealth and promote equality, including healthcare reform.

Second, ideology influences the extent to which policy outsiders can affect policies. The government is more likely to take the advice of outsiders whose ideas are close to their ideology. This is especially the case when there is one dominant ideology. For instance, when the Chinese government turned toward rightism in the 1980s, Deng Xiaoping, the then top CCP leader, invited a group of liberal economists, such as Milton Friedman, to join the reform plan discussion and offer suggestions for market economy reform (sohu, 2013). Some of their suggestions were adopted by the top leaders and implemented in the next decade in China, such as releasing foreign exchange control and disinflation. During the same period, one of China's most influential liberal newspapers, *Southern Weekend* (Rosenthal, 2002), was founded and started to exert an influence by spreading liberal



thoughts. Meanwhile, the Chinese government cut the health budget under the neo-liberal ideology, which touts the market's efficiency in health and focuses on economic growth while neglecting health (Duckett, 2010a). Although the causation between ideology and the influence of the outsiders is still not clear, the Chinese government was indeed open to outsiders with liberal ideas when rightism was the dominant ideology.

However, in addition to the dominant ideology, multiple ideologies exist in the society and even within the Chinese government (Duan, 2011). Holding similar ideas to the dominant ideology of the government is not a sufficient condition for outsiders to influence the government. Moreover, nationalism, leftist propaganda, and closed attitudes towards international society within the Chinese government and in the society could still inhibit outsiders' influence. For instance, the recent textbook reform (as time of writing, in 2015) has involved 'suppressing western ideas' is a threat to take over the intellectual discourse (Levin, 2015). Furthermore, outsiders must be 'politically right' in delivering an idea.<sup>12</sup> International organisations must follow China's rules and keep a safe distance from the Chinese government to avoid being suspected of lobbying the Chinese government and interfering in China's domestic issues while working together with the government.<sup>13</sup>

The peak of the ideological influence on health policies occurred with the debate on healthcare reform that began in 2005. The Development Research Centre of the State Council published a report that criticised the previous liberalised and commercialised health reform for causing affordability and inaccessibility problems (Ge et al., 2005). This report called for a new healthcare reform centred on social care, public goods, and equality. In the four years that followed, there were heated debates on the direction of the healthcare reform. There were mainly two factions, a pro-government faction and a pro-market faction. The pro-government faction is considered leftist and proposed government as the dominant power of resource relocation in health, while the pro-market faction is rightist and supported the market as the dominant power. Ideas that emerged during the debates influenced the healthcare reform policy.<sup>14</sup>

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<sup>12</sup> I will discuss this matter later in this chapter.

<sup>13</sup> Interview with 004, senior director of the China CDC, 9/19/2011, Beijing.

<sup>14</sup> I will discuss this process in detail in Chapter 6.

## 2.3 Political system

Ideology cannot influence politics or policies without fitting into a specific political system. The political system is significant in shaping policies and outsiders' influence because policy is made within the political system. I will discuss the political system from two perspectives: the leadership transition at the top of the political system and the fragmented authoritarianism of the whole political system. Because China is an authoritarian state with top-down control by one party within a strict hierarchy, top leaders have decisive roles in determining policies, while the bureaucracies in the hierarchy bargain for their interests in the policy process and thus shape the opportunities for outsiders to influence policy change.

### 2.3.1 Leadership transition

A leadership transition usually indicates a change in policy direction and principles in China. For instance, during Mao's period, class struggle was the direction and principle, so state development gave way to radical political and ideological revolution; during Deng's era, Deng changed the direction from class struggle to economic development and set opening up, marketisation, and science and technology development as priorities, so economic development became the key focus.

The leadership transition in 2002 and 2003 from Jiang Zemin and Zhu Rongji to Hu Jintao (Hu) and Wen Jiabao (Wen) changed the direction from Jiang's 'Three Represents',<sup>15</sup> which focused on the legitimacy of the CCP (Backer, 2006), to Hu's 'Socialist Harmonious Society', which 'favour policies that address social problems such as inequality and that benefit poor regions' (Duckett, 2012), although Hu did not reveal his political preferences or favoured policies at the beginning of the transition. The 'Socialist Harmonious Society' formed the basis of a sustainable and balanced development between economic and social development. Therefore, the policy direction during Hu's leadership turned towards social issues related to people's livelihood (*minsheng*), such as health, which made it possible to implement a dramatic health policy change.

The policy orientation of the 'fourth-generation' leaders, Hu and Wen, changed from focusing on economic development to solving some acute social problems. This was partly

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<sup>15</sup> The Communist Party of China should represent advanced social productive forces, advanced culture, and the interests of the overwhelming majority.

because Hu's leadership group 'consists of those like him who have risen to power through positions in the Communist Youth League and who have backgrounds in China's poor, inland provinces' (Duckett, 2012). The government tends to set policies close to this new policy direction on the agenda and prioritise policies that tackle social problems, such as 'improving rural conditions, developing poor interior regions, reforming the problematic health system and dealing with high house prices and education costs' (Duckett, 2012). Even though 'the regime is obsessed with control paradoxically.... it pays close attention to public opinion' (anonymous, 2014) because limited responsiveness to the public can help maintain its status as the only ruling power.

The leadership transition in 2003 had two direct consequences in the field of health. First, it prevented the reporting of SARS to both Chinese citizens and the world. The transition occurred through two legal steps: the selection of candidates for the National Party Congress in November of 2002 and the handover of power from the old leadership to the new leadership in the National People's Congress and Chinese People's Political Consultative Conference (*lianghui*) in March of 2003. The two congresses are the most important political meetings of the year. Usually during these meetings, there is extra security control (e.g., arrests of dissidents and suppression of petitions) in China to ensure that the meetings go smoothly without any disturbance, and these measures include control of the media (Wang and Wang, 2011). Moreover, the meetings in 2002 and 2003 dealt with a leadership transition – the most important political event in China. Therefore, the security control was even tighter to ensure that nothing negative was published in the media to affect the transition. However, this period coincided with the outbreak of SARS. The news of an unknown epidemic disease killing citizens in China was considered dissonance that would disrupt the crucial moment of the transition (Fewsmith, 2003). The reports of SARS might have been overlooked by the government because all attention was given to the leadership transition or because limited transparent information about SARS was sent to the decision-makers; it might also have been taken seriously by the government but the response delayed until the new leaders fully controlled the whole party and the state (Bo, 2007).<sup>16</sup> Either way, the smooth leadership transition impeded the timely response of the Chinese government to the SARS outbreak.

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<sup>16</sup> So far, there is no evidence showing whether the new leaders at that point were aware of the serious situation. Even if they had known about it, they might not have done anything when the leadership transition was still the priority. Therefore, I address both possibilities here.

Second, health was put on the agenda after the transition because it fit the new leaders' principles. As soon as the transition was smoothly completed, the new leaders quickly involved policy outsiders in the policy process and mobilised the whole society to fight SARS. Moreover, even after the SARS outbreak, the Chinese government continued to change the social policies for health and education and tried to respond to the problem of social and income inequality under Hu's principle of the 'Socialist Harmonious Society'. Therefore, the CCP's principle and policy preferences largely determined the direction of the practical policies. Policy suggestions that are close to the principles and policy preferences of the leadership are more likely to be accepted by the government and have an influence on policy change.

### **2.3.2 Fragmented authoritarianism**

The concept of fragmented authoritarianism is used to explain bureaucratic interests and bargaining within an authoritarian state (Mertha, 2009c, Lieberthal and Oksenberg, 1988). China is considered a fragmented authoritarian state. First, China is an authoritarian state, with the Chinese Communist Party (CCP) holding the ruling power. The CCP's control over the state involves a top-down approach that excludes outsiders who are not within the political system, and the policy process occurs mainly within bureaucracies (Aitchison, 1997). Second, China's political system is also fragmented such that bureaucratic divisions and territorial hierarchies have different interests, so they must negotiate and bargain in the policy process to shape policy in favour of their own interests (Lieberthal and Lampton, 1992).

Fragmentation creates fissures within the authoritarian system. There are two main causes of fissures. Different bureaucratic interests are the first cause. When developing a policy in the long term to address a broad issue, the top-level decision makers tend to look at a bigger picture of the state and thus leave out some bureaucratic or governmental interests. Even if the top-level decision-makers notice different interests, to serve the development of the bigger picture, those interests are sacrificed. As a result, bureaucracies with different interests must ally with outsiders with similar interests or perceptions to bargain in the policy process. Moreover, the central government's encouragement of the bureaucracies' self-support (financially) has 'strengthened the tendency of bureaucratic units to work vigorously to promote and protect their own interests in the policy-making process' (Lieberthal and Lampton, 1992).

Lack of information is the second cause of fissures. The fragmented authoritarian system ‘decreases the amount of information available, thus increasing its value’ (Mertha, 2009c). Within the authoritarian system, top-down control reduces bottom-up information feedback, and the fragmented system creates barriers for information exchange and sharing between different functional departments. The lack of information enables outsiders who possess the needed information to have an impact on the policies. For instance:

‘The Chinese government established filter mechanisms that monitor, collect and digest information and policy ideas from mass media, the internet and other academic or non-academic publications. Most ministries and local governments have information centres or public sentiment analysis institutes. Think tanks are therefore able to draw the attention of decision-makers by initiating or participating in public discussions or even by publicly criticising government policies’ (X. Zhu, 2011, p. 673).

Turning to the health system, the focus of this thesis, the fragmentation – and thus the bargaining – occurs between ministries, within the MOH, between central and local governments, and within the healthcare delivery system. First, different ministries, the MOH, and the MOH’s internal divisions argued for the principal role in policymaking to change policy in favour of their interests.<sup>17</sup> The principal role of the policymakers has a stronger voice in health policy in a system where ‘political and economic resources are scarce’ (Lampton, 1977).

Second, decentralisation has enhanced the fragmentation between local and central governments (e.g. Landry, 2008, Ho, 2010, Xu, 2011). Since the tax sharing reform of 1994, local government has been given financial leverage to determine local issues and fund its own departments (Duckett, 2010a). Therefore, under the authoritarian system, the fiscal relationship between local and central governments is decentralised and the local governments can set their own priorities, although the local priorities sometimes do not align with those of the central ministries (Saich, 2011). For instance, the MOH provided a county-level health station with special funding for epidemic prevention, but the health station did not use the money for the original purpose designated by the MOH. Instead, the county government used the money for economic development.<sup>18</sup> This occurred because, although the local health bureau is vertically subordinate to the MOH, horizontally, at the county level, the local health bureau is accountable to the local government. Because of the fiscal decentralisation, the local government is directly in charge of the financial and personnel resources of the local health system (Huang, 2013) while seeking additional

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<sup>17</sup> Follow-up interview with 014, senior MOH director, 09/24/2013, Beijing.

<sup>18</sup> Interview with 004, senior director of the China CDC, 9/19/2011, Beijing.

funds to support local development (Saich, 2011). Thus, the local health bureau would serve the local interest first instead of the priority of the MOH. Similarly, during the SARS outbreak, local health officials were ‘accountable first to the local leaders who appointed them’ (Duckett, 2003) rather than to their superiors in the healthcare system.

Third, the health service delivery system is fragmented. There are three main types of hospitals in the health service delivery system: the MOH, military and state-owned enterprise hospitals. Within China’s military system, there is an independent healthcare system owned and managed directly by the Ministry of National Defence. The MOH system and the military healthcare system do not link up with each other. Originally, the military hospitals mainly treated people working for the military and the top leaders of the state. Nowadays, each military hospital has in-patient, outpatient, and military departments. Civilian citizens can get medical services from the in-patient and outpatient departments using their health insurance. The military hospitals also administer medical workers’ education and training, medical research, and laboratory work, which are independent from the MOH system and local governments.<sup>19</sup> The state-owned enterprise hospitals were owned and managed by state-owned enterprises that were partly connected with the MOH system. This system mainly existed during the planned economy period when state-owned enterprises sponsored hospitals and clinics to serve enterprise employees, who were mainly urban workers. Since the state-owned enterprise reform in the 1990s, a majority of the state-owned enterprise hospitals have been merged into the MOH system, with the exception of the hospitals in the energy and railway sectors (Wang, 2013). Thus, state-owned enterprise hospitals in the energy and railway sectors are not under the authority of the MOH.

The political system combined with the ideology negatively prohibited the media report. First, the fragmented health service delivery system and the propaganda system blocked the way that the media know about SARS information. On the one hand, the hospitals taking SARS cases belonged to different systems. Therefore, there was no unified institutional channel or mechanism that could gather coherent and correct information about the infected cases from these hospitals. The media’s information source of SARS was limited. On the other hand, the government controlled the media’s limited information release ideologically. The propaganda system in China is conventionally seen as leftist and ‘has a “guiding” role over even larger sectors of China’s bureaucracy and political

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<sup>19</sup> For more information, please see <http://www.mod.gov.cn/hospital/index.htm>, accessed on 3/2/2014.

system... for ideological matters' (Brady, 2009), including the MOH and the Chinese army healthcare system. During the SARS outbreak, units dealing with SARS, such as hospitals and disease research institutions, were not only under the authority of the MOH or the army healthcare system but also under the direct supervision of the propaganda system, which 'would rather be on the "left" than on the "right"' (*ningzuo wuyou*).<sup>20</sup> In other words, the release of disease-related information to the media should be conservative and careful to avoid social instability, according to the leftist position adopted by the propaganda system. Therefore, the government did not allow the media to report information on SARS for months. Even though the World Health Organisation (WHO) used strategies to push the Chinese government to release the information little by little, like squeezing a tube of toothpaste, some hospitals answerable to the MOH and the army system as well as local governments still refused to release full information.<sup>21</sup>

Second, apart from the information flow, the combination of the political system and ideology also inhibited the expert's influence. The experts could not do scientific research of SARS because of the fragmentation of the health research system. The experts separated in different research institutions of the MOH and the army system at both the central and local levels were separated from each other (see Graph 2-1). For instance, within the MOH system, several research institutions were conducting medical research at the central level, such as the China CDC, Peking Union Medical College (*xiehe yiyuan*), the Guangzhou Institute of Respiratory Disease, and local universities. Within the military system, the Chinese Academy of Military Medical Science and military hospitals (e.g., the 301 Military Hospital) at the central level and local military hospitals (e.g., the PLA Guangzhou Military Region General Hospital) were conducting research.<sup>22</sup> Two scientific research institutions, the Chinese Academy of Science and the Chinese Academy of Engineering within the State Council (SC) administrative system were also conducting medical research. Some of these institutions kept the research information and SARS tissue samples (which were tested in labs for SARS research) for their own research (Cao, 2004b). Therefore, the capacity for research on SARS was weakened and the research was delayed. The experts could not offer accurate and timely policy suggestions because there was not enough scientific research.

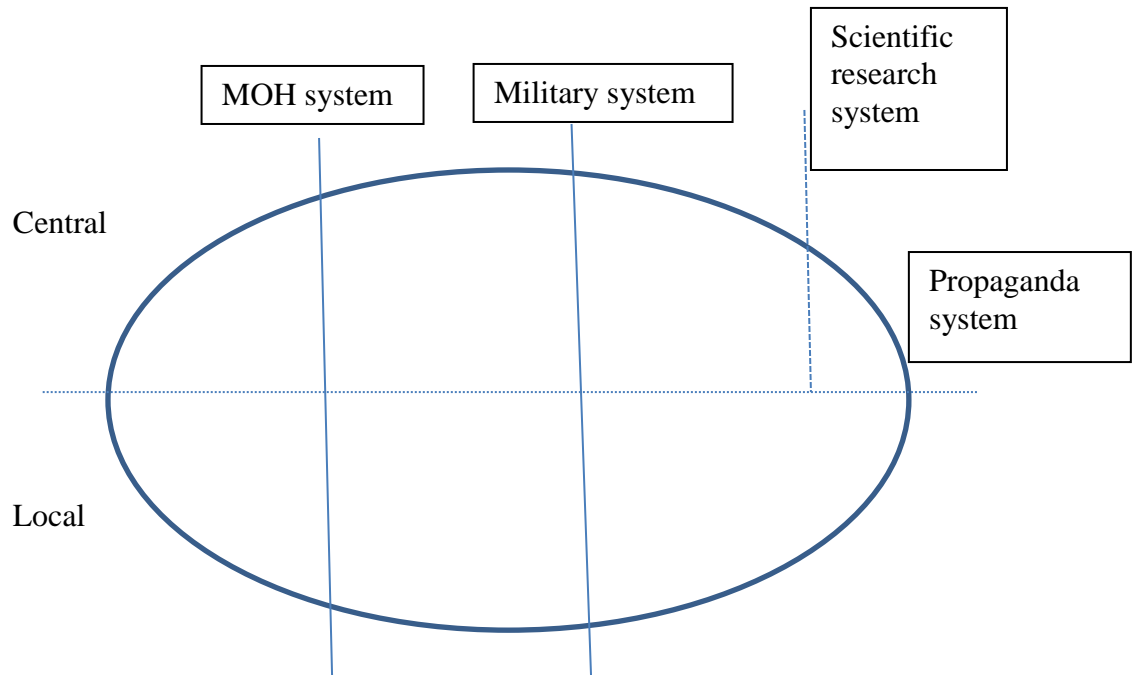
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<sup>20</sup> Interview with 005, journalist with Xinhua News, 25/9/2011, Beijing.

<sup>21</sup> I will discuss this matter further in Chapter 4.

<sup>22</sup> Please see <http://www.nhfpc.gov.cn/> and <http://www.mod.gov.cn:8080/hospital/index.htm> for more information, accessed 5/12/2014.

However, when outsiders affiliated with more than one of these institutions and had multiple identifications, they could cross the fragmentation between the institutions and ally with the media and international organisations to deliver information. In Chapter 4, I will further discuss how experts in Guangdong, together with the media and international organisations, contributed to the change in SARS policy.



**Graph 2-1 Fragmented health research system and propaganda control**

To sum up, the top leaders' principles and preferences determine policy direction and who and what to accept in the policy process accordingly. The fragmented authoritarian system has fissures that enable outsiders to enter the policy process and exert an influence.

## **2.4 Institutional design of the central bureaucracies in health**

After discussing the bureaucratic bargaining that occurs in the political system, I explain how different central bureaucracies enact different kinds of national health policies by looking at the institutional design. Therefore, I will discuss both the design of the central apparatus and explain how those bureaucracies differentiate their functions while making different health policies, and the consequences of the functional differentiation.



### 2.4.1 Central apparatus and hierarchy of health policies

Different levels of central governmental departments develop different health policy hierarchies. ‘Every polity has, and needs, several levels of policy in order to meet the needs of present and provide the flexibility with which to deal with the future’ (Lampton, 1977). There are usually two kinds of policy: dynamic, normative policy that gives general guidelines and action policy that translates the normative policy into concrete action plans. According to the level of the organ that makes the policy, there are three main types of policies in China: laws and principles, regulations, and departmental rules and guidance.

Figure 2-1 shows the central apparatus where health policies are developed.<sup>23</sup> The policies made by the NPC are laws (*falv*), while the policies made by the CCP Politburo, its Standing Committee, and the SC are principles (*yijian*). The laws have legal force, while the principles provide direction for policies and state development with the highest political force (Lieberthal and Oksenberg, 1988). Sometimes, these policies are only about health, such as the Laws of Prevention and Control of Infectious Diseases (*zhonghua renmin gongheguo chuanranbing fangzhifa*) (NPC, 2004) issued by the NPC, while, more often, health-related issues are set as part of the national development strategy. For example, the working reports sent from the SC to the NPC every year and the reports sent from the CCP Central Committee to the CCP National Congress every five years contain health-related content (e.g. Hu, 2007a, State Council, 2007d).

The policies issued by ministries (e.g., the MOH) take the form of regulations (e.g., *tiaoli*, *banfa*, and *guiding*), which have a senior level of administrative force. They provide more detailed and specific directions within the parameters of laws and principles (Lieberthal and Oksenberg, 1988). For instance, ‘Order: Management Measures of Infection Control within Hospitals’ (*yi yuan ganran guanli banfa*) (MOH, 2006b), issued by the MOH, regulates the infectious disease control methods used within hospitals under the Laws of Prevention and Control of Infectious Diseases. Among these ministries, the National Development and Reform Commission (NDRC) has a special position as a macroeconomic management agency and focuses mainly on broad administrative and planning control over the Chinese economy.<sup>24</sup> This position gives the NDRC special power to make policies

<sup>23</sup> Because of space constraints, I cannot list all ministries and ministerial departments here. Therefore, I list only some representative ones. Sources: <http://www.nhfpc.gov.cn/> and [http://www.gov.cn/guowuyuan/gwy\\_zzjg.htm](http://www.gov.cn/guowuyuan/gwy_zzjg.htm) accessed 6/2/2014.

<sup>24</sup> For more information on the NDRC, see <http://en.ndrc.gov.cn/>, accessed 3/7/2014.

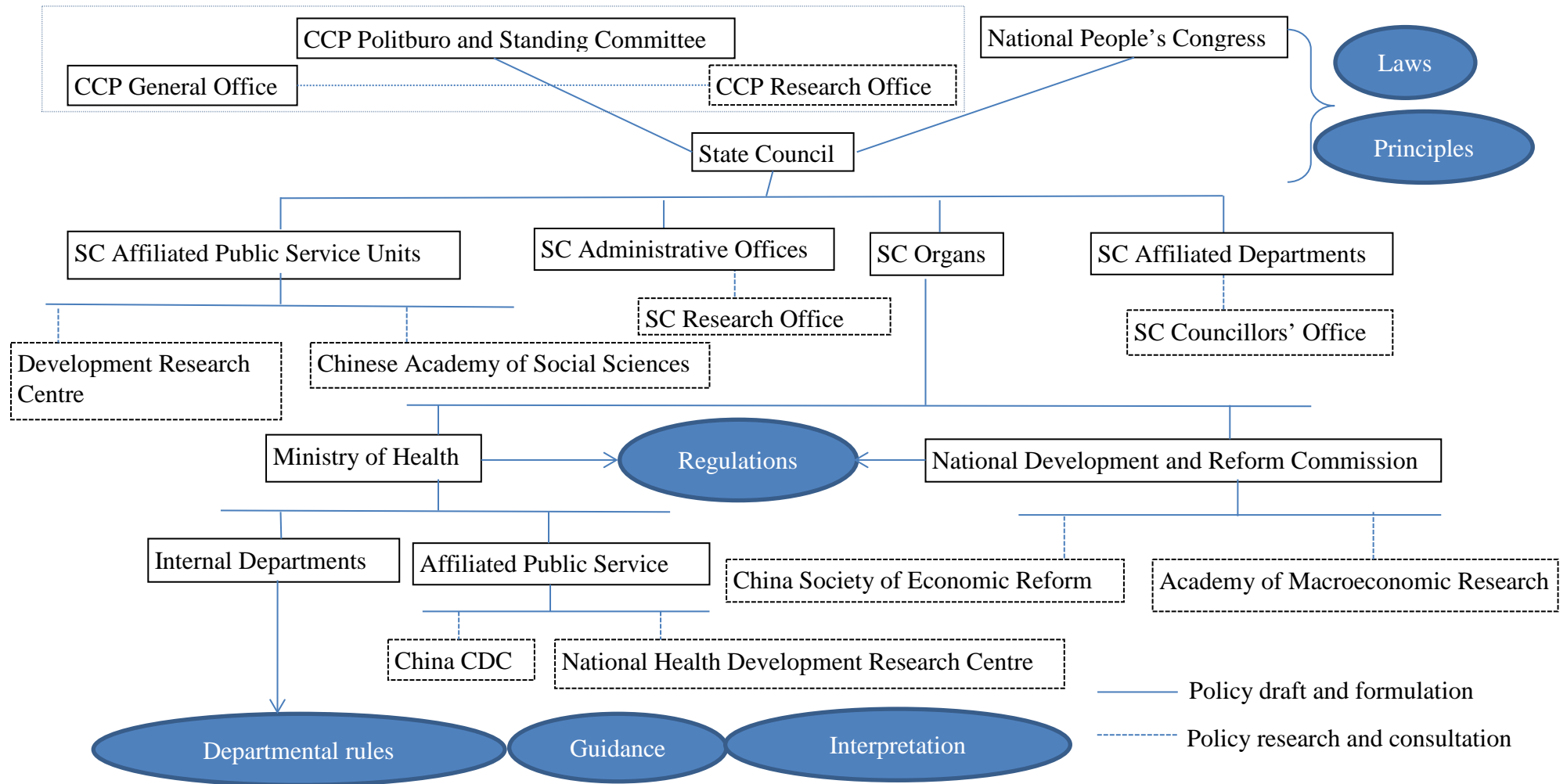
above the other ministries (but still below the SC). Sometimes, the NDRC's policies address issues related to health from various perspectives because some internal departments and affiliated units of the NDRC (e.g., the Department of Policy Studies and Department of Social Development) take into account health issues in their consideration of the social and economic development plan. Therefore, the NDRC's policies could give guidance to other ministries, such as 'Guidance of Medical Industry Development during the Eleventh Five-year Plan' (*yiyao hangye shiyiwu fazhan zhidao yijian*) (NDRC, 2006), issued by the NDRC.<sup>25</sup>

The policies made by ministerial departments take the form of departmental rules (*bumen guizhang*), guidance (*zhidao*), and policy interpretations (*jieshi*), which provide further detailed, operational, and practical instructions. For instance, some policies are set jointly by a few internal MOH departments, such as 'Opinions of Rural Health Organisations' Reform and Management' (*guanyu nongcun weisheng jigou gaigeyu guanlide yijian*) (MOH, 2002), issued by the Department of Primary Health and the Department of Maternal and Child Health. Some policies are set by a single department, such as 'Notice of Traditional Chinese Medicine Health Management Service Specifications' (*guanyu yinfa zhongyiyao jiankang guanli fuwu guifande tongzhi*) (MOH, 2013), issued by the State Administration of Traditional Chinese Medicine.

Health policies set by different levels of central departments have different aims and functions and varying hierarchies of legal and political force. However, these policy hierarchies cannot be distinguished by the words used in the policy titles. For instance, both the SC and the ministerial offices could use 'opinions' in their policies, but the SC's opinions are ranked much higher than the ministerial offices within the hierarchies. Therefore, instead, the levels of the departments that issued the policies distinguish the policy hierarchies. High-level departments set policies with a high level of legal and political force.

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<sup>25</sup> Some other ministries could also set policies related to health. For instance, the Ministry of Environmental Protection (MOEP) sets policies involving environmental health, and the Ministry of Commerce (MOE) sets policies on foreign investment in hospitals in China. When the health part falls within a broad policy of these ministries, they make the policy on their own and publish the policy documents in their own names; for example, 'Orders: Environmental Emergency Investigation Procedures' (*tufa huanjing shijian diaocha chuli banfa*), issued by the MOEP, contains health protection procedures. When the health part relates to other ministries, the policy is usually made jointly by the related ministries, and the policy documents are published in the names of all relevant ministries, as in the case of 'Notice on Establishing Wholly Foreign-Owned Hospitals' (*guanyu kaizhan sheli waizi duzi yiyuan shidian gongzuode tongzhi*), issued by the MOH and the MOE. Because of space constraints, I cannot list all the policies and ministries that set health-related policies.



**Figure 2-1 Central apparatus and hierarchies of health policies**

### 2.4.2 Functional differentiation

Besides the hierarchy, health policies are also distinguished by their functions. The departments (at both the ministry and division levels) with different functional areas set different health policies based on their interests and perceptions. For instance, the MOH would like to improve the healthcare delivery system by raising public hospital revenues; the Ministry of Labour and Social Security (MOLSS) would like to improve the risk protection scheme by funding medical insurance programmes (Kornreich et al., 2012).<sup>26</sup> There are also other ministries with different interests, such as the Ministry of Finance and Ministry of Agriculture (Duckett, 2010a). Sometimes the policies even compete with each other for scarce resources.

Within this functional differentiation and the highly dispersed (Huang, 2013) structure of the central government (Goldstein, 1991), to differentiate the policy process from the ‘winner-takes-all’ norm that prevailed during Mao’s era, the process requires inter-dependent actors to communicate with different departments and persuade them to compromise, collaborate, and cooperate to build a consensus (Wang and Fan, 2013). The decision-makers at the Political Bureau and the SC also need to play ‘the role of referee by resolving disputes between ministries and setting broad programmatic objectives’ (Lampton, 1977). These inter-dependent actors and referees could be high-ranking individuals or supra-ministerial organisations within the political system or the higher-ranking policy that ‘glues’ the differentiation together (Duckett, 2010a).

However, sometimes, the functional differentiation between the departments (at the ministry level and the ministerial department level) is ambiguous. The fragmentation within the central governmental departments makes it difficult to identify which department(s) should be in charge of certain issues. Moreover, there are new health-related issues that did not happen before; they do not fall into any pre-defined differentiation, so dealing with these new health issues requires the cooperation of a few related departments or even the setting up of a new department. For instance, within the MOH, the Bureau of Disease Prevention and Control was originally the Office of the National Patriotic Health Campaign Committee, mainly responsible for work concerning patriotic health campaigns in Mao’s era; but it extended its function to infectious disease prevention and control after

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<sup>26</sup> I will discuss this issue further in Chapter 6. The MOLSS changed its name to the Ministry of Human Resources and Social Security (MHRSS) in 2008. However, in this thesis, I still use MOLSS because the organisation joined the reform before changing the name.

the SARS outbreak.<sup>27</sup> The Department of Healthcare Reform (Office of State Council Healthcare Reform Leading Group) was built after the healthcare reform started in 2009.

Reform of the SC administrative institution, which has been carried out seven times since the opening-up and reform, has also contributed to the ambiguous functional differentiation.<sup>28</sup> The administrative institution reform transformed government functions (*zhuanbian zhengfu zhineng*) and reorganised the government structure (*zhengfu jigou chongzu*) (Wang and Qiu, 2002). The reforms moved some functions from one department to others and constantly changed the governmental functions. Therefore, although the institutional reform centred on ‘streamlining the structure, and enhancing administrative efficiency’ (Ma et al., 2005), it obscured the functional differentiation between departments. Because of poorly defined functional differentiation, ‘there is limited norm to determine what policies should be made by one department and what should be made jointly by departments’.<sup>29</sup>

The functional differentiation inhibits the coherence of health policies, although the decision-makers use policies high in the hierarchy to coordinate and facilitate these different interests and build consensus (e.g. Lampton, 1977, Wang and Fan, 2013, Huang, 2013) at the top level. At the lower level, each health unit receives multiple health policies from different departments. For instance, a local health bureau must deal with policies from ministries such as the MOH and the MOLSS as well as ministerial departments. Those policies set by departments with different functions at different levels sometimes contradict each other. The more contradiction there is in the policies, the more difficult it is to implement them. Therefore, to make the policies feasible, the policies allow leeway for the lower-level governments and units.

‘While making policies, the governments do not usually say things absolutely clearly. Because one department only knows its own business, this department is not sure whether the policy (at least partly) will contradict other departments’. The clearer the policy is, the more likely it is to contradict other departments’ policies because of their different perceptions and interests. Furthermore, a policy’s specific contents may not be generalised

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<sup>27</sup> Follow-up interview with 004, senior director of the China CDC, 9/24/2013, Beijing.

<sup>28</sup> Since 1979, there have been administrative reforms within the SC, undertaken in 1982, 1988, 1993, 1998, 2003, 2008, and 2013. For more information, see <http://www.lybb.gov.cn/index.php?c=MTY=&type1=60&sendId=68>, accessed 8/11/2014.

<sup>29</sup> Follow-up interview with 014, senior MOH director, 09/24/2013, Beijing.

to all of China because the areas vary dramatically in terms of population, economics, and development. Therefore, the policies are usually ambiguous. The lower-level governments must implement policies based on their own understanding. The ability to understand and interpret the meaning and intention of the policies is very important in their official careers'.<sup>30</sup>

Therefore, the lower the level of a government is, the more interpreted policies it will receive from upper-level governments and the more of its 'own understanding and interpretation' it will need to implement the policies. This is also called 'discretion by rule of mandate' (Birney, 2014) which results in deviation of policies from the original meaning based on the multi-level interpretation. To maintain the coherence of the policies, the upper-level governments need outsiders who cross the boundaries between the departments to find and solve the contradictions; the lower-level governments need outsiders to understand and interpret the complicated policies from different upper levels. Those outsiders usually come from policy communities that can cross boundaries and build a bridge between the state and society with science and policy research (Stone, 2007).

### **2.4.3 Policy community**

The policy community is a loose and informal group consisting of people from different disciplines with extensive education and expertise in a specific area for policy research and discourse. They could be insiders or outsiders working in different governmental departments and other organisations.<sup>31</sup> For instance, a health policy community consists of officials, experts and international organisation staff in health economy, medical science, and social policy. Therefore, the policy community spans different functional departments.

The personnel flow within the governments and between the governmental departments and other organisations is the foundation of the policy community. There are four ways of personnel flow. First, the personnel can flow between the government and research institutions. For instance, the MOH recruited personnel from the DRC and the National Health Development Research Centre; while some researchers who used to work for the

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<sup>30</sup> Interview with 011, senior researcher of the China National Health Development Research Centre, 24/9/2013, Beijing.

<sup>31</sup> I discussed this in Chapter 1. Insiders are officials and government personnel who make policies directly or have veto power; outsiders are those who do not make policies directly.

government left their governmental jobs and went to work for universities.<sup>32</sup> Second, the personnel could flow between the international organisations. For instance, Dr Hana Brix, a health economist, served in different international organisations respectively to conduct health projects in China, including World Bank, the WHO, and United Nations International Children's Emergency Fund; Dr. Daniel Chin, a specialist of tuberculosis, worked in the WHO Beijing office and Gates Foundation Beijing office respectively.<sup>33</sup> Third, the personnel can flow between international organisations and the research institutions. For instance, some Chinese experts change work between the WHO Beijing office and World Bank to China National health Development Research Centre or other health research units.<sup>34</sup> Fourth, the personnel can flow between Chinese government and the international organisations. For instance, some Chinese experts change work between the WHO Beijing Office to the MOH internal departments.<sup>35</sup> This personnel flow builds a network between people with similar interests and expertise and thus forms the policy community.

Within this policy community, people are connected to each other through their work and education experience. Some scholars use social networks to explain the connections among the actors who could influence policy (e.g. Zheng et al., 2010, Marsh and Rhodes, 1992b, Mintrom and Vergari, 1998, Chen, 2006, Keck and Sikkink, 1998, Hajer and Wagenaar, 2003). Some scholars use personal connections (*'guanxi'*) to explain this type of personal connection, but the term *guanxi* is largely used for relations between the government and the business sector (e.g. Gold et al., 2002, Xin and Pearce, 1996, Dunfee and Warren, 2001). However, these people are not businesspersons or working for medical companies. Instead, they are intellectuals working on policy research. This policy community is closely connected with hospitals and medical professionals, which is useful in finding out about health problems first hand data (Paterson and Rifkin, 1974). Within this policy community, both the policymakers and researchers share information on health, including medical technology, health economics, and social policies related to health. The information is then used as evidence for health policymaking (e.g. Whitworth, 2006, Guo

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<sup>32</sup> I will mention this in Chapter 6. Interview with 010, senior official at the National Health Development Research Centre, 9/13/2011, Beijing.

<sup>33</sup> For more information, please see <http://www.worldbank.org/en/about/people/hana-brix>, accessed 2/4/2015.

<sup>34</sup> Interview with 010, senior official at the National Health Development Research Centre, 9/13/2011, Beijing.

<sup>35</sup> Interview with 002, senior technician at the China CDC, 9/5/2011, Beijing.

et al., 2010). As a result, there is no direct business interest within the policy community, as there is between the government and the business sector.<sup>36</sup>

The policy community loosens the boundaries between the insiders and outsiders and thus lowers the barriers for outsiders to enter the policy process. Similar to the policy community in the UK (Marsh and Rhodes, 1992a, Smith, 1990), the people within the policy community open the discourse and discuss health issues via meetings, seminars, and forums inside and outside the government. Even outsiders who are in possession of health or medical expertise but do not have direct links with the functional departments could also join the policy process via the networks with the researchers who are linked to health officials. The idea exchange within the community is an opportunity for outsiders to influence health policy. However, unlike in the UK system, ordinary citizens have very limited access to the policy community in China, as the policy community is an elite one consisting of experts and policymakers.

To sum up, within the central government, the departments at different levels in the hierarchy set policies at different levels. The hierarchy influences the extent to which outsiders can affect policy. The functional differentiation of the government leads to the ambiguous identification of policymaking, which creates opportunities for policy outsiders to become involved. Officials and policy researchers shape the policy community, by which the outsiders may influence policy change.

## **2.5 Rationale for choosing the three types of policy outsiders for consideration**

The Chinese political system leaves opportunities for policy outsiders to influence health policy change to the extent that it needs such outsiders to engage in the policy process historically, ideologically, politically, and institutionally. Regarding those outsiders, I explain the reason that I chose three particular outsiders for consideration: experts, the media, and the international organisations.

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<sup>36</sup> Although some scholars indicate that some pharmaceutical and medical equipment companies are in alliance with think tanks to influence healthcare reform policy, there is no evidence showing that the people within the policy community are targeting specific policies for business interests or backed up by business sectors. In fact, the discourse within the health community is very general and diverse, so it is difficult for it to be manipulated by a few interest groups.



### 2.5.1 Technocracy

The inability of traditional bureaucracies to develop innovative and integrative solutions to policy problems increases the demand for expertise (Langford and Brownsey, 1991). The theory of technocracy suggests that the government needs the expertise of policy outsiders to solve practical problems and thus open windows of opportunity for them to enter the policy cycle (Cheng and White, 1990). Elites can enter politics because they possess the skills that are most needed by the state (e.g. Putnam, 1976, McDougall, 1982). The WHO (2005a) stated that such skills in health include identifying the medical problem, providing professional support, conducting laboratory analysis if necessary, and the capacity to work with different actors. During the SARS crisis, the most valued skills were those of medical technicians, which the CCP lacked. In other words, politics cannot cure an infectious disease or dispel public panic resulting from the disease. Therefore, the Chinese government had to open the health policy process to policy outsiders who had the medical expertise to help handle the SARS crisis.

The Chinese government health officials ‘consist mainly of specialists who are trained in natural and physical sciences, instead of generalists’ (Cheng and White, 1990). This was especially the case after the leadership transition in 2003, when the fourth-generation leaders, Hu Jintao and Wen Jiabao, reached the highest level of power in the CCP and the state. Most of the officials of Hu’s administration had higher education in natural science or engineering (Brown, 2011). The technocrats reached a consensus on the importance of science and technology, so they were willing to open the policy process to policy outsiders with expertise in those fields.

There is a caveat in interpreting the opening of the policy cycle to policy outsiders. Opening the policy cycle to policy outsiders does not mean that outsiders can challenge the political power of the CCP. These policy outsiders focus on technical matters rather than political issues, and their mission is task-oriented rather than power-oriented (Haas, 2008). Zhu (2008) also explained that, when experts persuade the government to change policies, it is very important to be ‘politically right’. Among the thousands of political outsiders with professional competency, the government determines what expertise they need and whether or not to accept certain experts into the policy process. Therefore, the government plays a decisive role in the engagement of outsiders in the policy process and determines whether or not these outsiders can influence policy change. The Chinese government, as ‘the core and main part of the public sector and public organisations’, uses a ‘statist

corporatist strategy' to cooperate and negotiate with a limited number of 'recognised' and 'trusted' individuals and organisations (Pieke, 2012). Therefore, even though the policy cycle is open to policy outsiders, the Chinese government still has veto power.

### **2.5.2 Three types of outsiders with their own expertise**

#### **Experts**

An expert is someone who specialises in a certain area through training or education and thus holds competence and a professional occupation in an area. Their influence on policy depends at least partially on the expertise that he/she holds.

Research on experts' influence adopts two main perspectives, considering experts as individual actors and considering experts as a group. Scholars who consider experts as individual actors use elite theory to examine individual experts as 'a small number of powerful political and social elites [who] influence policies through their close ties with other elites' (Zhu, 2012a). These elites' expertise in a particular area leads to a different perception of the dominant class and thus influence policies (Bourdieu, 1983). Individual experts influence policies using their connections, and the relationships in the connections are referred to as policy networks, social networks, or advocacy coalitions. (e.g. Keck and Sikkink, 1998, Weible et al., 2009, Mintrom and Vergari, 1996, Zhu, 2012c). For instance, scholars use policy network theory to explain how individual experts use their interaction with stakeholders in China to influence urban health insurance reform (Zheng et al., 2010).

There is also research that considers experts exerting influence as a group, such as the study of think tanks. Such research examines think tanks' ingredients and discusses what makes think tanks influential, successful, or failures in the political and policy process (e.g. Zhu, 2013, Weaver, 1989, McGann and Johnson, 2005). These scholars consider experts as a unit or a group rather than as individual actors and distinguish different kinds of collective actors, such as independent policy institutes, academic research centres, and government research units (Stone and Denham, 2004). The research on think tanks studies how different types of organisations engage with government and exert policy influence and political impact. For instance, Zhu (2013) explained different think tanks using their interactions with different stakeholders in China to promote the New Rural Cooperative Healthcare system. Furthermore, the epistemic community also studies professional

networks domestically (Thomas, 1997), although it originally focused on international relations and cooperation (Haas, 1992).

I focus on individual experts in different organisations instead of on the units they work for. I analyse how different actors deliver their ideas and expertise in the policy process and thus influence policy change. Of course, I will discuss the units they work for because the units give the experts additional credibility in the eyes of the Chinese government (Stone and Denham, 2004, Zhu, 2013). However, I will not treat the units as independent groups separate from the experts in this research. Furthermore, I focus mainly on domestic experts rather than international experts because it is still difficult for non-Chinese to influence China's policy (Brady, 2000). Most international experts enter China's policy process via international organisations or domestic research institutions.<sup>37</sup>

Experts can influence policy change in different ways. First, they make intellectual arguments and conduct analyses (Stone, 2006). Second, they conduct policy research, provide policy advice and technical assistance in policy formulation and evaluation, open policy dialogues at both the national and international levels, and train functional departmental policymakers and commission reviews (Bennett et al., 2011). In China, experts can influence policy as information filters, policy defenders, introducers of new ideas, and interlocutors with foreign interests (Shai and Stone, 2004) via administrative linkages, personal ties, and organisational identities (Zhu, 2009).

## **Media**

The media influence policy through information flow. The role of the media in politics in Western democratic countries, such as agenda setting, public participation, campaigning, and gatekeeping, has been widely studied (e.g. McCombs and Shaw, 1972, Shirky, 2011, Cook et al., 1983, McLeod et al., 1999). The media also play a key role in election and policymaking, such as the development of foreign policy, environmental policy, and education policy (Shirky, 2011, Graber and Dunaway, 2014, Page, 1996). Some scholars even consider the media a significant actor to counterbalance state power (Schultz, 1998).

However, in China, an authoritarian state without free elections or freedom of speech, the role of the media in overseeing or even challenging state power is limited (Sussman and

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<sup>37</sup> I will discuss this in Chapter 4-6.

Karlekar, 2002). ‘The Propaganda Department of the Central Party Committee, together with local propaganda departments, is directly in charge of media control at the national and local levels’ (Tai and Sun, 2007 p.996). Through this institutional mechanism, ‘the Chinese government maintains significant controls on traditional information channels and is enhancing its resources to establish authority over new media’ (USCC, 2004 p.214).

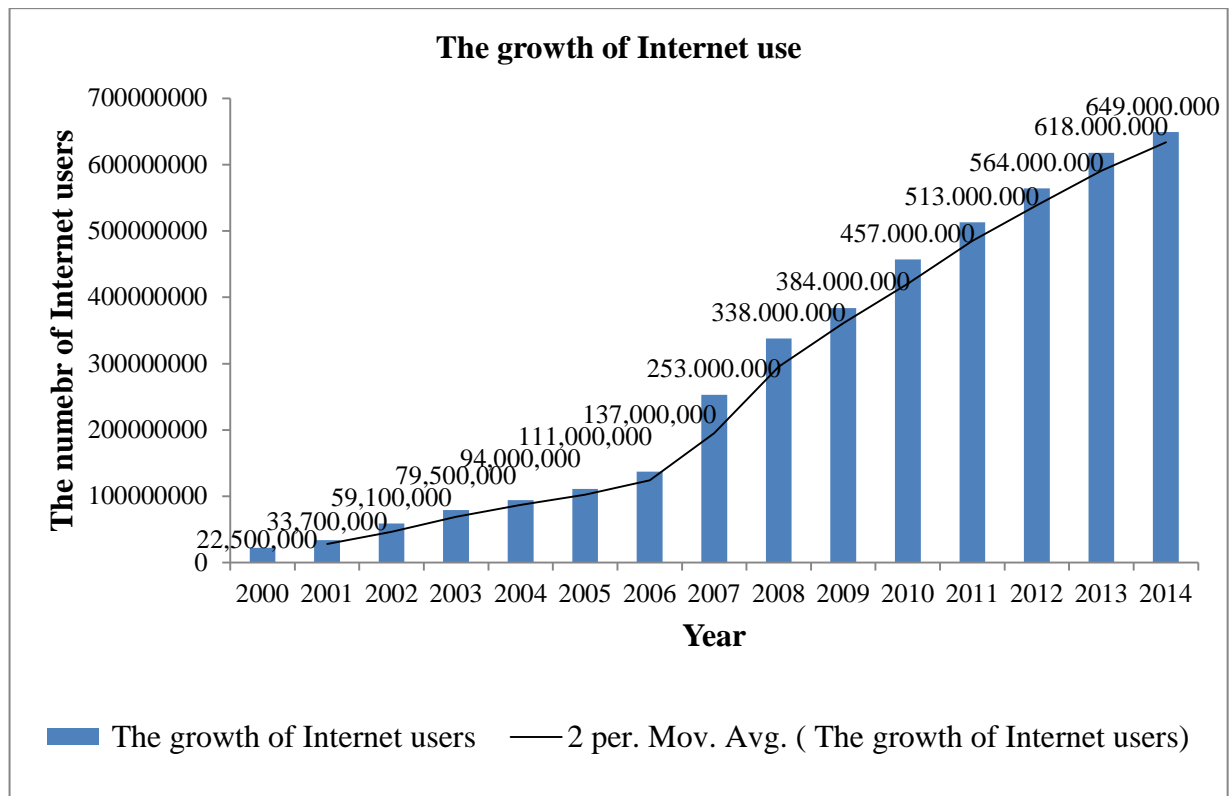
China’s media was under strict control when they were owned and fully sponsored by the state between 1949 and the early 1980s. However, the state started to loosen its control and give media news reporters leverage with the media commercialisation in the 1980s, when government financial support fell sharply (Zhao, 1998a). Because of the cut in government financial support, most non-state-sponsored media had to depend on circulation and advertising income. As a result, although the media (e.g., Xinhua, CCTV, and *People’s Daily*) sponsored by the state still hold a significant market share, non-traditional media (e.g. *Southern Weekend*, *Caijing*, *Caixin*), which generate income from the market, started to report more diversified content on certain issues, such as social topics, public issues, and investigative reporting.

Moreover, since 2000, the Internet has become increasingly important and the number of Internet users has grown rapidly. By the end of 2014, China had 649 million Internet users and 557 million mobile Internet users (CNNIC, 2015).<sup>38</sup> Figure 2-2 shows the fast-growing number of Internet users in China. As shown in the figure, the number of Internet users underwent a gradual increase from 2003 to 2006. From 2006 to 2007, there was a dramatic increase in the number of Internet users. The number in 2007 is two times the number in 2006. From 2007 to 2014, there was a continued increase in the number of Internet users. Compared to the figure in 2003, the number of Internet users in 2014 is about eight times higher. The Internet has become a significant part of Chinese citizens’ lives as ‘a platform for multi-way communications in which audiences play a brand new role’ (Tai and Sun, 2007 p.993). There are hundreds of thousands of registered users on major portal sites, and tens of thousands are engaged in online chatting on a typical day (Tang and Liu, 2004).

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<sup>38</sup> According to the China Internet Network Information Centre (CNNIC), Internet users are Chinese residents at the age of six or above who have used the Internet in the past six months; mobile Internet users are Internet users who have used mobile phones to access and surf the Internet in the past six months but not limited to those who surf the Internet only via mobile phones. Surfing the Internet via mobile is becoming more important than surfing the Internet via computers, to the extent that the number of mobile Internet users is increasing much faster than the number of normal Internet users, although it has emerged very late.

The Internet has also changed the information environment. On the one hand, the Internet, as an informal channel that is less controlled by the government, is acting as a potential facilitator that can provide a relatively objective interpretation of the happenings and facilitate the public's own subjective interpretations. On the other hand, it is also capable of bridging the distance that often separates people (Goldsborough, 2001), given the fact that people have a desire to reach out to others.

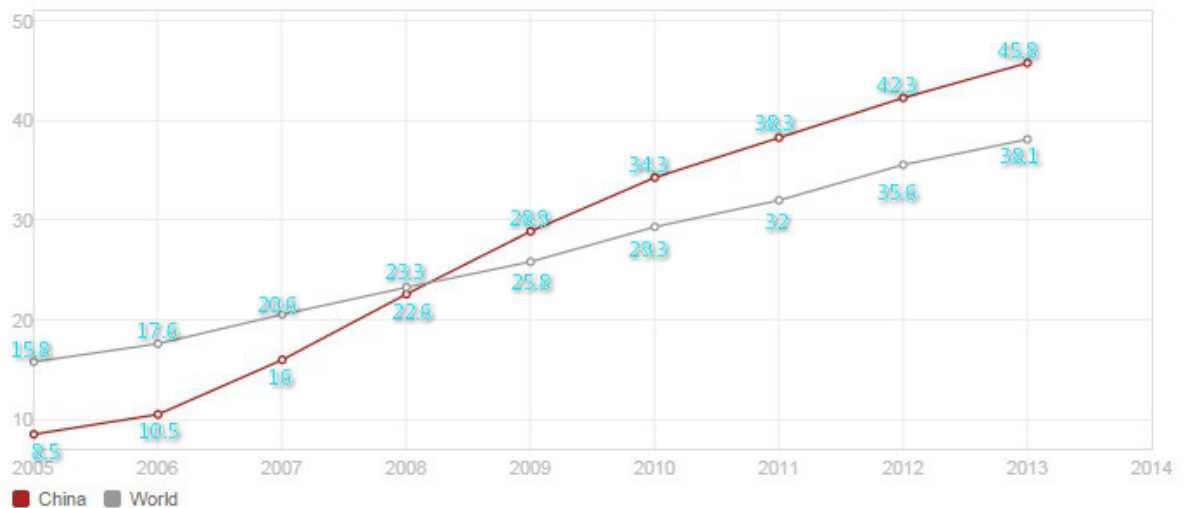


**Figure 2-2 Growth in the number of Internet users in China**<sup>39</sup>

According to modernisation theory, media expansion and access to the media will develop civil society and encourage citizens to become politically active, which influences policy and politics and even leads to democratisation (e.g. Lerner, 1958, Huntington, 1991, Gunther and Mughan, 2000, Dahlgren, 2000, Diamond, 2002). Figure 2-3 compares the number of Internet users in China and around the world. The growth in the number of Internet users in China has occurred much faster than it has in the rest of the world. Chinese Internet users account for 23.2% of the global online population and 55.4% of the Asian online population (Internet World Stats, 2010). However, even the faster-than-ever Internet expansion did not change China's political system. Instead, The CCP's control of

<sup>39</sup> Source: 'Statistical Report on Internet Development in China' from the China Internet Network Information Centre, <http://www1.cnnic.cn/>.

China persisted after the collapse of the Soviet Union, the Colour Revolutions, and the Arab Spring. The Chinese government rides the waves of the media because the media develop two lines: the party line and the bottom line (Zhao, 1998b, Huang and Hao, 2008). The party line is to obey government control, while the bottom line is to survive in the market without government funding. In other words, the government tolerates the media's publishing of reports that can expand their circulation but not challenge the party line – the rule of the CCP.



**Figure 2-3 Growth of Internet users (per 100 people) in China and around the world<sup>40</sup>**

As mentioned previously, since the media commercialisation, the media have been given leverage to report news as long as they do not challenge the bottom line. I will discuss how the media use this leverage to influence health policy change and consider different types of media, namely traditional media and new media, official media and non-official media, and mainstream media. First, the main news carriers include traditional media (originally using radio, TV, and newspapers) and new media (mainly relying on modern technology, e.g., the Internet). The main difference between these two types of media is new media have focus on interactions with the public and thus have more spaces for public to express their idea than the traditional media. Second, official media (mouthpieces of the government) have strong financial and institutional support from the government. In contrast, non-official media (set up by private enterprises based on market rules) largely depend on circulation and advertising, and they tend to provide a critical standpoint on political and social issues. Third, there are mainstream media and non-mainstream media. Mainstream media are very influential and mainly report political, social, and economic

<sup>40</sup> Source: World Development Indicators from the World Bank.

news and thus tend to have credibility among the public, with large circulation and broad coverage. Non-mainstream media have the opposite traits. I will only discuss the mainstream domestic media because media without credibility have limited influence.<sup>41</sup>

In this thesis, the interaction between the media and experts is considered a ‘mutually beneficial’ relationship. On the one hand, ‘experts now can leverage the press to form public opinion in order to exert pressure on the government’ (Zhu, 2013). On the other hand, media broadcast experts’ sources of information and commentary play a key role in amplifying their credibility and influence (Stone, 2006). The strict control of the media does not allow citizens’ disagreement to be covered by the media. However, citizens are tired of listening to one-sided stories in which ordinary citizens express their agreement with government policies because, throughout the CCP’s history, the propaganda system has arranged for citizens to voice their loyalty and support.<sup>42</sup> As a result, the media have to rely on a third sector (e.g., experts) with professional expertise and intelligence to strengthen cogency and attract both the public and the government, which enhances the credibility of the media and the influence of the experts.

### **International organisations**

International organisations influence health policy change with international pressure and regulations, funding, and advanced techniques and research. Regarding the actual carriers of the impact, the research on how international organisations affect domestic policy and politics is mainly conducted from two perspectives, the impact of formal organisations and the impact of informal networks. First, there are two kinds of formal organisations, intergovernmental organisations (IGOs) and nongovernmental organisations (NGOs). IGOs primarily consist of sovereign states, such as the United Nations, the WHO, and the World Bank. NGOs are non-profit organisations, such as Oxfam and Greenpeace. Both IGOs and NGOs are run by treaties, which are agreements, protocols, covenants, or conventions under international law (Shaw, 2003). In this thesis, I focus on IGOs’ influence on China’s health policy change because international NGOs’ behaviour is still restricted in China (Ho and Edmonds, 2007, Morton, 2005).

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<sup>41</sup> The international media in China was still underdeveloped in 2003-2009 and thus had limited influence on the public and policy. I excluded the international media from this research.

<sup>42</sup> Interview with 024, a senior journalist at the Xinhua News Agency, 10/02/2013 Beijing.

However, there are still two different kinds of IGOs: the ones within a foreign government, such as UK Department for International Development (DFID) and the ones consist of a few foreign countries, such as the WHO. The former ones represent a foreign country and are easily doubted about the intentions; while the latter ones are considered as neutral, because and do not belong to any countries. Therefore, these two different kinds of IGOs do not influence the policies in the same way. For instance, if the DFID pushes the Chinese government to change health policies, it might be easily considered interference in the internal affairs; while the WHO's pushing will be considered as effort for all human beings by a global health authority.

Second, research has been conducted on how informal international networks, such as epistemic communities, influence a country's domestic policy. Haas (1992) refined the concept of epistemic community (with experts mainly in natural science and engineering) to explain international cooperation and argued that this transnational network of professionals could influence state interests, issue framing and subsequent negotiations, and even policy formulation. However, the influence of informal international networks on China's domestic policy is limited because China lacks a developed domestic epistemic community to cooperate and engage with the global epistemic community (Zhao, 2006). For example, in the area of medical policy, the lack of an indigenous knowledge-based epistemic community to engage with global counterparts inhibits systemic change in China's medical policy, although China signed the Agreement on Trade Related Aspects of Intellectual Property Rights, which pushes for affordable medicines (Lee and Chan, 2014).

To play an active and prominent role in the international society, 'China has joined or is seeking to gain entrance to the key accords and treaties' (Economy, 2001). Therefore, China must accept the regulations of the international organisations (although not always), which will influence China's domestic policy. For instance, the interaction between IGOs and China shapes the context in which decisions are made by taking Chinese experts with access to China's leaders into international discourse and developing new ideas, values, frameworks, and orientations among China's leaders (Economy, 2001).

IGOs apply the carrot-and-stick approach to influence China's health policy change. First, the IGOs impose pressure on the Chinese government and force them to accept and face problems internationally and domestically. For instance, because of the initial failure to acknowledge the seriousness of SARS by the Chinese government, the Special ASEAN Leaders Meeting on SARS held in Bangkok in April 2003 initially excluded China (Chan



et al., 2009). However, China took the initiative to make a request to participate in the summit. In the meantime, various embassies in Beijing and Guangzhou also sent information (mostly gossip and rumours because of the lack of official information) to the WHO and their own home countries, which in turn pressured the Chinese government to release SARS information and take action (Schnur, 2005).

Second, pressure alone is not enough to influence China's health policy because the Chinese government and the public might interpret the pressure as interference in China's domestic issues. Therefore, IGOs also take a soft and indirect approach by providing aid, personnel training, and technique guidance. For instance, 'from 1982 to 2009, China received a total of \$86.5 million of regular budget from the WHO' (Jing et al., 2011).<sup>43</sup> The IGOs (e.g., the WHO and the DFID) trained China's medial workers, health experts, and policymakers with cutting-edge health research and knowledge, so they were able to use their knowledge in China and influence China's policymaking (Bloom et al., 2009, International Development Committee of Great Britain, 2009). Furthermore, the IGOs (e.g., the WHO, the American CDC, and the DFID) also provided practical technical guidance in pilot projects conducted in China, and the evaluation and feedback became policy evidence (Bloom et al., 2009). Finally, the IGOs shared samples and other disease-related information with the Chinese government and research institutions to strengthen the global disease research capability (Huang, 2013).

To strengthen their influence, IGOs must collaborate with domestic experts and the media. As previously discussed, IGOs need the support of China's experts with access to China's leaders to deliver new ideas and inspire new thought. IGOs also need the media to provide the Chinese public with information from outside China, although the IGOs must comply with the Chinese rules that all information given to the media should be discussed with the Chinese government first.<sup>44</sup>

## 2.6 Summary

This chapter has provided contextual information to help understand how policy outsiders can influence health policy change, and was explained the choice of three outsiders for

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<sup>43</sup> Direct aid from the international society started to decrease after 2008 because the WHO cited China as a model of health policy development and encouraged China to offer aid to developing countries, such as African countries, instead of receiving aid. Interviews were conducted with a few MOH officials in Beijing.

<sup>44</sup> I will discuss this further in Chapters 4 and 6.

analysis: experts, the media, and international organisations. I argue that historical, ideological, political, and institutional factors define the context in which the Chinese government has opened the policy process to the PEC so that the organisations, with their expertise and capability, have opportunities to influence health policy change.

First, the historical health policy development in China has two consequences: previous health policies led to the problem of unaffordable and inaccessible healthcare, and the problems offered opportunities to outsiders to help the weak and marginalised MOH to regain their power and position in the central government and to set health on the agenda as a state development priority. Thus, outsiders in possession of expertise and knowledge became important in the process of the health policy change.

Second, ideology also plays an important role in health policy. It influences the extent to which policy outsiders can affect health policy, as decision-makers are more likely to take the advice of those whose ideas are close to their own. Decision-makers' ideology is not fixed and permanent, which means that policy outsiders also need to pay attention to ideological transitions to exert an effective influence on the making of health policy. In addition to a dominant ideology, the existence of multiple other ideologies results in debates in the health field. The debate concerning traditional Chinese medicine and Western medicine and the debate between the pro-government and pro-market factions over the health care reform plan are, in essence, debates on different fundamental ideologies, which have a tremendous influence on health policy change and healthcare reform.

Third, regarding the political system, although the leadership transition from Jiang and Zhu to Hu and Wen at first inhibited the fight against SARS, it resulted in changing the state development principle from economic development to social welfare, which favoured the setting of health issues on the agenda. The fragmentation of the healthcare system created fissures for outsiders in possession of information, expertise, or channels of information to enter the health policy process and influence health policy change. Outsiders can take advantage of fissures created by the fragmentation and enter the policy process. First, the outsiders include alliances of bureaucracies to bargain for their mutual interest. Second, the outsiders reconcile the different interests between the bureaucracies and glue the bureaucracies together with mutual interests, forming stronger collective bargaining power. Third, the outsiders deliver valuable information to the government in the policy process. Fourth, the outsiders serve as referees between bureaucracies with different interests. To

balance different interests, the upper-level governments need a third party with expertise to value and coordinate different interests. Experts and international governments thus can coordinate and shape the different interests in the policymaking process and influence the resulting policy.

Fourth, the institutional design within the central government resulted in a policy hierarchy, while the functional differentiation led to ambiguous policymaking, which gave opportunities for the outsiders to move within the central government as referees and intermediaries and to bridge the gaps among functional departments. The setting of research institutions within the government and the staff movement among them constitute a loose policy community, through which ideas flow in and out of the government. The policy community is thus a channel and an idea pool for policy change. These constitute the institutional ground for outsiders to have an impact on health policy change in China.

The historical, ideological, political, and institutional context contributed to the openness of the health policy process to outsiders. The technocracy determines the technical capacity of the outsiders that are highly valued by the government. The government needs outsiders' expertise on knowledge and technology for decision-making.

In this thesis, I chose three types of policy outsiders, experts, the media, and international organisations, to assess their influence on China's health policy change from 2003 to 2009, as they exerted a constant influence on health policy throughout the period as a coalition. Both individual experts and groups of experts were able to influence policies. The commercialisation of the media in China gave the media some space to influence policy in a regulated way. The influence of international organisations requires a carrot-and-stick approach. Having explained the context of the policy change in this chapter, I will explain how health policy changed from 2003 to 2009 in the next chapter.

### 3 Health policy change in China from 2003 to 2009

Chapter 2 showed that, within different historical, ideological, political, and institutional contexts, health policy can change and policy outsiders can influence the change. This chapter and the following three chapters, discuss health policy change in China and outsiders' influence on it. This chapter focuses on the health policy change that occurred from 2003 to 2009, after the SARS outbreak. I argue that, from the SARS outbreak that began in 2003 to the start of the healthcare reform initiative in 2009, health policy systematically underwent both normal and paradigmatic changes.

Health policies during the SARS outbreak, particularly SARS policies, changed from passive defence to a proactive initiative, which greatly contributed to dramatically different responses to the crusade against SARS in 2003 (Ahmad et al., 2009, Balasegaram and Schnur, 2006). After the SARS outbreak, health system policy embraced a mixed approach with government leading and market supplementation (Zhang, 2011), where the nature of health services was redirected toward focusing more on public welfare.

The health policy change that began in 2003 in China was not a one-off shift in response to a public health emergency but a continuing dynamic policy movement even after the crisis of the SARS outbreak. I will analyse leaders' oral and written instructions, laws, administrative regulations or orders, decrees, governmental plans, programs, instructions, and reports to discuss the health policy change, beginning with the SARS policies and extending to the whole healthcare system step by step. The first section discusses concepts of health policy and policy change. The second section analyses the health policy change in China from 2003 to 2009 in terms of SARS treatment policies, SARS control policies, health information policies, and healthcare reforms policies. The third section further discusses the paradigm shift in the overarching goals of the health policy. The fourth section summarises the argument.

#### 3.1 Health policy change

China's health policy contains goals for future development as well as detailed plans on how to accomplish the goals. 'Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society', which 'defines a vision for

the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people' (WHO, 2011). As discussed in Chapter 2, health policy in China could be classified as goals, principles, practical guidance, and plans based on the hierarchies of the departments that set the policy. The goals and principles are set by the organ of supreme power, such as the Political Bureau or the State Council (SC). The practical guidance and plans are developed by ministerial departments and governmental departments, such as the Ministry of Health (MOH), the Ministry of Finance (MOF), and its divisions, whose administrative regulations have legal and political validity.

Policy change is the process of substituting one or several policies for the current policy or policies, which includes the abandonment, amendment, adjustment, revision, and termination of a current policy and the implementation of a new policy (Anderson, 1975). There are two patterns of policy change: normal change and paradigmatic change. First, a policy is a continuation of the past policies and practices, and even a new policy originates from an existing policy, which is described as an 'incremental' fashion (Hayes, 1992). In this pattern of normal policy change, coherence between the two policies can be maintained. Second, paradigmatic policy change is a dramatic change that presents a major 'reconceptualisation and restructuring of policy' that involves 'periods of stabilities and incremental adaptations interspersed by periods of revolutionary upheaval' (Howlett and Ramesh, 1998 p.471). The policy process was three central elements, overarching goals, policy instruments and the precise settings of these instruments (Hall, 1993). A change in the overarching goals leads to a change in the other two elements, and constitutes paradigmatic policy change, because the overarching goals guide policies in a particular field.

Health policy change involves normal changes in practical policies and paradigmatic changes in policy goals. In a narrow sense, health policies could be classified by function. For instance, treatment policies address disease treatment, and health information policies address the delivery of health information. These policy changes are usually normal changes because the changes are made mainly to practical policies rather than to goals. In a broader sense, health policies can include a wide range of policies related to the healthcare system, involving organisations, institutions, resources, people, information, and actions whose primary intent is to promote, restore, or maintain health (WHO, 2005c), such as comprehensive healthcare

system policies. These changes are usually paradigmatic changes because the fundamental change in the healthcare system results from a change in the overarching goals.

## **3.2 Health policy change in China from 2003 to 2009**

Since the SARS outbreak, health policy in China has changed dramatically. I will discuss the change in SARS treatment policies, the change in SARS control policies, the change in the health information policies, and the change in health policy direction. The first two are normal policy change; the third one involves process of both normal and paradigmatic change; while the fourth one is a paradigmatic change.

First, in dealing with an epidemic disease, whether or not the disease can be treated effectively greatly determines the success of disease control. The change in the SARS treatment policies from no treatment to rifampicin, an inappropriate treatment method, and then explicitly to corticosteroid treatment significantly influenced the effective treatment of SARS. Second, since the key points of the government's response changed from treatment policies towards control policies, there were series policies changes, including SARS control policies within the hospitals, medical workers protection and motivation policies, SARS isolation policies. Third, the successful control of SARS also benefited from the change in information reportage policy, which continued even after the SARS outbreak. From 2003 to 2009, the health information reportage policies changed from strict control of SARS information to opening up with regulations, which eventually contributed to the building of a disease prevention and control system. Fourth, the health policy direction changed from marketisation to a mixed approach of government leadership and market supplementation after wavering between the two directions.

### **3.2.1 The change in SARS treatment policies**

SARS treatment policies are health policies for SARS treatment. To set accurate treatment policies, 'prompt recognition and identification is the initial and indispensable step in facing any communicable diseases' (Petrosillo et al., 2005 p.707). However, the Chinese government was neither prompt nor accurate in recognising the cause of SARS, which negatively influenced the treatment policy.

From November 2002, when the first SARS case appeared in Guangdong Province, to January 2003, there was no national SARS treatment policy, but there were some clinical trial policies in Guangdong. In January 2003, a few health experts wrote an investigative report, ‘Investigation Report of Unknown Disease in Zhongshan from the Guangdong Expert Group’ (*Guangdong zhuanjiazu guanyu Zhongshanshi bumingyuanyin feiyan diaocha baogao*) (Guangdong Experts, 2003) to the Health Department of Guangdong Province, which recommended corticosteroids as a preliminary trial treatment for the unknown disease.<sup>45</sup> Together with traditional Chinese medicine (TCM) treatment, the whole set of methods was copied into ‘Working Guidance for Guangdong Hospitals Taking and Treating SARS Patients’ (Health Department of Guangdong Province, 2003) – the official health policy of Guangdong Province – on 11 March 2003. However, the central government denied the existence of SARS at the same time. Therefore, there was no national treatment policy.<sup>46</sup>

From February to April 2003, the national SARS treatment policy recommended rifampicin based on the chlamydia bacteria found by the China Centre for Disease Control (CDC). On 18 February 2003, the MOH said that they believed that the original cause of SARS was chlamydia.<sup>47</sup> The China CDC formally confirmed the finding via China Central Television (CCTV) and recommended rifampicin<sup>48</sup> as the ‘special effective’ treatment (Fu, 2003).<sup>49</sup> The MOH then set rifampicin treatment based on the chlamydia finding as the first national SARS treatment policy (Wong and Zheng, 2004), although experts in Guangdong who drafted the investigation report strongly opposed the measure.<sup>50</sup>

From late April 2003 to the end of the SARS outbreak, the national SARS treatment policy was changed to corticosteroids with supplementary TCM treatment. On 14 April 2003, the real

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<sup>45</sup> Corticosteroids are a class of chemicals that includes steroid hormones naturally produced in the adrenal cortex of vertebrates and analogues of these hormones that are synthesised in laboratories. There is still scepticism and controversy regarding the use of corticosteroids, centering on their effectiveness, adverse immunosuppressive effects, and impact on final patient outcomes.

<sup>46</sup> I will discuss this issue further in Chapter 4.

<sup>47</sup> Chlamydia is a genus of pathogenic bacteria.

<sup>48</sup> Rifampicin is a bactericidal antibiotic drug of the rifamycin group.

<sup>49</sup> Although the CCTV reported the China CDC’s finding of the virus, it downplayed the seriousness of the unknown and highly transmissible characteristics. Instead, it asserted that the disease was under control and told the public to calm down without taking precautions.

<sup>50</sup> I will discuss this issue further in Chapter 4.

cause of SARS, ‘SARS coronavirus<sup>51</sup> (CoV), ‘was isolated by the cooperation research team of Guangdong local experts together with Hong Kong University’ (Allegra, 2007 p.58) and formally confirmed by the WHO on 16 April (Thiel, 2007). Therefore, corticosteroids, which Guangdong experts supported, were cited in ‘Clinical Diagnostic Criteria and Recommendation Treatment for SARS’ (MOH, 2003a) as the national treatment policy that explains how to use corticosteroids to treat SARS patients of different ages with different infection situations.

Time	Central Government	Guangdong Local Government
November 2002–January 2003	No treatment policy	Preliminary: corticosteroids
February–April 2003	Policy of using rifampicin (chlamydia)	Policy of using corticosteroids with supplementary of TCM treatment (CoV)
April 2003	National treatment policy of using corticosteroids with supplementary TCM treatment (CoV)	

**Table 3-1 The change in SARS treatment policy**

Table 3-1 shows a brief pattern of the normal change in the SARS treatment policies. The goals of the policies remained the same for SARS treatment, but the settings changed. First, there was a preliminary trial of corticosteroid use in Guangdong but no such policy at the central level. Second, the central government set the rifampicin treatment policy based on the chlamydia finding, while the Guangdong government opposed it and insisted on using corticosteroids. Finally, the central government changed the national policy to adopt corticosteroid treatment.

### **3.2.2 The change of SARS control policies**

The central government’s key points of responses towards SARS gradually changed from treatment policies to control policies in the end of April. In late April, then President, Hu Jintao, gave a speech, in which he changed the principle from ‘mass prevention and treatment’ (*qunfang qunzhi*) to ‘mass prevention and control’ (*qunfang qunkong*). The prevention and control policies changed around the same period. There are three parts of the disease

<sup>51</sup> The SARS coronavirus, sometimes shortened to SARS-CoV, is the virus that causes severe acute respiratory syndrome (SARS).



prevention and control policies: SARS control policies within the hospitals, medical workers protection and motivation policies, SARS isolation policies.

First, the policies of SARS control within the hospitals changed dramatically. ‘The hospitals acted as major sites for transmission and multiplication of SARS cases’ (Ahmad et al., 2009 p.40). Because the then pandemic disease control policies within hospitals were outdated and not effective for an unknown high infectious disease. During the outbreak of SARS the policy, which was used for infection control within hospitals was the one launched in 2000, named ‘Measurements of hospital infection control (trial)’ (*yi yuan gan ran guan li gui fan shi xing*). However, the details of the measurements were ambiguous. For instance, the words like ‘use necessary methods’ (*cai qu bi ya o de cuo shi*) or ‘use relevant methods’ (*cai qu xiang guan cuo shi*) were quite common in the policy without giving clear guidance on how exactly the medical staff should control the infection within the hospitals (MOH, 2000). The direct result of the outdated infection control policy within the hospitals was that there were more SARS cases infected within the hospitals than outside the hospitals.<sup>52</sup>

In April 2003, some new policies added more details of disease prevention and control measurements. ‘Emergent notice of SARS cross-infection control within hospitals’ (*wei sheng bu bangongting guan yu jin yi bu zuo hao yi yuan fei dianxing fei yan zhen liao gong zuo zhong fang zhi jiao cha gan ran gong zuo de jin ji tong zhi*) and its attachment ‘Standard of SARS antisepsis and quarantine within hospitals (trial)’ (*yi yuan shou zhi fei dianxing fei yan bing ren xiao du geli gong zuo gui fan shi xing*). In the two updated policies, there were specific procedures which medical workers and hospitals need to follow while dealing with SARS patients (MOH, 2003n, MOH, 2003h). The hospitals in Beijing began to isolate cases since late April. The Chinese government even built a special hospital only for SARS cases, *Xiaotangshan* Hospital, in late April to move separate SARS cases from normal patients.

In May 2003, the MOH issued ‘Guiding principles of SARS infection control within hospitals (trial implementation)’ (*chuan ranxing fei dianxing fei yan yi yuan gan ran kong zhi zhi dao yuan ze (shi xing)*). This policy drew lessons from the experience of the work of SARS and focused mainly on three parts. It separated clearly different types of control methods within the hospitals, including outpatient service, observing room, suspected cases and SARS cases.

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<sup>52</sup> Interview with 008, senior official of the China CDC, Beijing, 26/09/2011.

It listed detailed methods, including air sterilisation, ground and surface sterilisation, patient direct relevant stuff sterilisation, sewage and dead body dispose (MOH, 2003l).

Second, the policies of medical worker protection changed. There were limited policies on how to protect medical workers. As a result, the medical staff did not have a clear guidance to rely on while dealing with SARS in the very beginning or have a sense of self-protection from the disease. At the early stage of SARS, ‘medical workers were the first group of infected people and were transmission link of hospital infection’ (Wei et al., 2003 p.703). SARS was the very disease that hits the record of number of infected medical staff (Wei et al., 2003). But ‘Emergent notice of SARS cross-infection control within hospitals’ firstly confirmed that the priority of the medical work was the patient quarantine and medical staff protection (MOH, 2003h). ‘Guiding principles of SARS infection control within hospitals (trial implementation)’ further specified medical staff protection guidance, including three levels protection based on the direct contact with patients. Because of the changed policy, medical staff knew more about protecting themselves and preventing disease spread and cross infection in hospitals. Consequently, the infection rate of medical staff decreased sharply (Wei et al., 2003).

Moreover, in order to encourage the medical workers to fight against SARS, there were series policies issued. For instance, originally, the medical workers were not covered by insurance (China Youth News, 2003b). It greatly de-motivated the medical workers who faced dangers in the hospitals with high infection rate. But the insurance policy change in April 2003. The SC promulgated ‘Industrial Injury Insurance Regulations’ that, for the first time, confirmed that the infection of medical staff while dealing with SARS is considered occupational injury and should be insured (State Council, 2003d).

Third, besides SARS control within the hospitals, the Chinese issued policies to control the SARS spread in the society. For instance, the MOH issued ‘Emergency Notification of Health and Quarantine Work in Ports during SARS’ (*guanyu jiaqiang kou'an feidian weisheng jianyi gongzuo de jinji tongzhi*) which controlled the infections via transportations (MOH, 2003f). The MOH also issued ‘Guidance of SARS Treatment and Control in Rural Area’ (*guanyu jiaqiang nongcun chuanranxing feidianxingxing feiyan fangzhi gongzuo zhidao yijian*) which controlled the SARS spread in the rural area with weak health services (MOH, 2003j). Besides, in late April the Chinese government suspended all primary and secondary schools in

Beijing for two weeks and strongly recommended the citizens to avoid going to public places (Abraham, 2005).

The changes of SARS control policies within the hospitals, medical workers protection and motivation policies, SARS isolation policies were further legalised in two ‘Regulations of Public Health Emergencies’ (*tufa gonggong weisheng shijian yingji tiaoli*) (State Council, 2003e) and ‘Law of the People's Republic of China on the Prevention and Treatment of Infectious Diseases’ (*zhonghua renmin gongheguo chuanranbing fangzhifa*) (NPC, 2004). But those changes were normal policy change because the goal remained the same -- SARS control.

### **3.2.3 The change in health information reportage policies**

Apart from the change in the treatment policies, the change in health information policies also contributed to the control of SARS. The health information policies consist of two types of policies, media reportage policies for delivering information to the public, and disease surveillance policies for delivering information within the government. The media reportage policies not only warned the public of the disease, thus contributing to disease prevention, but also started to address the public's right to know by pushing the government to open the information flow; the disease surveillance policies not only helped to control SARS but also benefited the surveillance of other diseases. The changes in the information reportage policies persisted even after the SARS outbreak.

#### **The change in media reportage policies**

From November 2002 to March 2003, media reports of SARS were strictly controlled at the national level. Although there were rumours of the spread of an unknown disease via mobile text messages and the Internet as well as occasional local newspaper reports of the disease in Guangdong, there was very limited national media coverage of the existence of the disease or its infectiousness.<sup>53</sup>

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<sup>53</sup> I will discuss this issue further in Chapter 4.

However, from mid-April 2003, the government lifted the restrictions on the media reporting of SARS. For instance, although the first report about SARS in *People's Daily* appeared on 3 April 2003, asserting the government's effective response and control instead of providing explicit protection and control methods, it was not until 22 April 2003 that *People's Daily* started formally to report on the real infection situation according to the central government's daily report on SARS (Liao, 2010). The four biggest official media, *People's Daily*, *Guangming Daily*, *China Daily* and the CCTV started to report SAS news intensively between early and middle of April, although the reports mainly focused on efforts of the CCP and the government (Zhang, 2003).

The change in the media reportage policy continued and was formally legalised after the SARS outbreak. In August 2004, the Propaganda Department of the CCP launched a new policy, 'Regulations for Improving and Strengthening Media Reporting of Domestic Emergencies' (*Gaijin he jiaqiang guonei tufa shijian xinwen baodao gongzuode ruogan guiding*), which formally confirmed the media's responsibility for information disclosure (Propaganda Department, 2004). In August 2005, the Ministry of Civil Affairs and State Secrets Bureau published a policy, 'Notice of Declassification of Death Toll and Related Data of Natural Disasters' (*Guanyu ziran zaihai daozhide siwang renshu zongshu jixiangguan ziliao jiemide tongzhi*) that abolished the conservative confidentiality of the information that should be open to public; and further indicated that the death toll caused by natural disasters should be published publicly in a timely manner (Ministry of Civil Affairs and State Secrets Bureau, 2005). In January 2006, the SC published 'National Contingency Plans for Public Health Emergencies' (*Guojia tufa gonggong weisheng shijian yingji yu'an*), which not only detailed media reportage requirements in terms of time, accuracy, objectivity, and comprehensiveness but also provided for punishment of those who delay, lie about, and conceal information from the public. In August 2007, the National People's Congress (NPC) published a new law, the Emergency Response Law of the People's Republic of China (*Zhonghua renmin gongheguo tufa shijian yingduifa*) which supported media reportage of emergencies with the highest legal force (Hu, 2007g). In May 2008, 'Regulation of Government Information Disclosure' (*Zhonghua renmin gongheguo zhengfu xinxi gongkai tiaoli*) clearly defined the government's legal duty (*fading yiwu*) of information disclosure via the media and set out the media as a crucial channel for government publicity (State Council, 2007b).

Table 3-2 shows that the media reportage policies changed from strict control to opening up since the SARS outbreak. In 2003, although the government did not allow the media to report on SARS in the beginning, the restriction was eventually lifted, which contributed to the fight against SARS. However, the change towards opening up was not formally institutionalised until later by the change in a series of policies. The scope of the media reportage expanded from a particular disease, namely SARS, to general public health emergencies, and then to general natural disasters. These policies were set by different levels of government, from ministerial departments to the SC and the NPC, and thus had increasing legal and political force. The media reportage policies not only gave legal force to the media but also forced the government to open the information to the media actively.

Time	Department	Policy or norm
November 2002– March 2003	N/A	Strict control
April 2003	N/A	Control lifted but focusing on propaganda
August 2004	Propaganda Department	Regulations to improve and strengthen media reports of domestic emergencies
August 2005	Ministry of Civil Affairs; State Secrets Bureau	Notice of declassification of death toll and related data on natural disasters
January 2006	SC	National Contingency Plans for Public Health Emergencies
August 2007	NPC	Emergency Response Law of the People's Republic of China
May 2008	SC	Regulation of government information disclosure

**Table 3-2 The change in media reportage policies**

However, the media reportage did not become as free as in the West. Although, compared to the media reportage before 2003, the government gave legal rights to the media, the government regulated the media reportage. Therefore, the media's leeway was still limited. For instance, the Emergency Response Law of the People's Republic of China stated that the government should tell the public about the forecast, analysis, and evaluation of the emergency timely while regulating the related media reportage (*bingdui xiangguan xinxi de baodao gongzuo jinxing guanli*).

## The change in disease surveillance policies

A disease surveillance system is significant in an epidemic response because it is the first layer of protection that dispatches emergency workers and guarantees the safety of health workers in legitimate ways (Gates, 2015). However, when the SARS outbreak occurred, there was no such system in China. The system was then built via changes in a series of disease surveillance policies.

There was no functioning disease reporting system for SARS during the SARS outbreak. First, the sanitation and anti-epidemic stations (*weisheng fangyizhan*) that were supposed to supervise and report epidemic disease at the local level had lost function since the 1990s because of a lack of financial support (Huang, 2013). Second, under the existing epidemic disease reporting policy, SARS, a new disease did not fall into any category that should be reported to the health departments (NPC, 1989).<sup>54</sup> There were no guidelines to follow regarding whether and how to report a new disease. Furthermore, the healthcare system was fragmented and separated into the MOH, military, and state-enterprise systems,<sup>55</sup> where SARS cases were dispersed. Therefore, there was no unified system to supervise and report the infections.

The policies on SARS surveillance started to change in April 2003. On 8 April 2003, the MOH issued ‘Notification of Classifying SARS as Legal Infectious Disease’ (*Weishengbu guanyu jiang chuanranxing feidianxing feiyan lieru fadingguanli chuanranbingde tongzhi*), which classified SARS into an existing epidemic disease category that should be reported to the MOH based on the existing disease reporting policy (MH, 2003b). Days later, two further supplemental policies were issued, namely ‘Emergency Notice of Regulation of SARS Reports’ (*Weishengbu guanyu guifan chuanranxing feidianxing feiyan yiqing baogaode jinji tongzhi*) and ‘Further Emergency Notice of Regulation of SARS Reporting Work’ (*Weishengbu bangongting guanyu jinyibu jiaqiang chuanranxing feidianxing feiyan yiqing baogao gongzuode jinjitongzhi*). These two policies specified the channel and format by which SARS should be reported, i.e., through the use of a standardised disease report form (MOH,

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<sup>54</sup> The existing policy categorised three types of diseases that should be reported to the health departments but did not state what to do about a new disease that did not fall into an already defined category.

<sup>55</sup> I discussed this issue in Chapter 2.

2003e, MOH, 2003c), based on which local health units (the CDCs and hospitals) started to submit information on SARS cases using a secure Web-based system (Wang et al., 2008b).

The policy change went beyond reports of SARS to include disease surveillance using this Web-based-system. The government established a national disease reporting and information management system in 2003 (Gu, 2004). In November 2003, the MOH issued ‘Management Measures for Epidemic Situation Surveillance Reports of Public Health Emergencies’ (*Tufaxing gonggong weisheng shijianyu chuanranbing yiqing jiance xinxi baogao guanli banfa*) (and an amendment in 2006), which formally regulated the use of a more advanced online electronic reporting system for systematic and accurate disease reports (MH, 2003a). This system was later called the China Information System of Disease Prevention and Control (*Jibing yufang kongzhi xinxi xitong*) (CISDCP).<sup>56</sup> In 2004, the Law of the People's Republic of China on the Prevention and Treatment of Infectious Diseases (*zhonghua renmin gongheguo chuanranbing fangzhifa*) legalised the use of the CISDCP to supervise and report disease. In January 2005, the MOH issued ‘Regulations Establishing a Disease Prevention and Control System’ (*Weishengbu guanyu jibing yufang kongzhi tixi jianshede ruogan guiding*) to detail the disease reporting system development in terms of timely and case-based reporting, by which over 93% hospitals and clinics from the central to the township level could timely report independent disease cases (not only epidemic diseases) with detailed information, such as age, sex, occupation, and area (Wang et al., 2008a). Since 2005, the MOH has issued a yearly series of policies, ‘Key Points of Disease Prevention and Control (Patriotic Sanitation)’ [*Jibing yufang kongzhi (aiguo weisheng) gongzuo yaodian*], and continued to develop the disease reporting system, via which most of the health units (e.g., hospitals, clinics, health bureaus, and CDCs) are connected and deliver a broad range of health information in a timely and accurate manner.<sup>57</sup>

Table 3-3 shows that the series of policies improved the disease reporting system step by step. The range of reported diseases broadened from a few epidemic diseases to general diseases. The legal force of the policies increased along with the upgrading of the issuing department of

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<sup>56</sup> For more information, please see

<http://1.202.129.170/UVSSERVER2.0/login?fromSmp=true&fromCDC3=true&service=http%3A%2F%2F1.202.129.170%2Fportal%2FcasAuthUser%3Fvsite%3Dguojia> (accessed 6/9/2014).

<sup>57</sup> Interview with 004, a senior director of the China CDC, Beijing, 19/09/2011.

the political hierarchy from the MOH to the NPC. The policies thus improved accurate and timely reporting by building a comprehensive Internet-based disease reporting system.

<b>Time</b>	<b>Department</b>	<b>Policies</b>
Before April 2003	NPC	Law of the People's Republic of China on the Prevention and Treatment of Infectious Diseases (1989)
8 April 2003	MOH	'Notification of SARS Involvement in Legal Infectious Disease'
April 2003	MOH	'Emergency Notice of the Regulation of SARS Reports' & 'Further Emergency Notice of Regulation of SARS Reporting Work'
November 2003 (amended in 2006)	MOH	'Management Measures for Epidemic Situation Surveillance Reporting of Public Health Emergencies'
2004	NPC	Law of the People's Republic of China on the Prevention and Treatment of Infectious Diseases
January 2005	MOH	'Regulations Establishing a Disease Prevention and Control System'
2005–present	MOH	'Key Points of Disease Prevention and Control (Patriotic Sanitation)', a yearly series of policies

**Table 3-3 The change in disease reporting policies**

To sum up, the change in China's health information policies involved both normal and paradigmatic changes. During the SARS outbreak, the goal was information control, but the goal changed to openness since the end of April 2003. This change was the paradigmatic change. Both the media reportage policies and the disease surveillance policies gradually underwent normal changes to build systematically the comprehensive reporting system. I will discuss further how and why due to the important role played by outsiders these policies changed in Chapter 4. However, the ailing healthcare system exposed by the SARS outbreak could not be fixed simply by changing these policies. Instead, a fundamental change in the healthcare reforms was needed.

### **3.2.4 The health policy change during healthcare reforms**

After the SARS outbreak, the Chinese government began to undertake healthcare reforms to fix the healthcare system problems, such as unaffordability and inaccessibility (Ge et al., 2005). Although the government formally issued a new reform programme in 2009, its opinions oscillated between stressing the role of the government to stressing the role of the market in the policymaking process. Therefore, instead of a one-off health policy change



beginning with the reform policies in 2009, the health policies changed between the pro-government and the pro-market direction between 2003 and 2009. I discuss this process in a chronology in this section.

The healthcare reforms were built on consensus between two factions, a pro-government faction and a pro-market faction (Wang and Fan, 2013). The reform policy consultations sparked a fierce debate between the factions, which I discuss further in Chapter 6. The pro-government faction was led by the MOH, which insisted that the government should dominate the healthcare reform by funding the supply side, such as public hospitals; the pro-market faction was led by the MOLSS, which insisted that the market should dominate the healthcare reform through government funding on the demand side, such as insurance companies (Duckett and Langer, 2013, Kornreich et al., 2012).

The Chinese government commercialised health from 1980s. In the 2000s, the Suqian city government commercialised and privatised most public hospitals, which was seen as a milestone of the health marketisation (Mu, 2006). Moreover, although the central government started the New Rural Cooperative Medical System (NCMS) with increased government funding at the end of 2002 to improve health services in rural areas, it followed the same pattern of marketisation by emphasising the role of the market in building health service networks in rural areas. '[The government will ] use market mechanism, attract social capital via various channels, and develop non-government medical institutions... the public health services could either be held by the government or purchased from the other health institutions' (State Council, 2002).

The government began to question the health marketisation immediately after the SARS outbreak. In August 2003, the MOH investigated the health marketisation in Suqian. Although there was criticism of the 'Suqian model', the debate between the pro-government and the pro-market factions within the MOH was unresolved (*Southern Weekend*, 2005).

The health policies turned slightly towards the pro-government direction. In December 2003, a few ministerial departments issued a policy, 'Notice of Further Building of the New Rural Cooperative Medical System (Trial)' (*Jinyibu zuohao xinxing nongcun hezuo yiliao shidian gongzuo zhidao yijiande tongzhi*) to guide the NCMS further. Unlike the 2002 NCMS policy,

this policy document did not include the ‘market’ (*shichang*), although it encouraged the input of the collective economy and non-governmental medical institutions in the NCMS. This policy repeated ‘farmers joining as voluntary’ and ‘listening to farmers’ opinions’. Moreover, it linked the NCMS to poverty alleviation and medical aid (MOH et al., 2003). Therefore, this policy had some public welfare elements in the sense that it stressed the government should listen to and care for people who could not afford healthcare services. In July 2005, the Minister of Health, Gao Qiang, made a public speech and criticised the health marketisation (Gao, 2005).

Later on, the health policies became neither pro-government nor pro-market but embraced a mixed approach instead. In October 2005, the China Insurance Regulatory Commission (*Shongguo baoxian jiandu guanli weiyuanhui*),<sup>58</sup> a ministerial department of the SC, issued ‘Guidance of Insurance Companies Joining Trials of the New Rural Cooperative Medical System’ (*Guanyu wanshan baoxianye canyu xinxing nongcun hezuo yiliao shidian gongzuode ruogan zhidao yijian*), which formally initiated the joint work of business insurance companies and the NCMS. ‘The insurance companies offer management services with the government commissions. The services include insurance calculation, reimbursement management, and settlement and payment. Insurance companies charge the government for management fees’ (China Insurance Regulatory Commission, 2005). Although the insurance companies do not take responsibility for the profits and losses of the NCMS fund, this policy first confirmed the role of the business sector in health risk protection and thus was a trial for a mixed approach. In February 2006, the SC issued ‘Guiding Opinions on the Development of Urban Community Health Services’ (*Guowuyuan guanyu fazhan chengshi shequ weisheng fuwude zhidao yijian*), which formally confirmed the leading role of the government and the supplemental role of the market. ‘Insist on the public welfare nature of community health services and focus on the fairness, efficiency, and accessibility of health services. The government should lead in community health, encourage social participation, and develop community health services via multiple channels’ (State Council, 2006a).

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<sup>58</sup> The China Insurance Regulatory Commission (CIRC) is authorised by the State Council to conduct administration, supervision, and regulation of the Chinese insurance market and to ensure that the insurance industry operates stably in compliance with law.

Later, the health policies became pro-market. In March 2007, Wang Jun, then the Vice Minister of Finance, told the media that the government should purchase public health services from third parties and invest in private hospitals (An, 2007). In July 2007, the SC published a new policy for medical insurance trials – ‘Directing Opinions Concerning the Development of Urban Residents’ Basic Medical Insurance Trials’ (*Guowuyuan guanyu kaizhan chengzhen jumin yiliao baoxian shidiande zhidao yijian*), which aimed to cover the medical insurance of unemployed urban residents. Compared to the previous policy centring on urban citizens in work, this policy increased healthcare accessibility to non-working citizens. However, it focused on the pro-market direction by channelling the funding to subsidise the medical insurance companies on the demand side (State Council, 2007).

The government issued a draft guideline on health system reforms for soliciting public opinion in October 2008 (State Council, 2008). In April 2009, two formal reform policies were launched to start the medical reform, ‘Opinions of the CPC Central Committee and the State Council on Deepening the Healthcare System Reform’ (*Guanyu shenhua yiyao weisheng tizhi gaigede yijian*) (hereafter referred to as ‘the Opinion’) and ‘Implementation Plan for the Recent Priorities of the Health Care System Reform (2009-2011)’ (*2009-2011 nian shenhua yiyao weisheng tizhi gaige shishi fang'an*) (hereafter referred to as ‘the Plan’).

The two formal reform policies contained aspects of both the pro-market and pro-government positions. ‘We shall insist on the public welfare nature of public health, adhere to guidelines giving priority to the disease prevention, focusing on rural areas and separate government administration from public institutions, strengthening the government's responsibility, [and] increasing investment’ (State Council, 2009c). The government will dominate the public health part, such as disease prevention and rural health, but market mechanisms exist in other parts, such as hospital management and the pharmaceutical industry. Healthcare services could also be profitable under the guidance and regulation of the government.

According to the Opinion and the Plan, to maintain healthcare’s public welfare nature, the government should dominate healthcare. ‘We shall strengthen the responsibility of government in the basic medical and health care system, increase the functions of government in the development of rules, planning, financing, services, supervision, etc., maintain the public nature of public medical and health care, and promote fairness and equity’ (State

Council, 2009c). The principle of the reform was ‘people-centred, putting people’s health rights first’ (*yiren weiben*). To provide basic healthcare to all citizens, the government would invest 850 billion yuan in the following three years, including 331.8 billion yuan from the central government (State Council, 2009a). The budget provided for more spending on health institutions than on social risk protection (Duckett, 2010k). Therefore, the government took the leading role in healthcare by prioritising the supply side over the demand side.

However, the Plan also refined and enhanced the role of the market. ‘We shall pay attention to the role of market mechanisms, mobilise social forces to participate, promote the formation of an orderly competition mechanism, and improve the operating efficiency, service level, and quality of medical and health care to satisfy the multi-level and diversified demands of the people for medical and health care’ (State Council, 2009c). In the draft guideline, essential medicines were still under the state control. ‘The government should control essential medicines with open tender and direct distribution; unified retail prices of medicine should be [set] on the basis of maintaining a reasonable profit in the production chain; ensure the production and supply of essential drugs’ (State Council, 2008). However, the Opinion stated that ‘efforts should be made to bring into full play the role of market forces in pushing forward the merger and restructuring of pharmaceutical manufacturing and distribution enterprises. Open tender and unified distribution shall be adopted for the procurement of essential medicines, and intermediary links shall be reduced to ensure the people’s access to essential medicines’ (State Council, 2009a). The change in the policy clarified the fundamental principle of an essential medicine system under the rules of a market economy. Compared to the vague guidance of the government on essential medicine prices, it is very clear that the market will be involved in the production and distribution of essential medicines via open tender.

Table 3-4 shows that the change in health policy direction involved both normal and paradigmatic changes. The healthcare reforms did not entirely exclude the goal of marketisation but confirmed the market’s role as long as it was conducted under the guidance of the government. After several rounds of switches, the health policy direction was changed to a mixed approach that combined the government’s leading role with the market’s supplementing role from the previous healthcare marketisation approach. I discuss in detail how these policies changed in Chapter 5 and 6. To sum up, the continued health policy change

went beyond the range of SARS, an epidemic disease, to the comprehensive healthcare system design from 2003 to 2009.

<b>Date</b>	<b>Events/Opinions/Policy</b>	<b>Department</b>	<b>Directions</b>
2000s	Suqian health privatisation and commercialisation	MOH	Pro-market
October 2002	‘Decisions Further Strengthening of Rural Health Work’	SC	Pro-market
August 2003	The MoH investigated Suqian	MOH	N/A
December 2003	‘Notice of Further Development of the New Rural Cooperative Medical System (Trial)’	MOH, MOF, Ministry of Agriculture, Ministry of Civil Affairs, National Development and Reform Commission, Ministry of Personnel	Pro-government
1 July 2005	Gao Qiang: the health reform has not been successful	MOH	Pro-government
October 2005	‘Guidance for Insurance Companies Joining Trials of the New Rural Cooperative Medical System’	China Insurance Regulatory Commission	Mixed
21 Feb. 2006	‘Guiding Opinions on the Development of Urban Community Health Services’	SC	Mixed
March 2007	Wang Jun: Government purchases health services from third parties	MOF	Pro-market
3 July 2007	‘Directing Opinions Concerning the Development of Urban Residents’ Basic Medical Insurance Trials’	SC	Pro-market
15 October 2008	‘Opinion on Deepening the Healthcare System Reform: Seeking Views’	SC	Mixed
7 April 2009	‘Opinions on Deepening the Medical and Health Care System Reform’ and ‘Short-term Major Implementation Plans for Medical and Healthcare System Reform’	SC	Mixed

**Table 3-4 The change in health policy direction during the health reform policymaking process**

### 3.3 Paradigm shift in the health policy's overarching goals

Not only were the health policies changed but also the overarching health goals in the national development strategies also were changed from being considered inferior to economic development to being considered as important as economic development. As discussed previously, the policy set by the decision-makers (e.g., the Political Bureau and the SC) is the principle and guideline of national development. The principle of national development includes the overarching goal of policy in different areas, such as health. Analysing the health-related aspects of the policy mentioned by decision-makers could reveal the change in the overarching health goals with respect to national development. I will analyse the change in the overarching goals of the health policy addressed in communiqués from the CCP National Congress (CCPNC) once every five years and the SC's working report of the National People's Congress's (NPC) annual session.<sup>59</sup>

There was a paradigm shift in the overarching goal of the health policy in the communiqués and the working reports. In theory, the CCPNC is at the top of the CCP pyramid, with the highest political power; the NPC is the highest state organ with legislative power, similar to a parliament in the West (Saich, 2011). Although scholars consider both congresses 'rubber stamps' because the decisions are usually made within the Political Bureau before the congresses consider them, decisions on national development are published in the form of communiqués and reports (Saich, 2011). The narrative on health in both documents is the guidance and principle of health within the national development strategy. A change in the overarching goals leads to a paradigm shift in health policy.

#### 3.3.1 The goal change in communiqués of the CCPNC

Two CCPNCs were held around the time of my research, the 16th Congress in 2002 and the 17th Congress in 2007. Before the SARS outbreak, the CCP did not take healthcare development seriously. Health was not part of the national development strategy. At the 16th Congress in 2002, CCP Secretary General Jiang Zemin presented a communiqué titled 'Build a Well-off Society in an All-Round Way and Create a New Situation in Building Socialism with Chinese Characteristics' (*Quanmian jianshe xiaokang shehui kaichuang zhongguo tese*

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<sup>59</sup> The CCPNC is usually held in autumn. The NPC is usually held in spring.

*shehuizhuyi shiye xinjunian*), which clearly set economic development as the priority and ignored health. ‘It is of vital importance to take economic development as the central task’ (Jiang, 2002). This report consisted of 10 sections,<sup>60</sup> but mentioned health (*weisheng*) or medical (*yiliao*) issues only five times in three sections. Among the five mentions of health, two were in the ‘Well-off Society’ and ‘Cultural Development’ sections, and they were more like slogans than development plans. Although the other three instances, found in the ‘Economic Development’ section, discussed health in a bit of detail, they focused more on medical insurance without specific plans for how to improve health for all citizens. As Jiang stated (Jiang, 2002):

‘We should stick to and improve the basic old-age pension and medical insurance systems for urban workers.... Wherever conditions permit, we should try to establish systems of old-age pensions, medical insurance, and subsistence allowances in rural areas. We should establish a medical service and health care system that meets the requirements of the new situation. We should improve medical and health conditions in rural areas and the medical and health care for urban and rural residents’.

Neither goals for health development nor detailed plans were included. The CCP overlooked health before the SARS outbreak.

However, the health goals have changed fundamentally since the SARS outbreak. The CCP set health development as an important goal in the communiqué of the 17<sup>th</sup> Congress in 2007. The CCP Secretary General Hu Jintao presented a communiqué titled ‘Hold High the Great Banner of Socialism with Chinese Characteristics and Strive for New Victories in Building a Moderately Prosperous Society in all Respects’ (*Gaoju zhongguo tese sheui zhuyi weida qizhi weiduoqu quanmian jianshe xiaokang shehui xinshengli erfendou*), which greatly confirmed health development as an essential goal. ‘Everyone will have access to basic medical and health services [in a moderately prosperous society]’ (Hu, 2007a). The document also mentioned human rights and saw them as important for Hu’s principle of a harmonious society (*hexie shehui*). ‘We must do our best to ensure that all our people enjoy their rights to education, employment, medical and old-age care, and housing to build a harmonious society’ (Hu, 2007a). To accomplish the goal, ‘we will promote the development of basic medical insurance systems for urban workers and residents and a new type of cooperative medical care

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<sup>60</sup> One section summarised past work, and nine sections set out the future development strategy: ‘Three Represents’ (*sange daibiao*), ‘Well-off Society’ (*xiaokang shehui*), ‘Economic Development’, ‘Political Development’, ‘Cultural Development’, ‘Army Building’, ‘One Country, Two Systems’ (*yiguo liangzhi*), ‘International Relations’, and ‘Party Building’.

system in rural areas' (Hu, 2007a). Moreover, this communiqué clearly planned a systematic strategy for health development.

'Establish a basic medical and health care system and improve the health of the whole nation. Health provides the foundation for people's all-round development and has a direct bearing on the happiness of each family. We must maintain the public welfare nature of public medical and health care services, always put disease prevention first, centre on rural areas, and attach equal importance to traditional Chinese medicine and Western medicine. We will separate government administration from medical institutions, management from operation, medical care from pharmaceuticals, and for-profit from non-profit operations. We will increase government responsibilities and spending, improve the national health policy, and encourage greater participation of nongovernmental sectors to develop systems of public health services, medical services, medical security, and medicine supply to provide both urban and rural residents with safe, effective, convenient, and affordable medical and health services. We will improve the system to prevent and control the outbreak of major diseases and enhance our capacity to respond to public health emergencies. We will improve the three-tier rural health care network spanning the county, township and village, and urban community-based health care system and deepen reform of public hospitals. We will set up a national system for basic pharmaceuticals to ensure their supply' (Hu, 2007a).

The overarching health goals changed in the CCP's national development strategy from subordination to economic development with a focus on medical insurance without clear plans to become a significant part of the CCP's principles with comprehensive and strategic plans for citizens' rights. The fundamental shift in the goals also appeared in the working reports of the NPC.

### 3.3.2 The goal change in working reports of the NPC<sup>61</sup>

In the 2002 working report of the NPC, health (*weisheng*) or medical (*yiliao*) issues were mentioned three times. The main health goals were medical insurance for urban employees and disease prevention in rural areas. Although the report mentioned medical services in rural areas, there was no detailed plan on how to improve it. As Zhu (2002) pointed out:

'We will continue to reform the basic medical insurance system for employees in urban areas, the medical and public health systems, and the pharmaceutical production and distribution system. We will expand health services and pay special attention to public health and to medical services in rural areas and invest more in them. We will explore

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<sup>61</sup> Seven NPCs were held from 2003 to 2009. Each NPC working report consisted of two sections, a summary of the work of the previous year and the plans for the work in the next year. However, the 2003 working paper did not mention health (*weisheng*) or medical (*yiliao*) issues in the future plan section but only reviewed the work of the previous year. Therefore, I use the 2002 working paper instead of the 2003 report as a reference regarding healthcare before the SARS outbreak.



various forms of health security in rural areas and improve the medical conditions of rural hospitals. We will prevent and treat major diseases, including contagious, occupational, and endemic diseases’.

The goals began to change with the 2004 working report of the NPC. SARS (*feidian*) was mentioned 13 times, apart from which health (*weisheng*) or medical (*yiliao*) issues were mentioned over 20 times. The specific goals were a ‘public health system focusing on epidemic prevention and control and in rural areas’. To do so, ‘the National Plan for Developing an Information System for Public Health Monitoring and the National Plan for Developing a System for Medical Rescue and Treatment in Public Health Emergencies were formulated and implemented. A system was set up for early warning and response for public health emergencies’ (Wen, 2004).

In 2005, the goals changed from a disease prevention system to a more comprehensive medical system for handling public health emergencies. ‘This year we will complete development of the system for disease prevention and control and basically complete the medical system for handling public health emergencies. We need to truly focus our medical and health care work on rural areas, upgrading the health care infrastructure and raising the overall level of medical personnel there’ (Wen, 2005).

Beginning in 2006, the goals began to target the problems of the inaccessibility and unaffordability of healthcare. Health became a priority:

‘We will give a high priority to medical and healthcare work. We will concentrate on the following three areas to resolve gradually the lack of adequate and affordable medical services. First is to speed up the development of a rural medical and healthcare system. Second is to strengthen urban community health services. Third is to deepen reform of the medical care and health service system and fully restore and standardise order in medical services and the production and marketing of medicines’ (Wen, 2006).

In 2007, the goals did not change from accessibility and affordability, but a more systematic and practical plan to develop a medical insurance system in rural and urban areas for all citizens was added. As the government report stated (Wen, 2007):

‘We will accelerate the reform and development of public health programs. One is to energetically promote a new type of rural cooperative medical care system. Two is to accelerate the establishment of a new type of urban health care service system based on community facilities. Three is to launch a trial of basic medical insurance for urban residents that mainly covers major illnesses, with the government providing necessary

assistance to the poverty-stricken population. Four is to do a good job in work related to the prevention and treatment of major communicable diseases’.

In 2008, the goals changed to building a basic healthcare system with a public welfare nature that is safe, effective, convenient, and affordable for everyone. As the government report states (Wen, 2008):

‘We will promote the reform and development of health care. First, we will accelerate the establishment of a system to ensure access to medical care for both urban and rural residents. Second, we will improve the public health service system. Third, we will continue development of the medical service systems for urban and rural areas. Fourth, we will set up a national system for basic drugs and a system for ensuring the drug supply to ensure the quality and adequate supply of basic drugs and hold down prices’.

In 2009, the goal was actually a combination of all previous health: a nationwide basic healthcare system to provide universal coverage of public goods for both urban and rural citizens. As the government report stated (Wen, 2009):

‘We will carry forward pharmaceutical and health care reform and development. First, we will develop a system that ensures basic medical care. Second, we will establish a national system for basic drugs. Third, we will improve the community-level medical and health service system. Fourth, we will steadily promote equal access for all to basic public health services. Fifth, we will carry forward pilot reforms in public hospitals with the emphasis on reforms in their management system and their operation and oversight mechanisms’.

The overarching health goals changed significantly in the annual working reports of the NPC from 2003 to 2009. Before the SARS outbreak, the health development goals were limited to a few areas, such as medical insurance for urban employees, and there were no detailed plans for how to accomplish the goals. However, after the SARS outbreak, the goals changed from disease prevention and control to the building of a basic healthcare system for all citizens. Moreover, the goals became increasingly clear with systematic plans.

The paradigmatic shift of the overarching goals in both the CCP and the SC’s policies indicated that the decision-makers began to set health goals rather than neglecting health. Changing goals usually leads to revised policy processes, which radically transforms policy as a paradigmatic shift. For instance, as soon as the goals changed to disease prevention and building a control system in the 2004 and 2005 NPC working reports, a series of policies was implemented to build a health surveillance system (as discussed in the second section); the disease prevention and control law also changed to strengthen the capability to handle public health emergencies. Beginning in 2006, the goals changed to healthcare reform, and a series of

policies were changed to target the problems of inaccessibility and unaffordability of healthcare, such as policies addressing urban community health. Since 2008, the goals of healthcare development have been clearly set to include the public welfare nature of healthcare, and thus the healthcare reform policies also insisted to this nature.

### 3.4 Summary

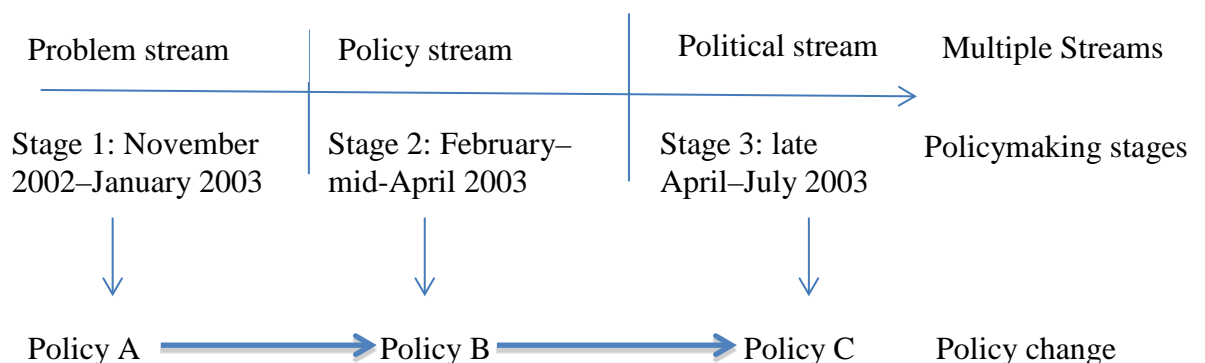
From 2003 to 2009, health policy in China underwent both normal and paradigmatic changes. The SARS treatment and control policies did not shift the goals of treating SARS but changed the policies on how to treat and control SARS. The goals of the media reportage policies changed from strict control to regulatory openness, which was a paradigmatic shift; although the goals of disease prevention and control did not change, the disease surveillance policies changed from non-functional disease prevention policies to the implementation of comprehensive health surveillance and reporting system. The policy direction changed between pro-government and pro-market in the healthcare reform policymaking process and eventually changed from the previous marketisation approach to a mixed approach involving both the role of government and the role of the market. The changes in the overarching health goals in both the CCP and the SC principle policies were paradigmatic changes that began to include health as a significant part of the national development strategies.

Having summarised the policy change that occurred from 2003 to 2009, I will discuss *how* the policy changed in the following three chapters in a chronology by analysing the influence of policy outsiders. I will first discuss the influence of outsiders during the SARS outbreak in next chapter.

## 4 The PEC's influence on SARS policy change

As mentioned in Chapter 3, during the SARS outbreak, the policies used to control the spread of SARS and treat the disease changed significantly. At first, there was no official confirmation that the disease existed; then, there was no national policy to control the spread of the disease and provide guidance on how to treat it. However, after April 2003, a series of policy documents were launched to guide, regulate, and coordinate the treatment of SARS and control its spread. Not only were new policies created but existing policies were also changed and updated.

I will now show how and why these changes occurred in the following three chapters. In this chapter, I argue that the Policy Entrepreneurial Coalition (PEC) engaged with the policy process at different stages of the SARS outbreak and thus influenced the change in SARS policies. As discussed in Chapter 1, when the problem stream, the political stream, and the policy stream converge, a public policy can result (Kingdon, 2003) and policy change can occur. The PEC influenced the SARS policy change by converging the three streams – the streams of problems, policies, and politics. The problem stream recognises the problems and their nature. The policy stream generates solutions to the problems. The political stream is people engaging in political activities, which generate the ‘national mood’.



**Figure 4-1 The argument structure of the chapter**

Figure 4-1 shows the basic structure of the argument in this chapter. In Stage 1, from November 2002 to January 2003, the PEC identified and defined the disease and exerted external and internal pressure on the Chinese government to confirm officially the existence of the problem. The PEC's influence was mainly focussed on the problem

stream; however, there was some nascent development in the political stream. In Stage 2, from February to mid-April 2003, a limited number of PEC members entered the SARS treatment policy process, worked on possible solutions, and formulated an ‘alternative specification’ (Kingdon, 2003), which constitutes the policy stream. The influence of the PEC was mainly in the policy stream. There was continued development in the political stream, as the PEC continued to put pressure on the Chinese government to accept the problem and take action. In Stage 3, from late April to July 2003, the SARS policy process was open to different kinds of PEC members, and both the public and the government were mobilised to fight SARS. To resolve the SARS problem, defined in the first stage, became an important part of the government’s agenda. This constitutes the political stream. The three streams developed and converged, opening the policy window and restructuring the decision agenda and existing policies. Further changes were made to health policies as a result of SARS. Indeed, a new policy, Regulations for the Prevention and Control of SARS (*chuanranxing feidianxing feiyan fangzhi guanli banfa*) was issued as a result. In addition, the law on epidemic disease prevention and control was changed by the State Council (SC).<sup>62</sup>

The chapter is organised as follows. I explain in the following three sections the PEC’s influence on SARS treatment, control and media reportage policies at the three stages of the policy process. The fourth section discusses the consequences of the PEC’s influence beyond its impact on SARS policies. The fifth section compares the actors of the PEC and discusses the three streams. The last section summarises this chapter.

## 4.1 The problem stream

The PEC influenced the Chinese government to change from initially downplaying SARS to eventually recognising its existence in Guangdong, which was problem identification.<sup>63</sup> This occurred in the problem stream in Stage 1. At the time, there was no official information from the central government or specific policies to deal with SARS. In this stage, the main PEC members who participated directly in the SARS policy process were experts from different fields. These experts conducted epidemiological field investigations that confirmed and identified the seriousness of the disease. They then offered technical and medical suggestions to inform Guangdong’s provincial SARS treatment plan, which

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<sup>62</sup> I discuss this in Chapter 3.

<sup>63</sup> The experts at least identified the problems partly, because the central government did not admit.

eventually became a significant part of China's national SARS policy. At the same time, the Chinese government strictly controlled SARS reports in the media, but rumours of this unknown and fatal disease were already spreading rapidly via mobile phone text messages and in the international society. The pressure on the Chinese government to release official information about SARS was then forming.

#### 4.1.1 Direct involvement of experts in Guangdong

The Guangdong provincial government invited several groups of experts to undertake medical investigations and provide suggestions regarding potential policy solutions.<sup>64</sup> On 21 January 2003, the Health Department of Guangdong Province sent several groups of experts to the city of Zhongshan to investigate an unknown serious disease (Ye, 2010).<sup>65</sup> The experts included epidemiologists, medical scientists and scholars, respirologists, and experienced clinicians from the Guangzhou Institute of Respiratory Disease (GIRD), the Third Affiliated Hospital of Sun Yat-sen University, the General Hospital of Guangzhou Military Command of PLA, and the Guangdong Centre for Disease Control (CDC).

The China CDC also sent four established experts from the central government to Zhongshan, and these experts worked together with the experts from Guangdong (Zhang, 2011) to analyse the infected patients, give a diagnosis, provide technical suggestions, and determine possible pathogenesis since 'the central level was informed by Guangdong Province and assistance requested in January 2003' (Schnur, 2005 p.25).<sup>66</sup>

After the investigation, the experts drafted a report together, titled 'Investigation Report of Unknown Disease in Zhongshan from the Guangdong Expert Group' (*Guangdong zhuanjiazu guanyu Zhongshanshi bumingyuanyin feiyan diaocha baogao*). The report systematically described the SARS symptoms and made a proposal for the prevention and treatment methods to tackle the infectious atypical pneumonia, laying a solid foundation for SARS policymaking in Guangdong Province (Guangdong Experts, 2003). Picture 4-1 shows the first page of the report. According to the report, the Health Department of Guangdong Province should set up a provincial coordination group and four expert groups

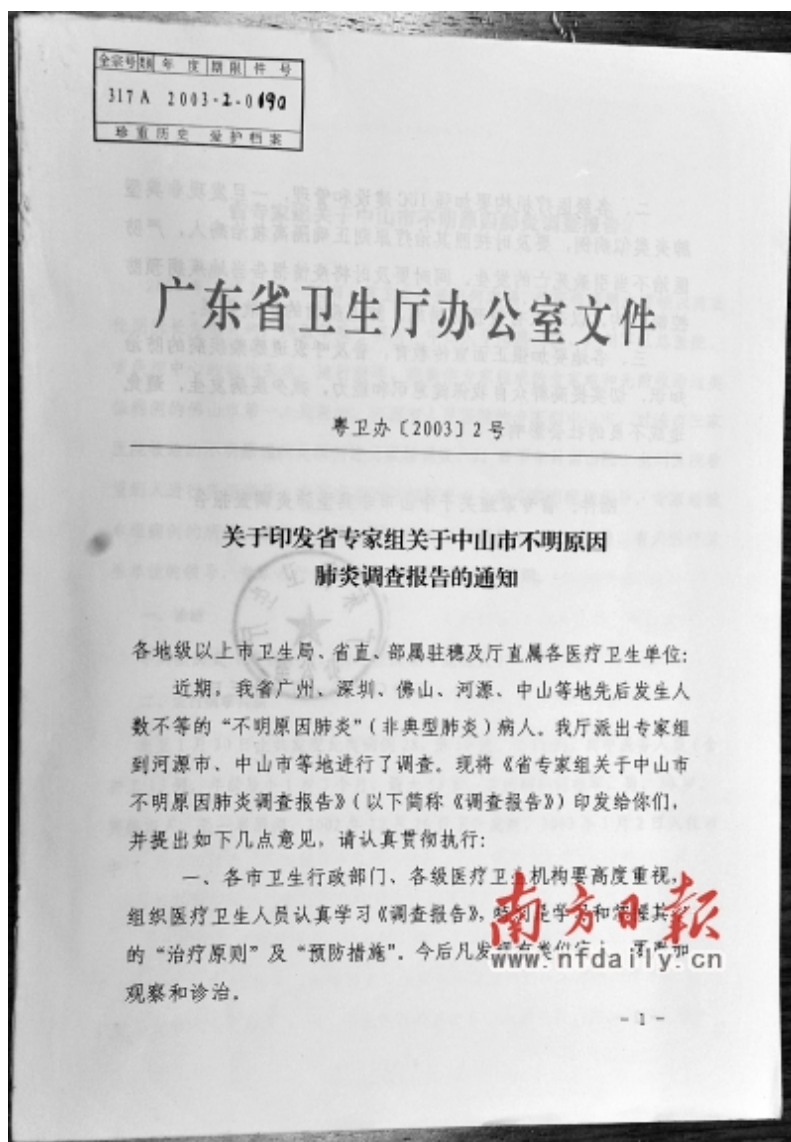
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<sup>64</sup> Guangdong's provincial government took active actions until early January 2003, although, as early as November and December 2002, unknown communicable cases were found in cities in Guangdong.

<sup>65</sup> Those experts included Zhong Nanshan, Xiao Zhenglun, Huang Wenjie, and Deng Zide.

<sup>66</sup> As discussed in Chapter 1, the established experts are employed within the central policy and administrative system.

to carry out disease prevention and control work in Guangdong Province.<sup>67</sup> The report strongly indicated that the disease could be easily transmitted by air droplets through the respiratory system. Thus, it necessitated mandatory quarantine for those who were either suspected or confirmed of having the disease. Moreover, the report recommended using a corticosteroid injection as the main treatment.<sup>68</sup>



<sup>67</sup> SARS Prevention and Control Coordination Office (*guangdongsheng feidian fangzhixietiao bangongshi*), SARS Prevention and Control Coordination Group (*guangdongsheng feidian fangzhixietiao xiaozu*), Medical Aid Guidance Expert Group (*guangdongsheng yiliaojiuhu zhuanjia zhidaoxiaozu*), Epidemiological Survey Guidance Expert Group (*guangdongsheng liuxingbingxue diaocha zhidaoxiaozu*), and Pathogen Detection Technique Expert Group (*guangdongsheng bingyuanxue jiancejishu zhidaoxiaozu*).

<sup>68</sup> Corticosteroids are a class of chemicals that includes steroid hormones naturally produced in the adrenal cortex of vertebrates, and analogues of these hormones that are synthesised in laboratories. There is still scepticism and controversy about the use of corticosteroids, centring on their effectiveness, adverse immunosuppressive effects, and impact on final patient outcomes.

**Picture 4-1 ‘Investigation Report of Unknown Disease in Zhongshan from the Guangdong Expert Group’** (*Guangdong zhuanjiazu guanyu Zhongshanshi bumingyuanyin feiyan diaocha baogao*). Source: *Nanfang Daily*.<sup>69</sup>

This report identified problems and offered potential solutions. It contributed to identification of the existence of the disease, the infection path, human body systems that are vulnerable to the infection, and possible treatments. This report became a significant reference point later in the process, when national policies aimed at treating and controlling the spread of SARS were created.

#### **4.1.2 Indirect involvement of the media and the International organisations**

In contrast to the direct involvement of experts, in this stage, the media were not directly involved in the SARS policy. When SARS first broke out in November 2002, there was no media coverage, but rumours about the unknown but fatal disease spread via spontaneous SMS and Internet chatting among citizens (e.g. Tai and Sun, 2007, Yu, 2009, Zhang and Fleming, 2006, Zhang, 2004). The rumour originated in Heyuan and Zhongshan, where the first cases were found at the end of 2002 (Xu and Yan, 2004). Chinese people wrote, rewrote, and widely circulated SMS messages regarding the politics of SARS (Yu, 2009). Over 40 million SMS messages about a mysterious virus were sent daily in early February just in Guangzhou, the capital of Guangdong Province (Chen and Jiang, 2003, Jiang, 2003). For instance, ‘the highest instruction: wash your hands before meals and after toilet; wash your hands upon returning from outside; wash your hands after catching public transport; wash your hands after touching anything’ (Yu, 2004). People warned their relatives and friends to take care of their personal hygiene in a sarcastic way, which indicated an infectious disease while avoiding mentioning sensitive words related to ‘disease’ so that the messages would not be blocked. ‘In popular internet chatrooms, similar messages were circulating’ (Tai and Sun, 2007).

Massive rumours and no official information led to public panic in Guangdong. One resident reported, ‘I remember people were crazily talking about a mysterious and serious disease that caused death fast and directly. Only isatis root, antiviral medicine, and roxithromycin could cure it.’<sup>70</sup> My mum and I queued hours to buy those medicines in a

<sup>69</sup> [http://epaper.southcn.com/nfdaily/html/2013-03/27/content\\_7176837.htm](http://epaper.southcn.com/nfdaily/html/2013-03/27/content_7176837.htm), accessed 02/01/2014/

<sup>70</sup> Isatis root is a traditional Chinese medicine; roxithromycin is usually is used to treat respiratory tract, urinary tract, and soft tissue infections. Actually, there was no official information on the disease or the



couple of pharmacies, but they were all sold out. What made things worse, even the daily supplies, such as salt, rice, oil, and vinegar were all sold out'.<sup>71</sup> Some businesspeople took the opportunity to hoard and speculate those goods, which caused market chaos (Hai, 2013).

The rumours about SARS spread in the international society as well. The WHO received increasing reports and enquiries from other countries where the disease was found, most of which were geographically close to China (Schnur, 2005). Moreover, foreign embassies in China, especially consulates in Guangzhou, sent constant enquiries to the Chinese government, their home countries, the WHO Beijing Office, the Regional Office for the Western Pacific in Manila, and the WHO Headquarters in Geneva about the rumour of the unknown disease in Guangdong. Therefore, in this stage, the pressure was forming in the international society due to the lack of information from the Chinese government.

As a result, in this stage, the PEC mainly influenced the problem stream through expert identification and definition of the disease in Guangdong. In addition, the rumours spread via the SMS and in the international society formed the pressure, which constituted the nascent development in the political stream.

## **4.2 The policy stream in the middle of SARS**

After identifying that the problem was a transmitted disease and suggesting preliminary treatment and measures to control the spread in Guangdong, the focus of the second stage was to identify the causes of the disease and make accurate national SARS treatment policy, which composed the policy stream. Moreover, the media in Guangdong and the WHO compelled the local and central governments to release SARS information. In this stage, the PEC influenced the finding of the cause and the SARS treatment policy and pressured for information disclosure.

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treatment. These medicines could not cure the disease, but the citizens were scared because the rumours. They crowded to buy the medicines for psychological comfort.

<sup>71</sup> Interview with 017, a Shenzhen citizen, in London, 02/02/2012. People also believed that the salt and vinegar could kill the virus.

#### 4.2.1 Debate among experts about SARS treatment policies

The established experts from the China CDC conducted the medical research on the original SARS virus. In February 2003, the CDC announced that they had found the original virus. On 18 February 2003, the MOH said that they believed the original viral cause of SARS was Chlamydia,<sup>72</sup> which was found in the dead patients' bodies (Xu, 2013). Li Liming, the director of the China CDC, confirmed the finding of Chlamydia and recommended rifampicin as a 'special effective' treatment medicine,<sup>73</sup> which was the first national SARS treatment policy (Wong and Zheng, 2004).

However, the non-established experts from Guangdong disagreed with this policy. Among those experts in Guangdong, Academician Zhong Nanshan,<sup>74</sup> the director of the GIRD, who had participated in the SARS work from the beginning, clearly and openly stated that he was sceptical about the finding by the MOH and CDC at an expert conference conducted by the Health Department of Guangdong Province. Zhong insisted that the clinical symptoms and treatment did not support the finding and that Chlamydia might be one of the causes of death but was not the cause of the disease (Jing, 2006). He and the expert group in Guangdong also opposed the use of rifampicin to cure SARS patients; instead, they insisted on using the treatment method previously proposed by the Guangdong Expert Group, corticosteroids, until they confirmed the cause of the disease. Zhong's idea was supported by Guangdong Health Bureau, which was the reason that he was allowed to conduct joint research with the University of Hong Kong, although the disease information and research were classified as secret (Ye, 2010).

Zhong not only opposed the MOH's SARS policy but also conducted research on his own. The clinical study proposed by Zhong started as early as mid-February and was carried out by the GIRD, Guangzhou Medical College, the Department of Microbiology, University of Hong Kong, and the Guangzhou Chest hospital. On 14 April, 'SARS coronavirus (CoV)' was found by the cooperative research team from specimens of three patients with SARS (Allegra, 2007 p.58).<sup>75</sup> SARS CoV is a very different virus from Chlamydia and thus a

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<sup>72</sup> Chlamydia is a genus of pathogenic bacteria.

<sup>73</sup> Rifampicin is a bactericidal antibiotic drug of the rifamycin group.

<sup>74</sup> Zhong is also a member of Chinese Academy of Engineering (CAE), which is the national academy of the China for engineering.

<sup>75</sup> The SARS coronavirus, sometimes shortened to SARS-CoV, is the virus that causes severe acute respiratory syndrome (SARS).

different treatment method is needed. On 16 April, this new finding was formally confirmed by the WHO (Thiel, 2007).<sup>76</sup>

Zhong and his research group not only found the cause of SARS but also established a set of effective treatment methods, including diagnosis, a radiography test, clinical features, and corticosteroid dosage. In addition, traditional Chinese medicine (TCM) experts invented a TCM treatment, including the use of herbs to unblock the respiratory system and rebuild lung function.<sup>77</sup> The control of SARS in Guangdong Province benefited from these medical treatment methods.<sup>78</sup> The treatment methods were recommended by the Health Department of Guangdong Province for medical professionals in treating SARS patients. On 11 March, 2003, the whole set of methods was published in ‘The Working Guidelines for Guangdong Hospitals Taking and Treating SARS Patients’ (HealthDepartmentofGuangdongProvince, 2003) – the official health policy of Guangdong Province.

In April, the MOH changed the national SARS treatment policy to the use of corticosteroids together with the traditional Chinese medicine treatment. ‘Clinical Diagnostic Criteria and Recommendation Therapy of SARS “Trial”’ promulgated listed in detail how to use corticosteroids together with TCM to treat SARS patients of different ages with different infection situations(MOH, 2003a).

Zhong’s multiple identification helped him to cross boundaries between different systems within China and between China and the international society. First, Zhong benefited from his dual identification, being both health and science. Zhong was a clinical expert and respirologist in health system as well as an expert in science system.<sup>79</sup> As discussed in Chapter 2, each functional department has its own system. For instance, the MOH is in charge of the health system, while Ministry of Science and Technology (MOST) is in charge of science and technology system. But functional differentiations may lead to

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<sup>76</sup> The sequence of the SARS coronavirus was first confirmed by Dr Marco Marra’s research group on 12 April 2003.

<sup>77</sup> Interview with 018, senior manager of the Hospital of the Guangzhou University of Traditional Chinese Medicine, 01/10/2012, Guangzhou.

<sup>78</sup> I am not saying that Zhong’s treatment method was the only effective one; to the contrary, other methods used by other doctors also proved to be useful, such as a traditional Chinese medical method that was also recommended by the WHO as an effective treatment. However, at this stage, Zhong’s method was the main one that was accepted for inclusion in Guangdong’s provincial SARS policy, which was also a significant reference for the national SARS policy later.

<sup>79</sup> Because the CAE is in the science system and links to Ministry of Science and Technology.

estrangement between the systems, which could prohibit cooperation. In this stage, the health system could not work out the cause of SARS without advanced scientific research that the science and technology system could have support. But the cooperation between the two systems were limited due to competition between the two systems (Cao, 2004b). For instance, not many experts could access to tissue samples, without which the scientific research of the cause was impossible.<sup>80</sup> But Zhong accessed to the tissue samples because he was a health expert and dealt with SARS initially and also did scientific research with the tissue samples because the GIRD was equipped with advanced scientific research sources and capability. Second, Zhong's broad international network enabled him to cooperate with international society. The studying abroad experience gave him a broad vision to value the significance of international cooperation in scientific research of the epidemic disease (Ye, 2010). Therefore he initiated the cooperative scientific research between Guangdong and Hong Kong. This joint research was also based on his network with his students who worked in University of Hong Kong (Ye, 2010).

Even though the MOH pushed for the SARS treatment policy based on suggestions from the CDC experts, the non-established and local experts, such as Zhong, used their own research and SARS treatment experience to resist the MOH policy and invent their own treatment methods. The MOH then abandoned the original CDC methods and changed the national policy direction towards the suggestions from the Guangdong experts. The experts' direct involvement in the SARS treatment policy enabled them to offer policy alternatives and a possible solution to SARS, constituting the policy stream. The significance of the non-established experts' expertise was recognised by the central government, and they, notably Zhong, became increasingly influential in the health policy process afterwards.

#### **4.2.2 Breakthrough of the media**

Along with the spread of SARS from Guangdong to most areas in China with increasing number of infected cases, more information of SARS was released from media, despite the existence of censorship. In this stage, occasional SARS reports by the media in Guangdong pushed for the information disclosure in Guangdong.

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<sup>80</sup> Interview with 021, senior journalist with Health News, Beijing, 29/9/2011.

The government strictly controlled the traditional media. Zhang (2003) analysed four major traditional media, *People's Daily*, *Guangming Daily*, China Central Television and *China Daily* and found that it was only after 2<sup>nd</sup> April 2003 that those traditional media started to report SARS intensively, although the tones of the report were optimistic mainly about the disease being controlled.

However, Southcn.com, a website of the Southern Media Group, had broken the control and first reported the unknown disease and the public panic caused by it on 10 February 2003, although the report was deleted a few days later (Xu and Yan, 2004).<sup>81</sup> *Southern Metropolitan News* also provided follow-up reports of the unknown disease and the chaos in the markets, although the editor and journalist responsible for the reports were later dismissed (Yu, 2004). Similarly, on February 13, *Guangzhou Daily*, an official local news agency, reported that residents in Guangzhou had rushed to the supermarkets and stocked up on basic goods as if they were preparing for a prolonged siege (Wenbulaohu, 2003). The report indicated that the general public was panicking about the disease. However, the propaganda department of Guangdong Province soon tightened control of the media. For example, in April, a new editor in chief was appointed to *Southern Weekly*, a relatively liberal newspaper in Guangdong, to control the news reporting (Zhang and Fleming, 2006). Apart from the official information about SARS, no more information was released by newspapers after that point.

Although the party propaganda departments at both the central and provincial levels issued several oral and written directives to ban media coverage (Wade, 2003a), the government in Guangdong Province was finally pushed to release official news first. On February 10, to quell the panic, the Guangzhou city government convened a press conference and formally confirmed the existence of the infectious disease in Guangzhou with '192 infected cases and 2 deaths' (Hai, 2013). The Information Office of Guangdong Province also issued an official press release to an official local newspaper, the *Yangcheng Evening News*, to confirm the disease. Within the following two days, Guangdong's provincial government and the Health Department of Guangdong Province held two separate press conferences about the disease and released information in Guangdong suggesting that the disease was under control: the number of cases (305 infected and five deaths) was dropping (Zhang and Fleming, 2006 p.325). The other mainstream newspapers in

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<sup>81</sup> Both Southcn.com and Southern Metropolitan News belonged to the giant Southern Media Group, which is famous for critical and liberal reports.

Guangdong, such as *Guangzhou Daily* and *Nanfang Daily*, continued to report on SARS even though the party had clearly banned such reports (Zhu, 2007). Under the increasing pressure of the public panic caused by SMS messages and mainstream newspapers, the Guangzhou city government broke the propaganda ban, which further pushed the Guangdong provincial government to confirm the existence of the disease, although the official tone sought to ease the tension by suggesting that things were not serious and were under the control of the government.

Moreover, citizens not based in Guangdong could also go to the Internet to spread information. Table 4-1 shows that, on the two main Internet portals, the number of pieces of SARS news increased gradually. Website managers were instructed by government directives to remove 'negative' postings about deadly diseases, and violators could face fines or punishment (e.g. McNair, 2003, Saiget, 2003, Wade, 2003b). At first, major portal sites closely followed government orders in filtering out 'undesirable' postings; however, as time went by and the epidemic spread to more localities, many content managers turned a blind eye to SARS-related postings and left them unremoved (Kuhn, 2003). Meanwhile, 'many chat room and forum administrators adopted a more tolerant attitude towards posted messages' (Tai and Sun, 2007 p.1001). In this context, the Internet emerged as a viable alternative and, in some cases, as the main source of information for people in China, especially in the early phase of the SARS outbreak (Kuhn, 2003, Xiao, 2003b, Xiao, 2003a).

The official confirmation by the Guangdong government and the wide spread of information on the Internet overcame the control over the media reporting of SARS on 26 March, when the central government issued the first official report on SARS through the Xinhua News Agency. The report mentioned that 'Beijing had effectively controlled and contained SARS' (Yu, 2009). The Health Minister, Zhang Wenkang, further confirmed the report in an interview on CCTV.

Internet portal	Time (month/date)	Pieces	Pieces in total	Date of the first piece
Sina	1 February–31 March	121	8,228	10 February
	1–10 April	290		
	11–20 April	986		
	21–30 April	3,237		
	1–10 May	2,961		
Sohu	1 February–31 March	1	3,821	11 February
	1–10 April	132		
	11–20 April	460		
	21–30 April	1,648		
	1–10 May	1,139		

**Table 4-1 News of SARS on two main Web portals, *Sina* and *Sohu*, from February to April (Xia and Ye, 2003)**

Since the information provided by Chinese governments was very limited, the media tried to find alternative ways to acquire more information. ‘Media representatives started to call and visit the WHO office in large numbers from the week of February 10 with the quantity and intensity of media integration continually increasing until May’ (Schnur, 2005 p.26). On 16 April 2003, the WHO mission presented its report on its first investigation in Beijing to the MOH and the media, which was followed by a tumultuous question-and-answer session. In the report, team members estimated around 100–200 probable SARS cases and over 1,000 suspected cases and cases under observation in Beijing, which contrasted sharply with the official report two days earlier of only 37 cases in Beijing (Schnur, 2005). Table 4-1 shows that around this point, the number of news reports increased considerably. The media coverage of the WHO’s information created a dilemma for the Chinese government: should it keep covering up or tell the truth?

Moreover, the international media report of Dr Jiang Yanyong’s whistleblowing was the last straw that pushed the Chinese central government to open the information about SARS to the public. In April 2003, Dr Jiang, a retired military doctor, wrote a letter to CCTV and Phoenix TV (based in Hong Kong) comparing the dubious official SARS figures in Beijing with the first-hand data from his colleagues at a military hospital he had once worked in. Since Jiang did not receive any response from either outlet, he sent a letter to *Time*, an American magazine. On 8 April, *Time* published an interview (Jakes, April 08, 2003) with Jiang that ‘led to a change in media policy on SARS reportage’ (Yu, 2009 p.87). Before he

blew the whistle, the policy was tight control; afterwards, it opened up SARS reporting (I will further explain this in the next section).

Based on the rumours spread via SMS messaging and the Internet in the first stage, local mainstream newspapers in Guangdong first reported the disease, which forced the government of Guangdong to confirm the disease officially even though the propaganda system had banned the release of information on SARS. This news breakthrough further triggered the central government to release official information on the disease, but with false numbers. An international media report of a Chinese medical expert's first-hand data exposed the inaccurate data and information provided by the Chinese government, which pushed the Chinese government to open reports on SARS fully.

### **4.2.3 Involvement of the WHO**

The WHO became involved in SARS in China on 10 February 2003 'after receiving a telephone call from an embassy in Beijing and an email rumour about reports of a strange contagious disease in Guangdong Province' (Schnur, 2005 p.26). After that, the WHO became involved in the SARS policy process both indirectly and directly and then influenced the policy change. Indirectly, on one hand, the WHO, pushed the Chinese government hard to release information; on the other hand, the WHO asked to investigate the area in China with SARS cases. Directly, the WHO gave technical and information guidance to the Chinese government, which helped to keep the SARS policy change in line with international standards.

First, from early February to early March, the WHO pushed the central government to release the official information on the disease and asked for an investigation of the disease. On 12 and 17 February, the WHO's office in Beijing informed the MOH that the WHO learned of the disease in Guangdong, requested epidemiological information, and offered assistance (Whaley and Mansoor, 2006). Although the MOH eventually replied to the WHO, the MOH did not accept the WHO's help and stated that the disease was under control (WHO, 2003b).<sup>82</sup> On 20 February, an upper-level WHO department, the WHO's Western Pacific Regional Office (WPRO), called the MOH 'to request permission for a WHO team to investigate the Guangdong outbreak' (Whaley and Mansoor, 2006). After the negotiation, the first WHO mission to China (Beijing only) involving experts arrived

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<sup>82</sup> Interview with 010, former WHO Beijing Office employee.



on 23 February 2003 to assist the WHO country office.<sup>83</sup> One week after the WHO team's arrival, the team started to discuss suspected causes of the disease, such as Chlamydia and H5N1, with the MOH.<sup>84</sup> After receiving clinical, epidemiological, and laboratory information from the China CDC on 6 March, both China's and WHO's experts agreed to exclude H5N1 as the cause, but the CDC insisted that the cause was Chlamydia.

Second, from mid-March to early April, the WHO placed increasing pressure on the central government while offering more assistance. On 11 March, the WHO Director-General, the highest WHO leader, expressed the serious concerns of the international society via the WHO's Beijing office with evidence of the same disease outbreak in other countries, such as Vietnam, and thus strongly recommended further investigation in Guangdong (Whaley and Mansoor, 2006). Under this pressure, the central government started to react actively and asked the WHO for laboratory training (Balasegaram and Schnur, 2006). After issuing the first global health alert in history on 13 March, the WHO listed Guangdong as an 'affected area'. While pressuring the central government to permit further investigation in Guangdong in this way, the WHO also shared laboratory information from other countries with the MOH and encouraged the MOH to do the same by joining the Global Network.<sup>85</sup> However, the MOH insisted that the disease in China was not the same as the one in the other countries and that it was under control. The WHO's Beijing office also held press conferences because of the increasing media concern both domestically and internationally (Schnur, 2005), although the WHO briefed the MOH about the information released at the press conferences in advance. Later, the WHO listed China on the list of affected countries. While pressing for the investigation in Guangdong, the WHO also organised international experts to compare the cases in Guangdong with those in other countries based on 'presenting features, progression, treatment, prognostic indicators, and discharge criteria' (WHO, 2006c). On 26 March, the WHO concluded that the disease in Guangdong was the same as the one in other countries and thus emphasised the significance of visiting Guangdong (Balasegaram and Schnur, 2006). Under the strong evidence presented, the MOH agreed to provide up-to-date reports from all provinces but still refused the WHO to investigate in Guangdong. Because the continuous spreading of

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<sup>83</sup> The experts were from the US CDC, Japan's National Institute for Infectious Disease (NIID), the WPRO, and the WHO's China Office.

<sup>84</sup> A bird-adapted strain of H5N1, called HPAI A (H5N1), a highly pathogenic avian influenza virus of type A and subtype H5N1, is the highly pathogenic causative agent of H5N1 flu, commonly known as avian influenza ('bird flu').

<sup>85</sup> On 17 March, the WHO established three global networks on SARS to share public information via telephone and on secure websites.

the virus, on 2 April, the WHO issued its most stringent travel advisory for Hong Kong and Guangdong, which strongly recommended that people postpone unessential travel to these places.<sup>86</sup>

From early to mid-April, the central government opened more information to the MOH and cooperated more actively with the WHO. From 3 to 8 April, the WHO team was finally permitted to visit Guangdong to investigate the cases. After the investigation, the team members, together with Guangdong experts and health officials, briefed international consulates in Guangzhou to inform them that the SARS outbreak was contained within a good surveillance system. After the investigation, the team also met Vice Premier Wu Yi to report on the situation in Guangdong. Although Guangdong responded well, the team was worried about reporting, contact tracing, and isolation practices in other places in China, such as Beijing (WHO, 2003c). Later, the WHO team was also permitted to visit two military hospitals in Beijing, ‘on the understanding that the findings will not be released to the public’ (WHO, 2006c).<sup>87</sup>

On 16 April, the WHO announced globally confirmation of the cause of the disease, SARS coronavirus, which was found by a few experts in Germany, Canada, and China, based on the Global Network collaboration (WHO, 2003a). The WHO team was also questioned thoroughly by the media for true case numbers in China, especially in Beijing, but there was no clear answer, although Dr Jiang blew the whistle on the previous cover-up of reports. On 20 April, the Health Minister and Beijing’s mayor were dismissed because of the poor response to SARS and the intentional cover-up of information, which led to the massive breakout of SARS.

Table 4-2 shows the carrot-and-stick approach that the WHO used to influence the Chinese central government to change from denial to openness. First, the WHO strengthened the pressure on the central government by going up the hierarchy of contacts from the lower-level Beijing office to the highest-level WHO headquarters, and employing tones in their communication ranging from ‘enquiry’ to ‘warning’. The WHO also pressured the central government with scientific evidence and international concern from other countries.

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<sup>86</sup> From 2 April to 21 May, the travel advisory was extended to all of China. From 23 May to 24 June, the travel advisory was lifted for all of China.

<sup>87</sup> As discussed in Chapter 2, the military hospitals in China are within the military system, independent from the MOH. The military system is usually closed to the outside world. Allowing the WHO to visit the military hospital clearly showed the change in the SARS information policy from closed to open and the determination of the Chinese government to deepen their cooperation with the WHO.

Second, the WHO listed China's provinces as 'affected areas' and 'travel advisory areas', imposing increasingly stringent travel restrictions. At the same time, the WHO also offered scientific and technical assistance to the central government, including laboratory training, sharing of scientific research information from other countries with China, and directly bringing the WHO team and other external experts to China to assist in the investigation and disease research. The consequence of the increasing pressure and the assistance was a significant change in the central government's behaviour and attitude towards SARS. The central government opened the investigation from Beijing to Guangdong to the WHO team and external experts. The central government gradually shared increasing amounts of first-hand data, such as laboratory, epidemiology, and clinical aspects of the disease, as well as the number of cases. The central government went from denying the disease to submitting daily reports to the WHO.

WHO		Chinese central government	
	Carrots	Stick	Response
12 and 17 February	Offered assistance	The WHO Beijing Office asked the MOH for information	The MOH: the disease was under control
20 February		The WPRO asked the MOH for an investigation in Guangdong	The MOH: Beijing only
23 February	The WHO team arrived in Beijing		
Early March	The WHO team discussed with the MOH Chlamydia and H5N1		The China CDC shared clinical, epidemiological and laboratory information
11 March		The WHO Director-General strongly recommended further investigation in Guangdong with evidence of the same disease outbreak in other countries	The MOH asked the WHO for laboratory training
13 March	The WHO asked for an investigation in Guangdong	The WHO issued the first global health alert in history and listed Guangdong as an ‘affected area’	The MOH insisted that the disease in China was not the same one in the other countries and was under control
	The WHO shared laboratory information from other countries with the MOH and encouraged the MOH to do the same	The WHO’s Beijing office held press conferences after briefings with the MOH	
26 March		Conclusion: the disease in Guangdong was the same as the one in other countries and thus emphasised the significance of visiting Guangdong	The MOH agreed to provide up-to-date reports from all provinces
2 April		The WHO issued its most stringent travel advisory for Hong Kong and Guangdong	

<b>3-8 April</b>	The WHO team visited Guangdong	The team members together with Guangdong experts and health officials briefed international consulates	Permission was given for visits to Guangdong and two military hospitals in Beijing
<b>9 April</b>		The WHO warned of reporting, contract tracing, and isolation practices in other places in China, such as Beijing	A meeting with Vice Premier Wu Yi was held
<b>16 April</b>	The cause was confirmed: SARS coronavirus	Tumultuous pressure came from the media regarding the true number of cases	
<b>20 April</b>			The Minister of Health and Beijing mayor were dismissed

**Table 4-2 The WHO's approach to the Chinese central government and the central government's response in stage 2**

In this process, the WHO used carrot and stick strategy to push the central government to gradually release accurate SARS information and accept the WHO assistance. It led to two changes. First, the SARS treatment policy changed, partly because the WHO officially backed the Guangdong experts' plan of treatment and spread control strategy. Second, the central government started to release SARS information and allow the media to report it.

In this stage, the PEC directly influenced SARS policy mainly through its influence on the policy stream. The experts found the virus and developed effective treatment methods, which first became the Guangdong SARS policy and later the national SARS policy. The experts and the WHO largely contributed to the policy stream with policy alternatives, solutions, and proposals. The media and international organisations delivered the pressure accumulated in the first stage to the Chinese government, contributing to the political stream. The media pushed Guangdong and the central governments to confirm the disease formally and release detailed information, which was prelude of the media reporting policy change. With the carrot-and-stick strategy, the WHO pushed China to gradually release the SARS information and cooperate with the WHO. Furthermore, the WHO built mutual communication mechanisms with the MOH, the experts, and the media, which contributed to the sharing of information and the building of trust.

### **4.3 The political stream and policy change in the final stage**

The PEC contributed to the change in the Chinese government's attitude from denying SARS to openness through their influence mainly on the problem and policy streams in the previous two stages. The development in the political stream finally converged in the problem and policy streams in the stage 3 and resulted in policy change. On 13 April, the MOH set up an ad hoc SARS research group to lead and coordinate the SARS research work, especially on its etiology and pathology (*China Youth News*, 2003a), signalling that the window of opportunity for policy change was open. In this stage, the PEC influenced the change in the principles of SARS policy as well as control policies and media reporting policies.

#### **4.3.1 Expert's direct influence on SARS control policies**

In this stage, Beijing became the centre of the infected cases, with the highest number of cases. By early May, Beijing had reported more than 2,000 cases, and 100 new ones were reported daily (Whaley and Mansoor, 2006). More experts became directly involved in the

development of SARS policy with officials at different levels and thus influenced policy principles and practical policies.

The experts met directly with the decision-makers, the Political Bureau, to discuss the situation and offer policy suggestions to control the disease in Beijing. On 28 April 2003, Professor Zeng Guang,<sup>88</sup> a leading expert on epidemic disease in the China CDC, was invited by the MOH to give a lecture to the members of the Political Bureau at a regularly convened group meeting.<sup>89</sup> The theme of the lecture was ‘science development in China and how to use science to conquer SARS’. Two other experts, academician Wang En’ge from the Chinese Academy of Science (CAS) and Professor Xue Lan from Tsinghua University, mainly focused on the science development. Zeng discussed in particular scientific and technical prevention and control of SARS and offered proposals and policy suggestions to the Political Bureau.<sup>90</sup> Professor Zeng’s lecture was the first to focus on public health in the history of the routine group study. It was also the only lecture given during the SARS outbreak. Because the ‘students’ in this group study were the decision-makers, experts could directly influence their decision-making, shape the policy agenda, and influence the development of policies (Hu, 2004).

In the lecture, Zeng not only offered policy suggestions but also took the opportunity to report on problems of epidemic disease prevention systems and asked for information disclosure, which was beyond the scope that Vice Health Minister Gao Qiang had set with him.<sup>91</sup>

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<sup>88</sup> Professor Zeng Guang specialises in the field of epidemiology and public health countermeasures, works at the academic forefront of disease control and emergency response, and has given the government several suggestions and recommendations for public health policy. He was the chief policy consultant of the Beijing SARS headquarters in 2003, a recipient of the special allowance of the SC, a Beijing municipal government consular, and a member of national public health emergency expert group.

<sup>89</sup> The routine group study is open to members of the political bureau of the CCP. The content of the series of lectures is related to the development of the state and the society, and lectures are given by experts in the related fields. Topics involve current hot issues and lectures by experts centred on the problems and the solutions. Through this routine group study, top leaders can discuss a particular social or political issue and exchange ideas with experts face to face. This routine study started at the end of 2002 and since then has been organised on a regular basis. Since 2002, 77 sessions of the group study have been conducted and over 150 experts from various fields, including economics, law, history, culture, and education, have been invited. The 16<sup>th</sup> Political Bureau group study was held 44 times from 26/12/2002-28/9/2007. The 17<sup>th</sup> Political Bureau group study was held 33 times from 27/11/2007-28/5/2012.

<sup>90</sup> Zeng was asked by the MOH to deliver the lecture only one week in advance, while the other two experts had been preparing for months.

<sup>91</sup> According to the interview with Zeng, while preparing the talk, the MOH carefully checked every word of Zeng’s speech to make sure that there was nothing ‘negative’ or anything that would ‘make top leaders unhappy’... because ‘at that time, officials were still a bit conservative.... They were worried about the content of my talk and fearful that anything in my talk might annoy the decision makers. So they were

‘I told the Political Bureau that the SARS spread was about to be out of control because the citizens did not know the seriousness of the infection or how to protect themselves. Therefore, information disclosure to the public is significant. Covering the disease information only makes things worse. Even the health workers do not know how to protect themselves. The hospitals do not have enough professional equipment to isolate confirmed and suspected cases. The infections within the hospitals are more serious than outside. The government should open the disease information and mobilise the public to fight against SARS. The government should tell the citizens the infectious cases and areas, the prevention and isolation method, and a strong recommendation for people to stay inside. I even suggested building a professional hospital for SARS cases exclusively to stop infections within the hospitals’.<sup>92</sup>

Zeng recommended that ‘mass prevention and control’ (*qunfang qunkong*) as essential techniques to control and prevent the spread of the disease.<sup>93</sup> The ‘mass prevention and control’ means that, first, the disease information should be open to the public and thus everyone knew how to protect themselves from potential infected cases. Second, the channel of disease spread should be identified and interrupted by, for example, asking citizens to wear masks and wash their hands regularly. The interruption of the channel of disease spread relies on individuals’ efforts. Third, groups of people who are vulnerable to SARS, such as the elderly and children, should be identified and specially protected. He also suggested that, from a public health perspective, the highest priority was to control the spread and prevent more infections rather than establishing clinics and developing a vaccine, which could be done later. When the spread stopped, there would be enough time to do the latter two, but if the spread continued, the latter two would not be enough to address the seriousness of the disease, and by then, no one would know what would happen.

The suggestions of the control policy by Professor Zeng were adopted by the decision-makers the SARS policy principles. Before Zeng’s lecture to the Political Bureau, ‘mass prevention and treatment’ (*qunfang qunzhi*) was the motto which focused on treatment (*zhiliao*) rather than control (*kongzhi*). The treatment implied more on medical activities of doctors and hospitals instead of information disclosure for the public. But ‘Mass prevention and treatment’ was changed to ‘mass prevention and control’ as the national principle soon after Zeng’s control mechanism. Two days after the talk, the then President

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very cautious in picking and revising every word I would use in the lecture and strived to make sure that everything is politically and ideologically right’.

<sup>92</sup> Interview with 008, senior official of the China CDC, Beijing, 26/09/2011.

<sup>93</sup> Zeng stated that ‘mass prevention and control’ was not his own idea but derived from the knowledge and experience of a group of experts who were working on SARS. Because the top leaders ‘listened to and trust the experts’ expertise and respect the order of nature and science, they accept whatever you said’.



Hu formally confirmed the new principle in a public speech. ‘The most important thing is to apply comprehensive control measures, such as the admission, isolation, and treatment of the patients and suspected patients. We should also search for and isolate persons who have close contact with infected patients ... and widely mobilise the whole society to engage in mass prevention and control...’ (ChinaNewsAgency, 2003). Although, Hu did not clearly state information disclosure, it was a precondition of the effective control. Since then, the government put great efforts to urge information disclosure to the media and to build up a comprehensive disease surveillance system.<sup>94</sup>

The concept of ‘mass prevention and control’ and the associated control mechanism was a collective idea developed by experts working on SARS. Zeng grasped the opportunity and proposed the idea to top leaders, and the idea was then successfully adopted as the principle of the national SARS policy. Here, two factors are important. One is the concept developed by experts as a collective. Second, Zeng actively promoted the idea to the central leadership when an opportunity arose. The change of the principle from ‘mass prevention and treatment’ to ‘mass prevention and control’ shows that direct consultation worked.

In addition to the change in the policy principle from emphasising treatment to control, the experts also influenced practical policies by formulating technical policies with officials at different levels. ‘Our daily work was sitting in front of dozens of big screens that showed the epidemic situation in Beijing and analysed the situation. After that, we told the officials where to send what kind of medicine or how many ambulances and perhaps medical masks. We also worked on disease control within the hospitals. Our work was very detailed but directly related to the frontline work’.<sup>95</sup>

The experts’ influence was further institutionalised when the central government established the National Headquarters on SARS Control on April 24, which brought epidemiologists, scientists, medical scholars, and other experts to work within the government directly on SARS control.<sup>96</sup> The Headquarters clearly stated that it needed an

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<sup>94</sup> I discussed this system in Chapter 3.

<sup>95</sup> Interview with 020, a public health professor at the Peking University Health Science Centre, Beijing, 22/9/2011. Because SARS was an emergency and everything happened fast, not every policy was clearly written down on paper or went through every usual procedure. Quite often, the government’s decisions became their action directly. Hence, I also take into account the change in government actions as the benchmark of change in the SARS policy.

<sup>96</sup> The headquarters employed officials and staff from the CCP central committee, the SC, the military system, and more than 30 departments and units of the Beijing municipality. It led 10 working groups that

expert consulting group for an epidemiological investigation plan and a relevant technical plan; it also needed experts for clinical treatment, experts to consult on SARS emergency management, and experts for SARS control in schools and universities (State Council, 2003a). The central government mobilised all possible sources to fight SARS, including scientific and health sources, so the experts took the opportunity to work directly and closely within the government, which influenced the practical policies.

The leading expert, Zeng Guang, directly influenced the decision-makers' attitude towards SARS, which changed from 'mass prevention and treatment' to 'mass prevention and control' via direct meetings with Politburo members. Moreover, in order to effectively control SARS, the government agreed to open the media disclosure to the media and building disease surveillance system. The experts also worked with government officials and influenced the detailed and practical SARS policies, such as infection control policy within hospitals, SARS research policy, and control policies.

#### **4.3.2 A media spring**

In contrast to previous SARS reporting policies, in this stage, the central government encouraged SARS reporting and even actively fed information to the media to calm the public and stabilise society. The press offices in both the MOH and the city of Beijing actively organised media interviews for both Chinese and international media (Zhang, 2004, Yu, 2009); '...journalists were given the "green light" treatment, and the Chinese media experienced unprecedented freedom' (Yu, 2009 p.86). The spring of SARS reporting empowered the media to run stories about SARS to the greatest extent (Zhang and Fleming, 2006).

The mainstream media followed propaganda rules in their reporting on SARS. They mainly reported positive stories. For example, the mainstream media usually reported how medical staff members fought SARS as heroes to link the battle against SARS to a patriotic movement. This could greatly mobilise the public to fight SARS.

However, by increasing pressure among Internet users beyond the state-run media to inform the public of what was really happening (Tai and Sun, 2007), the Internet told the

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worked on different perspective; for example, the vice health minister led a group to work on SARS spread control and treatment, and the Minister of Science and Technology led a group to work on scientific research and experimentation on the SARS virus.

other side of the story and addressed the issue to get great attention from both the government and the public. This attention was reflected in a series of policy changes made just after the information was published online. Unlike the reports in the mainstream media, which portrayed medical professionals as ‘glorious workers’ making ‘heroic efforts’, the online posts from the end of April to the beginning of May revealed and summarised several brief, fragmented, and non-analytical cases of some hospital workers refusing to go to the ‘front lines’ and being punished afterwards. The debate soon expanded from judgments of the refusal to the issue of respect for human rights. Around this time, a series of policies on how to protect the interests of medical staff was issued.

I analyse in depth a case with many reviews posted on one of the most popular Internet forums,<sup>97</sup> in China during the SARS outbreak, the *Tianya* club. On this type of forum, ‘...audience members are not only active consumers of information on the Internet, but they have the potential to become information producers and disseminators online as well’ (Tai & Sun, p.993). Thus, given its multiple functions, large number of loyal users, and significant social and political impacts, *Tianya* is the most important online forum in China. The posts on *Tianya*, to some extent, can present people's concerns and the main issues of the moment. During the SARS outbreak, tens of thousands of posts were made concerning the disease on *Tianya*. After searching the posts using the keyword SARS, I found that the case with the most reviews had a strong correlation with policy changes.

On 1 and 4 May 2003, two of the top ten posts<sup>98</sup> on *Tianya* focused on a very special phenomenon (Su, 2003, ZhiRouWuWei, 2003). Unlike the mainstream media reports, which portrayed hospital workers as heroes working hard to save lives without caring about the potential health threat to themselves, the *Tianya* posts reported that some hospital staff refused to go to the ‘front lines’. This post stirred up a heated debate that attracted 3,648 and 5,798 people to read the posts; 248 and 368 people joined the debate with their own opinions on the two posts, respectively.

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<sup>97</sup> Founded in 1999, *Tianya* is a comprehensive virtual community and large social networking platform with more than 50 million registered users and around 150,000-200,000 online users at any one time. It is a forum for various services, such as BBS, blogging, microblogging, online stores, and photo albums. The most important aspect is that, since its foundation, *Tianya* has had a huge number of loyal and thoughtful ‘residents’ who give *Tianya* an essential social role by posting about social and political problems. ‘Politicians have used [the] Tianya Club to campaign, answer questions from constituents, and gather grassroots support’ (You, 2006).

<sup>98</sup> Searching by the keyword ‘SARS’ (*feidian*), there are 6,961 posts in total on *Tianya*.

Sacrifice and dedication have a long history in China. For example, the goal of characterising Lei Feng as a selfless and humble person was to mobilise people to follow the example. Traditionally, there is no fine line between public space and private space (Tomoko, 2003). Since 1949, particularly during the first thirty years of the CCP's rule, there was a strong leftism ideology of sacrifice for the common good, 'the people'. As a result, open advocacy of individual private interests is widely deemed immoral, though everyone agrees that an individual should have his or her own interests. However, when the private interest of the individual is in conflict with the collective interest, the pursuit of private interest would be regarded as an evil act.<sup>99</sup>

In addition, because the basic principle of hospital work is to save lives, medical professionals are usually described as 'life-saving angels' (Beijing Youth News, 2003), especially during the SARS crisis. Moreover, many doctors and nurses were infected while working in the hospitals and even died (CCTV, 2003). As a result, praise for their noble character became one of the main features of media reports. With the severe development of the epidemic, they began to be deified; the words used to describe the hospital workers became much stronger. Descriptors such as 'national hero', 'stand out at the critical moment', 'fulfil the mission', 'strong backing', 'fearless', 'dedication', and 'national backbone' filled most reports (Xia and Ye, 2003).

Medical personnel are human beings as well, and they feel fear, depression, and panic just as other people do, but this was ignored or at least avoided by the mainstream media. In the *Tianya* posts on 1 and 4 May 2003, some people expressed their understanding of the hospital workers' reluctance to take the job, and some people even supported the hospital workers' action. For example, some posts said that ordinary people cannot understand what a hard situation the medical staffs face, so it is unfair to criticise them. Some people said that it is not a fault to consider their own family and children when they refused to take a job on the front lines, especially as there was no governmental protection mechanism if the medical staff died of SARS. Nonetheless, those doctors and nurses who refused to go to the front lines to fight SARS lost their jobs or were punished by their hospitals. Soon, many people joined in the discussion on this topic and debated whether the hospitals had the right to punish workers because of their refusal to take up the job on the front lines. There were two main opposing opinions. On one side, in line with the leftist idea, some people said that it was their responsibility and obligation to save people's lives; thus, no

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<sup>99</sup> I discuss the ideology in Chapter 2.

matter how dangerous it was, they should work hard without retreating. Some people described the outbreak as a battle, where the soldiers cannot say no, so neither could the medical personnel during the outbreak; those who refused to work on the front lines were no longer fit for the medical professional. On the other side, many people sympathised with the medical staff who refused to go to the front lines. People argued that medical personnel had their own concerns as well and that they should be able to show their trepidation. For example, they might be worried about the possible impact on their own families. Some people said that the image of hospital workers shaped by standard media was too far beyond a human being's real reactions. People also criticised such news reports, citing their anti-human nature. For instance, they argued that there were many jobs that people could do to contribute to the fight against SARS, some of which were indirect, such as logistical support or psychological counselling. Therefore, there was no need for every hospital worker to go to the front lines and no sense in criticising the people who did not want to do this job.

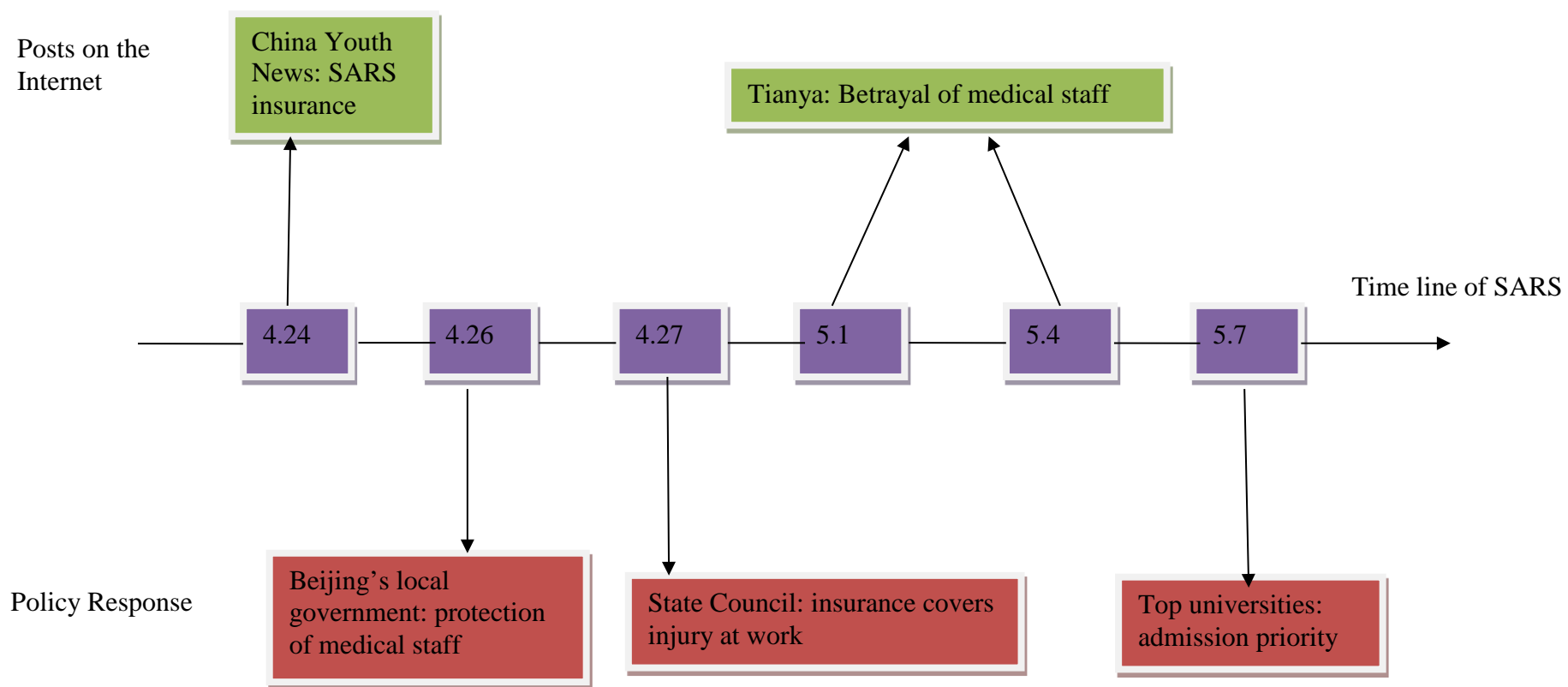
Around the same time, a series of policies providing protection to health workers, a concern expressed on *Tianya*, was issued. The original policy, issued by the China Insurance Regulatory Commission on 24 April 2003, did not cover the health workers' insurance (China Youth News, 2003b). The policy stated that, although insurance covered ordinary people's risk of being infected by SARS, because of 'many uncertainties', there was not yet any clear conclusion on the issue of whether the medical staff members' risk of being infected should be covered by insurance. From then on, the posts on *Tianya* appeared to care more about the health and safety of hospital workers. The policy started to change on 26 April, when Beijing's local government made several decisions regarding the protection of medical staff (Beijing, 2003). On 27 April 2003, the SC of the PRC promulgated 'industrial injury insurance regulations' that, for the first time, confirmed that the infection of medical staff while dealing with SARS is considered occupational injury and should be insured (StateCouncil, 2003). A further step was taken on 7 May 2003. According to a CCTV report, some top universities, such as Beijing University, Renmin University, Wuhan University, and Tianjin University, would give priority to the children of front-line anti-SARS medical staff in the recruitment of new undergraduate students (Chinanews, 2003). The National Matriculation Test (*gaokao*) is an extremely significant issue in almost every family in China, and parents do everything they can to send their children to top universities. Thus, this new statement was a strong signal of protection of the interests of the medical staff members and their families. Both policies indicate that the

government was acting to alleviate concerns that had been the focus of Internet forum discussions.

Figure 4-2 shows the timeline of posts on the Internet and the policy responses. The posts on the Internet and the policy responses were interlaced. The first online debate on the health safety of medical staff occurred on 24 April, while the most heated discussion took place on *Tianya* on 1 and 4 May. People's concerns on this issue reflected in the online debate gradually accumulated during this period. Regarding the policy response, the government's awareness of the issue was shown for the first time on 27 April with the SC's promulgation of industrial injury insurance regulations that addressed the protection of anti-SARS medical staff three days after the first concern regarding the same issue was published online. The development of the policy response occurred during the period when public concern on the issue was accumulating through Internet debate. It is reasonable to argue that people's concerns on the issue put some pressure on the government. Although there is no direct evidence of how those opinions published on the Internet were translated into the actual policies, the state censorship that was discussed previously implied that the state had the technology to analyse the online chatting.<sup>100</sup> People express their concerns via Internet debate, which creates indirect pressure on the government to take action and promote policy change.

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<sup>100</sup> I discussed it in Chapter 2.



**Figure 4-2** Timeline of posts on the Internet and the policy response regarding the medical staff issue

### 4.3.3 New phase of WHO involvement

In the previous stages, the WHO pushed the central government to release more accurate information and data and to cooperate with the WHO using the carrot-and-stick strategy. Through these two stages, the WHO not only directly worked with Chinese government on the SARS control policies and information policies but also built trust and reputation in the Chinese government.

First, the WHO continued offering technical assistance to the Chinese government. In late April, the WHO brought in a foreign travel health expert, who recommended that temperature screening of passengers should be started before the May Day holiday to prevent the spread of the disease through transmission on planes, trains, boats, and buses (Whaley and Mansoor, 2006). One day later, seven central departments, including the MOH, issued an emergency notice to intensify the health quarantine and travel hygiene work (MOH, 2003f). The WHO arranged for more than 80 experts from 14 countries to support the technical work of the MOH (Schnur, 2005).

Second, the WHO played the role of referee to evaluate, supervise, and inspect the central governmental departments' response and the local implementation of SARS policy. The feedback provided to the central government improved the SARS policy. The WHO team extended the visits to most of China, including Shanghai, Heibei, Guangxi, Henan, Anhui, Tianjin, Shanxi, and Inner Mongolia. The team commented that some places, such as Shanghai, responded well, but some places, such as Beijing and Hebei, did not perform well. The Beijing Health Bureau still kept some SARS data secret; migrant workers in Hebei were the main cases of infection, caused by the lack of control (WHO, 2006c). The WHO reported the feedback to Vice Premier Wu Yi on 14 May. Six days later, the policy of SARS treatment and control in rural areas was published in which the tracing and surveillance of migrant workers were listed specifically (MOH, 2003j).

Third, to obtain better data from the central and Beijing city governments, the WHO continued to use the carrot-and-stick strategy. Apart from reporting the 'secret data' to the decision-makers, the WHO continued listing more provinces in China on travel advisory lists. However, the WHO also persuaded Beijing's government to release all the data and information to the public because the citizen 'needs to have more information on when and where infection is happening' (Whaley and Mansoor, 2006). Eventually, the Beijing Joint Working Team for SARS Prevention and Treatment opened a media centre that was



greatly contributed to by the WHO's support for the city of Beijing. The media centre was established not only for the release of more information but also to handle public relations during the crisis; it was led by an external intermediary, Serge Dumont (Leitner, 2014). In this way, Beijing's government released more and better data while rebuilding the government's image with the help of the WHO and the external experts.

This influence on the media and information went even further after SARS. With the WHO's media strategy and the lessons learned from the panic caused by the initial cover-up, the Chinese government built its own press spokesman system that still exists today. Both the local and central governments and different government departments have their own press spokesperson for publishing their own ideas (WHO, 2006a). The system published timely and official information during the H1N1 and H5N1 outbreaks,<sup>101</sup> which greatly contributed to the fight against the diseases (Liu, 2013c).

Fourth, the WHO brought China into the global health framework. On the one hand, within the Global Network, where the clinical, epidemiological, and laboratory data on SARS were shared globally, the WHO changed China's role from that of mainly an aid receiver to that of a scientific contributor (WHO, 2006a). By doing so, China opened the health research to the WHO and actively joined global health research.

On the other hand, the WHO contributed to the disease surveillance system in China together with the World Bank. The WHO assessed the Chinese healthcare system and informed the Chinese government about its weaknesses based on experience and information from the surveillance systems in other countries (WHO, 2006b). The WHO also discussed methods to improve Chinese surveillance through direct discussion with the MOH officials, China's experts, and the World Bank's financial support.<sup>102</sup> Beginning in May, these suggestions were reflected in two policies, 'Ordinance of a Emergency Public Health Event' (*tufa gonggong weisheng yingji tiaoli*) (State Council, 2003b) of 9 May and 'Regulations for the Prevention and Control of SARS (*chuanranxing feidianxing feiyan fangzhi guanli banfa*)' (MOH, 2003m) of 12 May. Both policies, issued by the main governmental departments dealing with SARS, included particular sections on how to monitor, analyse, and report on the disease. These sections were written based on previous MOH working policies, such as 'Emergency Notice of Further Regulation of SARS Report

<sup>101</sup> H1N1 is the subtype of influenza A virus that was the most common cause of human influenza (flu) in 2009.

<sup>102</sup> Interview with 007, a senior official of the World Bank's Beijing Office, 21/9/2011, Beijing.

Work’ (*weishengbu bangongting guanyu jinyibu jiaqiang chuanranxing feidianxing feiyan yiqing baogao gongzuo de jinjitongzhi*) (MOH, 2003c) and the WHO’s suggestions. The disease surveillance system was further confirmed to be built independently as a significant enhancement of the healthcare system when ‘Management Measures of the Epidemic Situation Surveillance Report of a Public Health Emergency’ (*tufaxing gonggongweishengshijian yu chuanranbing yiqingjiance xinxi baogao guanlibanfa*) (State Council, 2003b) was issued in November 2003. In the policy, the surveillance system was set up systematically from several perspectives, such as management, reporting, investigation, information management, and punishment. The WHO also sent experts with advanced experience and technology and provided funding to help the Chinese government to develop software for the disease surveillance and reporting for the MOH.<sup>103</sup>

The PEC’s influence on SARS policy mainly centred on the political stream in this stage. After the previous two stages, the epidemic disease problem had been identified and defined; treatment methods and policy solutions became available; the control policies and information discourse started. Though the PEC did put pressure on the Chinese government in the previous two stages, the pressure accumulated and reached its peak in this stage. The convergence of the three streams opened the policy window for policy change. The experts influenced the change in the policy principle to ‘mass prevention and control’ via direct meetings with the decision-makers, which formally set the agenda. The experts and the WHO influenced the change in practical SARS control policies both inside and outside the city of Beijing with technical assistance by working directly with government officials. The media influenced policies of medical workers’ motivation which was part of SARS control policies. The PEC also influenced information policies of both media reporting and disease surveillance policies by putting pressure on the Chinese government and through public relations strategies. Moreover, the PEC took the opportunity of SARS, a public health emergency and started to ask about the fundamental problems of China’s healthcare system, leading to the healthcare reforms that I will discuss further in the next two chapters.

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<sup>103</sup> Interview with 004, a senior director of the China CDC, Beijing, 19/09/2011.

#### 4.4 The consequences of the PEC's influence beyond SARS policies

The Chinese government controlled SARS as soon as the 'mass mobilisation and prevention' principle was launched along with the PEC's influence on the practical SARS policies. Beginning at the end of May, the WHO gradually removed China's provinces from the 'affected area' and 'travel advisory' lists (Ahmad et al., 2009). In May 2003, 'Wu Yi admitted shortcomings in China's control of SARS and management of information related to the disease' at the World Health Assembly (Zheng and Liang, 2004 p.67). On 24 June, the WHO declared that Beijing was 'SARS-free', marking the successful end of the SARS war (Abraham, 2005). In June 2003, the Minister of Foreign Affairs, Li Zhaoxing also conveyed Hu's idea publicly that China would like to cooperate with the international society in public health and epidemic disease control.<sup>104</sup>

However, the influence did not occur only in one direction from the PEC to the Chinese government but mutually between the Chinese government and the PEC. There were further consequences. First, the Chinese government institutionalises experts' consultancy role in the policy system. In January 2006, the National Expert Advisory Committee of Public Health Emergencies (*guojia tufa gonggong weisheng shijian yingji zixun weiyuanhui*) was founded within the MOH (MOH, 2006a). The committee consisted of both establishment and non-establishment experts who participated in the response to SARS, such as the CDC, the China Medical Association (CMA), universities, and public hospitals. There were 105 experts on the committee and six groups. According to three public emergency policies, the main job of the committee was to classify public health emergencies, provide governments with primary measures and preparations, make and amend contingency plans and technical proposals regarding public health emergencies, and give technical guidance to the handling of emergencies (State Council, 2003e, State Council, 2006b, State Council, 2006c). The committee is also responsible for giving advisory opinions to evaluate all actions after the termination of the emergency (LI, 2006b). In 2011, the organisational structure of the committee was further expanded. The number of experts was increased to 169, and the number of expert groups was changed to eight (MOH, 2011). The General Group was eliminated, while a crisis management group, a plague prevention group, and a psychological rescue group were added. The change in

<sup>104</sup> For the information of the speech, please see <http://www.fmprc.gov.cn/123/wjdt/zyjh/t23416.htm>, accessed 6/9/2014.

the expert groups shows that the policy consultancy area was broadened to include more specific areas of expertise. The update and improvement of the committee in 2011 enhanced the influence of the experts with more specified rules of organisation, management, working rules, funding, and publication. For example, it is mandatory for central and local governments to consult the committee for 'expert suggestions' on when and how to act when dealing with an emergency.

The Chinese government also hired individual experts who contributed greatly to the SARS response with their expertise. In April 2005, Zhong Nanshan was elected the seventh president of the CMA, the only one in history who did not serve as the Minister of Health.<sup>105</sup> The CMA has a long history in China and has a significant link with the MOH.<sup>106</sup> Zhong's joining the CMA was initiated by the Vice President Wu Yi with the aim of reforming the CMA to make it a less bureaucratic and more academic institution to better serve the society with its expertise (Ye, 2010).

Moreover, another expert, Zeng Guang's institutionalisation was via officially recognising his program and assigning him governmental commissions. In 2001, Zeng set up the Field Epidemiology Training Program (FETP) to train senior academics in the public health sectors in American Epidemic Intelligence Service (EIS) techniques.<sup>107</sup> Before 2003, the program was not recognised by the Chinese government. The program had to rely mainly on funding from the WHO and the United Nations International Children's Emergency Fund (UNICEF). However, since 2003, the Chinese government's financial support for the FETP has increased dramatically.<sup>108</sup> In 2006, the FETP became a formal cooperation program between the MOH and the United States Department of Health and Human Services (HHS) with the support of the MOH. Moreover, the Chinese government also hired Zeng as governmental commissioned experts to value and compare its response

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<sup>105</sup> For more information, please see <http://www.cma.org.cn/ensite/>, accessed 20/9/2014.

<sup>106</sup> The Chinese Medical Association (CMA) was established in 1915. It is a non-profit registered academic and commonweal corporate body voluntarily formed by Chinese medical science and technology professionals, and an important social force in the development of medical science and technology in China. The CMA was responsible for medical research and national policies in its sphere of expertise in the history.

<sup>107</sup> For more information, please see <http://www.cdc.gov/eis/index.html>, accessed 3/9/2012.

<sup>108</sup> Interview with 008, senior official of the China CDC, Beijing, 26/09/2011.

towards SARS and H1N1 in 2010.<sup>109</sup> The evaluation and feedback was considered as crucial reference for public health policy adjustment.

Second, the Chinese government changed the news reporting policies and the relationship with the media. The government learnt the lesson that news coverage could lead to public panic and social instability because the information will be leaked via different types of media. As mentioned previously, in the third stage, the Chinese government not only provided daily reports SARS but also established a media centre to deal with public relations with the support of the WHO and external experts. It was the first time that public relations became an issue on the government agenda, indicating that the Chinese government was concerned about the public opinion of its image. Therefore, the Chinese government systematically set up a spokesperson mechanism for information disclosure (Liu, 2013a). For instance, a series of policies was changed after the SARS outbreak to encourage news reporting and information release in the public sector (State Council, 2007b, CCP General Office and State Council, 2005).<sup>110</sup> Furthermore, the State Council Information Office started to organise the first formal spokesperson training programme in September 2003 for the professionalisation of information disclosure and public relations.<sup>111</sup> Since then, both the central and local governments have built their own spokesperson systems (Liu, 2013a).

The Chinese government also institutionalised the media. Some mainstream and traditional media that were influential in health or specialised in health news reporting, such as the *Beijing Evening News* and *Health Times*, were absorbed into the CMA as formal members, although the CMA never had media members before the SARS outbreak.<sup>112</sup> As members of the CMA, these media outlets have privileges to access senior health experts and senior MOH officials to obtain news. The government also held training sessions for health journalists and informal media briefings (*meiti tongqihui*) before formal press releases. The training of the health journalists was aimed to build a trusting relationship between the government and the journalists; the journalists could also have professional knowledge to judge the seriousness of a disease or the authenticity of health related information.<sup>113</sup> The informal media briefings were aimed to inform the media about the situation in advance

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<sup>109</sup> Ibid.

<sup>110</sup> I discuss this further in Chapter 3.

<sup>111</sup> For more information, please see <http://www.scio.gov.cn/>, accessed 14/3/2015.

<sup>112</sup> Interview with 009, senior journalist with the Beijing Evening News.

<sup>113</sup> Interview with 021, senior journalist with Health News, Beijing, 22/9/2011.

and refute rumours, if possible, so that the media could ask questions and report with greater focus at the formal press conferences.<sup>114</sup> The institutionalisation thus shaped the methods and tones of the news reporting. Compared to the strict control of the media before and during the SARS outbreak, the government changed from mandatory orders to soft ways of regulating the media report while giving leverage, although the media do not have as much free speech as their counterparts in Western democracies.

Third, the Chinese government learnt to obey international rules because the WHO brought it into the Global Network. The WHO made a resolution on SARS based on the experience of global cooperation and revised International Health Regulations to better regulate countries and respond to the global health threat (WHO, 2005b). The Chinese government not only strongly supported these policies but also actively operated under the regulations. For instance, while dealing with H1N1, the Chinese government contacted the WHO in the very beginning and asked for advice regarding the spread and treatment (Zhu and Liu, 2009). The Chinese government also invited a WHO team to visit China and shared laboratory information under the International Health Regulations (Wang, 2009a). In the meantime, the Chinese government worked closely with the WHO. For instance, ‘the WHO’s Beijing office and the China CDC usually work in the same labs and share health research information. We are so familiar with each other. People even change jobs among the MOH, its research institutions, and the WHO frequently’.<sup>115</sup>

The PEC’s influence extended profoundly beyond SARS policies. The Chinese government institutionalised the PEC while adapting to the PEC’s influence. As a result, the consequences of the PEC’s influence resulted in both the Chinese government’s adaptation and the PEC’s institutionalisation.

## 4.5 Discussion

### 4.5.1 Comparison of the PEC actors

Different types of actors functioned differently. First, the established experts within the central government have more credibility than the non-established and local experts to influence national policies because the established experts are closely connected with the

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<sup>114</sup> Interview with 006, senior journalist with Health Times, Beijing, 21/9/2011.

<sup>115</sup> Interview with 002, a CDC engineer, 5/8/2011, Beijing.

central government.<sup>116</sup> For instance, when the Political Bureau opened for direct meetings with the experts, Zeng Guang and established and central experts in the CDC were chosen to deliver a lecture with careful preparation, although his words were out of line in the end. However, the non-established and local experts could make their voices heard with the backing of local government, the media, and external authorities, such as the WHO. Although the established experts at the CDC insisted that the cause of SARS was Chlamydia, based on which the central government developed its original treatment policy, the non-established experts in Guangdong played a significant role in changing the SARS treatment policy with the support of the Guangdong Health Bureau and the WHO. The different attitudes toward the experts reflect a preference for working with ‘insiders’. Compared to the non-established experts, the established experts are ‘insiders’ to the central government because the established experts are linked to the central governmental agencies, such as the China CDC.

Second, the roles of the media differ between traditional and new media and between national and local media. When the central government controlled the media tightly, the rumours that spread via SMS and the Internet in Guangdong pressured the local government to lift the restriction and release information about the disease. This release pushed the central government to admit the existence of the disease. The follow-up reports in the newspapers, traditional and local media broadened the local government’s information release, although the national media were still under control. When the central government lifted the restriction on the media, the traditional media mainly reported positively to guide public opinion from the top down. However, the new media, particularly the Internet, became a main source of public concern from the bottom up. The local media have more leverage in the reporting than the national media, with the local government’s tacit permission. In contrast, the new media reflect the public’s thoughts more than the traditional media and are better able to leak restricted information because of the development of technology.

Third, the WHO and the Chinese central government compromised with each other. On the one hand, the WHO functioned as a corkscrew to gradually open the bottle of secrets in China using carrot-and-stick strategies. The WHO pushed the Chinese central government, as the representative of the international society, to express concerns about SARS and offer technical assistance, including disease investigation, laboratory research on the virus, the

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<sup>116</sup> I discuss this in Chapter 2.

setting of measurements for SARS treatment, and staff training. As an international health authority, the WHO brought China into the Global Network, which not only benefited the control of SARS in China but also pushed China to obey international rules and use internal standards in dealing with health matters in the future. However, the WHO also adapted to the Chinese context and obeyed China's rules. The WHO did not release any information before it was confirmed by the MOH. Moreover, the WHO's China office functioned as an intermediary in the cooperation and collaboration between the WHO and the MOH because the China office has experience working directly with the Chinese government. This mutual understanding is significant in maintaining a long-term and trusting working relationship between the WHO and the central government.

During the outbreak of SARS, the experts, media and international organisations coalesced unconsciously. Their coalition was very loose and informal. Each of them targeted some specific policies, but accidentally, some (or all) of their targets were the same, which influenced the policy change. For instance, both the Guangdong experts and the China CDC experts tried to influence the SARS treatment policies; while the WHO pushed the Chinese government to open the information and tried to find opportunities to access to the information in Guangdong. The Guangdong experts' finding matched the findings in other countries. Therefore, the WHO strongly backed the Guangdong experts and challenged the central government's decision which was the China CDC's finding. The Chinese government changed the SARS treatment policies accordingly and finally opened Guangdong for the WHO to investigate. The experts and the WHO wanted to influence the SARS control policies, in order to do which the Chinese government had to release the information to the public via media. The media pressured the government for SARS information. Therefore, the Chinese government lifted restrictions of media reporting first, then worked with the experts and the WHO and changed the control policies.

There is one essential condition for the PEC to function: the initial finding of SARS in Guangdong Province. The experts in Guangdong could resist the central government's order regarding the Guangdong Health Bureau's support. The media in Guangdong could report SARS information when the reports were mostly banned in other places in China because Guangdong had a long history of media commercialisation and leverage since the 1980s.<sup>117</sup> Guangdong has very close ties to Hong Kong geographically, culturally, economically, and socially. Therefore, when Zhong Nanshan used his personal network to

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<sup>117</sup> Ibid.



conduct joint research on SARS with the University of Hong Kong, the WHO received the result from Hong Kong in a timely manner, which gave the WHO strong evidence to persuade the central government to release more information. If SARS had not originated in Guangdong but somewhere else in China with an underdeveloped health system and poorly trained medical staff, conservative government, and strict media control, the PEC's influence would have been quite limited. The Guangdong government's actions (which were different from the central government) also reflect the gaps between the central and local governments (e.g., Guangdong's local governments) and among different governmental departments (e.g., propaganda departments and health departments) in accordance with the 'fragmented authoritarianism' theory.<sup>118</sup> The PEC operates within these fissures created by the fragmented political system and thus exerts its influence.

#### **4.5.2 The influence of the PEC on the three streams**

The three streams converged and resulted in the policy change. First, the PEC identified problems of the disease. There were two phases of the problem identification: the existence and the cause of the disease. The PEC first confirmed SARS in Guangdong and then studied the cause of SARS. The two phases of the problem identification influenced incremental changes in SARS treatment policy. The central government denied the existence of the disease at first and then insisted on using rifampicin as the main treatment. Later, the policy was changed to include the use of corticosteroids and the TCM treatment. Although Kingdon explained the problem stream and defined various types of problems, he did not identify the process of problem identification. The problems may not be identified at once but incrementally with the PEC's influence. For instance, the PEC increased the pressure on the Chinese governments and changed the problem identification of both Guangdong's local governments and the central government, after which the SARS treatment policy could be changed from the Guangdong local policy to the national policy. The PEC also incrementally changed the problem identification of SARS reporting. The PEC first pushed Guangdong's local governments to release the news of SARS, then, the PEC pushed the central government to release the news, and finally, the PEC pressured the central government to open the information of SARS fully.

Second, while identifying problems, the PEC also offered solutions to the government. Different problem identification methods are bound with different policy suggestions

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<sup>118</sup> Ibid.

because of achievement-oriented standards and technocracy in China.<sup>119</sup> The Chinese government sets achievement-oriented standards and needs expertise to solve practical problems. Therefore, the suggestions should be constructive, include possible solutions, and aim for a specific achievement. If the PEC wanted the decision-makers to accept their problem identification – their view of the problem – they had to offer specific solutions as part of a whole package while identifying problems. Then, the decision-makers accepted the policy suggestions after assessing the solutions, which is called ‘technical feasibility’ by Kingdon. For instance, in identifying the cause of SARS, the PEC offered treatment solutions. The Guangdong Health Bureau accepted and supported this policy solution because it was effective in treating patients in Guangdong. The central government eventually accepted the policy solution because both the WHO and Guangdong’s local government supported its usefulness. This process was a muddling through or a ‘trial balloon’, although it was not set by the central government intentionally. As discussed in Chapter 1, before a national policy is finally issued, the policy must be implemented in a few local areas as a trial. The results and feedback from the trial are then returned to the central government for further discussion and revision. If necessary, the trial–feedback–revision procedure can go through several rounds before a policy is finally implemented. When identifying the problems in Beijing, the PEC suggested mass prevention and control instead of treatment with solutions such as infection control within the hospitals and transportation control. The PEC shifted the SARS policy principle from treatment to control. When identifying problems with the disease surveillance system, the PEC offered solutions from the WHO’s Global Network, the experts’ technical expertise, and the World Bank’s funding. The surveillance system was then accepted by the central government and established very quickly.

Third, the increasing pressure and problem solutions raised by the PEC led to development in the political stream. Kingdon listed a few political activities that could lead to the formulation of government agendas in the political stream, such as the national mood, elections, shifts in legislatures, and interest group campaigns. During the SARS outbreak, the increasing public panic and international concern was the mood that pressured the Chinese government to release information and take action. Although China is not a liberal democracy with free elections, which could show the national mood directly, the PEC played the role of a bridge to transfer the mood to the Chinese government, like the Internet and the WHO did. Moreover, the PEC also set the mood. Jiang’s whistleblowing

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<sup>119</sup> Ibid.

to the international media was the culmination of the mood, after which the Chinese government put SARS on the agenda. However, instead of ‘flowing along independently’ as described by Kingdon, the policy change in China followed the multiple streams to the extent that the problem, policy, and political stream became entwined at the very beginning with an increasing degree of pressure. When this pressure accumulated to a certain point, the SARS policies started to change from denial and passivity to active defence.

Fourth, the Chinese government did not accept the PEC’s influence passively but adapted to the influence. During the SARS outbreak, the central government played a decisive role in the changing problem identification. At first, epidemiologists at the CDC were the leading experts, then, the clinicians and scientists in Guangdong were the main leading experts for treatment, and finally, the public health experts of the CDC were the leading experts on SARS control. Therefore, the government played a role in shaping the influence of the experts, although the experts influenced the government’s problem identification. The government’s commission of leading experts greatly determined the extent to which the experts could influence the policy change. For instance, Guangdong’s local governments supported Zhong from the beginning, so the SARS treatment and control were effective in Guangdong; while the central government’s support of the CDC experts in the beginning delayed treatment and control in Beijing. Therefore, even though Guangdong was the original SARS location, Beijing was the most seriously infected area, accounting for most of the infected cases.

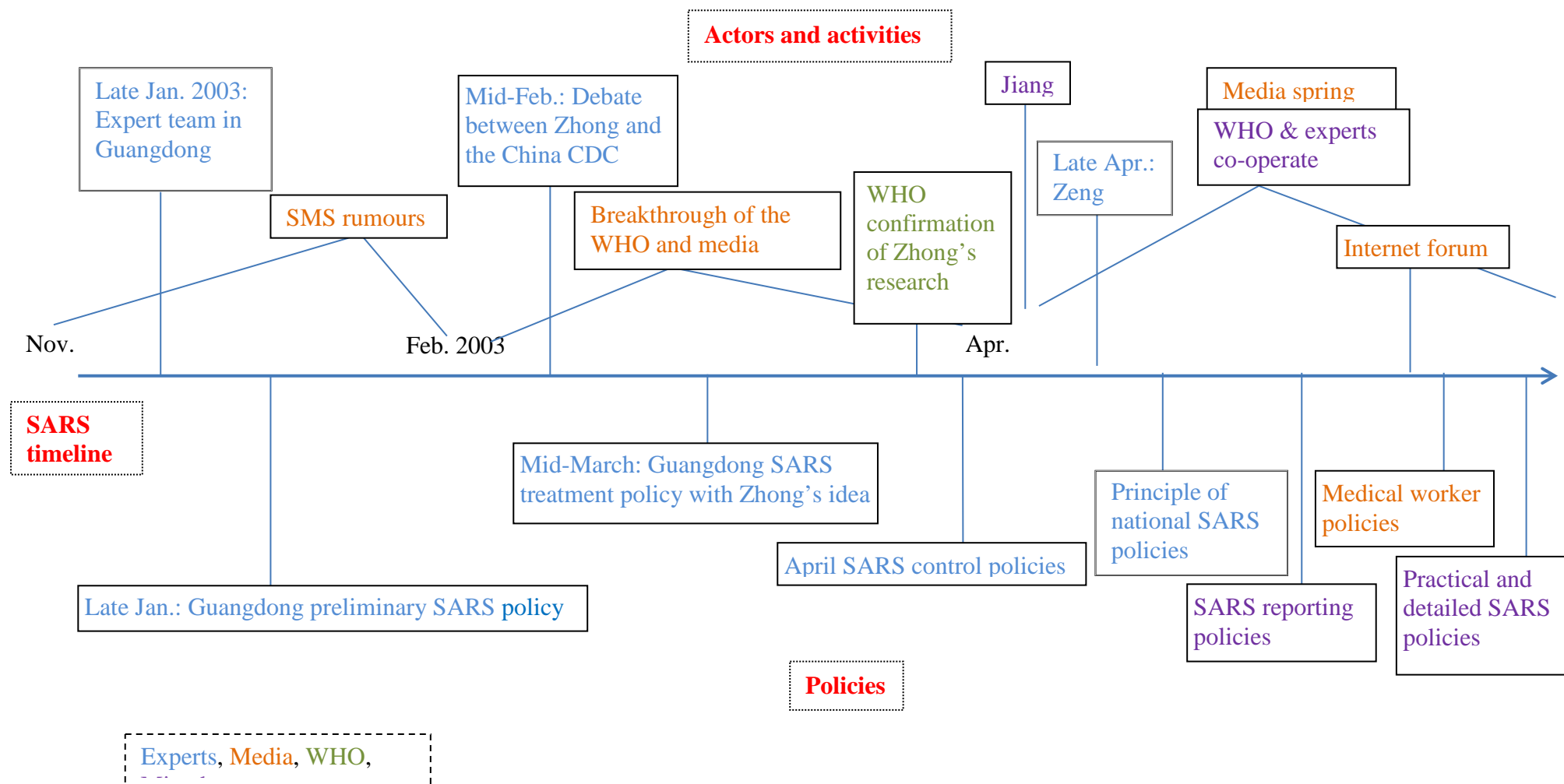
After the SARS outbreak, the Chinese government gradually institutionalised the PEC actors and absorbed their influence within the political system. On the one hand, the institutionalisation gave the PEC opportunities to gain access to stakeholders and government officials easily and thus exert their influence in the three streams. On the other hand, the institutionalisation also gave the Chinese government opportunities to exert influence on the PEC to take action under the government rules and regulations. The changes in the policies after the SARS outbreak resulted from a consensus built on the mutual influences.

## 4.6 Summary

The three actors functioned differently in the three streams during the SARS outbreak in three stages, as showed in Figure 4-3. The horizontal axis is the SARS timeline. The upper space shows the actors and their activities. The lower space of the graph shows the path of

SARS policy change. Different colours represent different actors. In stage 1, the experts played the main role in identifying the existence of SARS in Guangdong; while the indirect and limited influence of the media and the international organisations was to disseminate information about SARS. In stage 2, the experts identified the cause and effective treatment of SARS. The increasing public panic and news reporting in the media eventually pushed the Guangdong and central governments to admit the existence of SARS, and the WHO used the carrot-and-stick strategy to push China to release information and cooperate with the international society. In stage 3, the experts influenced the change in the SARS control policies principle and the practical policies. The Internet was a complementary channel for bottom-up information delivery and thus influenced the existing policy to provide more protection to the medical staff. The WHO joined in the control of SARS in China with open information and eventually brought China into the Global Network. In the end, the PEC's influence lasted after the SARS outbreak and extended to emergency policies, information disclosure policies, and health policies in general. The Chinese government even institutionalised the PEC's influence and adapted to the change actively.

To address the weaknesses of the health care system exposed by SARS, the Chinese government needs a fundamental health policy change – healthcare reform. The PEC continued and expanded their influence in the broader health policy area. In the next chapter, I will explain how the PEC initiated and set healthcare reform on the agenda, which started the ongoing health policy change.



**Figure 4-3 Detailed structure of the chapter**

## 5 The PEC's initiation of healthcare reforms

Chapter 4 showed how the Policy Entrepreneurial Coalition (PEC) influenced SARS policy change from November 2002 to June 2003 through defining the problem in the problem stream, providing policy solutions in the policy stream, and putting pressure on the government in the political stream, which contributed to the change of SARS treatment, control and media reporting policies. In this chapter, I argue that the PEC set healthcare reform on the agenda in 2005 by converging Kingdon's three streams (Kingdon, 1995a) via problem identification, policy solutions, and raising the national mood in the favour of the reform.<sup>120</sup>

The influence of the PEC during the SARS outbreak could have been a one-off influence that could not be sustained after the crisis. Although there was some contestation at first, the collaboration between the PEC and the government worked during the crisis because SARS was an emergency that could not be managed by political power (Huang, 2004). Even though the collaboration during the crisis proved to be successful in controlling SARS and the government was open to policy outsiders' ideas, there was no institutional mechanism within the authoritarian system for policy outsiders to continue to influence policy in normal times. Furthermore, there was no urgent need for the government to collaborate with the PEC after the SARS outbreak. The Chinese government does not necessarily need policy suggestions from the PEC and continual collaboration with the PEC in normal times.

However, the reality was that, after the SARS outbreak, the PEC continued to exert its influence on healthcare reform. The SARS crisis exposed flaws and problems in the medical care system. To fix these flaws and problems, the Chinese government started to implement medical care reforms in 2009 that led to a series of fundamental changes in health policy.

Based on this foundation, this chapter shows how the PEC continued to exert its influence on the initiation of healthcare reforms in 2005. The first section investigates how previous

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<sup>120</sup> The PEC members mentioned in this chapter, more specifically the experts and media, are not the same as those I discussed in the previous chapter. Besides the World Health Organization (WHO), one other international organisation is mentioned in this chapter. As I discussed in Chapter 1, the PEC members are not necessarily the same people or units, but the people and units share the same characteristics.

research has addressed the initiation of the healthcare reform. After indicating what researchers have overlooked in the discussions, the second section presents a detailed process about how a joint project by outsiders, namely experts of Development Research Centre (DRC), the WHO, and UK Department for International Development (DFID) set the agenda via media. The third section discusses the role that each type of outsiders played in the case. The final section summarises the chapter.

## 5.1 Academic consensus: the Report triggered the latest healthcare reform

There is a consensus among scholars studying healthcare reform in China that the research project conducted by the DRC in 2005 triggered a new round of healthcare reform (e.g. Huang, 2013, Kornreich et al., 2012, Thompson, 2009). The DRC carried out research on the healthcare system and published the DRC report (Reports) results,<sup>121</sup> respectively, in an internal journal and on China Youth Daily (CYD) (Wang, 2005f).<sup>122</sup> The CYD publicised the Report with a highly critical title, *The Healthcare Reform is Basically Unsuccessful*, which sparked a debate about the problems of the healthcare system. The debate also triggered a campaign to change the existing healthcare system and policy in the media. Three years later, a new healthcare reform started, with the final healthcare reform plan being launched in 2009.

The DRC is a think tank of the State Council (SC) and a research and advisory institution of the central government.<sup>123</sup> It has direct access to the SC, a core component of the political power structure. The main duty of the DRC is policy research and providing consultation for the Chinese Communist Party (CCP) Central Committee and the SC. Experts working in the DRC are established intellectuals who have an administrative rank within the political system. Although, compared to the central governments who have a

<sup>121</sup> Although scholars use the phrase 'DRC Report', which I think excludes the contributions of the WHO and the DFID, I use 'Report' in this chapter.

<sup>122</sup> For details on the Report, please see [http://zqb.cyol.com/content/2005-07/29/content\\_1150962.htm](http://zqb.cyol.com/content/2005-07/29/content_1150962.htm); for details on the whole series Report, please see <http://zqb.cyol.com/node/2005-07/29/zqgnb.htm>, accessed in December 2013.

<sup>123</sup> The DRC's close link to the Chinese government is similar to the links between The Bow Group and the British government, led by the Conservative party, with which the researchers of the DRC could be promoted as government officials, just as the researchers of The Bow Group could become officials of the Conservative Party. The DRC's research area is economic, social, and public policy, including health education and housing, which is similar to the area addressed by the Institute for Public Policy Research in the UK. Details on the DRC can be found at <http://www.drc.gov.cn/>, accessed in January 2014.

decisive role in policies, the DRC is still an outsider, according to the experience of established experts of the China Centre for Disease Control (CDC) during the SARS outbreak,<sup>124</sup> the Chinese government normally turns to established experts for policy advice (see Chapter 4). Therefore, the DRC was in a privileged position and was able to deliver advice and ideas to decision-makers.

However, this did not occur. What most scholars studying China's healthcare reform overlook is how the healthcare reform was initiated after the Report was published. The Report did not set the healthcare reform on the agenda easily within the policy system. Therefore, the DRC turned to external sources, namely the media. What happened after the publication of the Report? Why did the government initiate the reform? I present the full story – the whole process of the initiation of the healthcare reform.

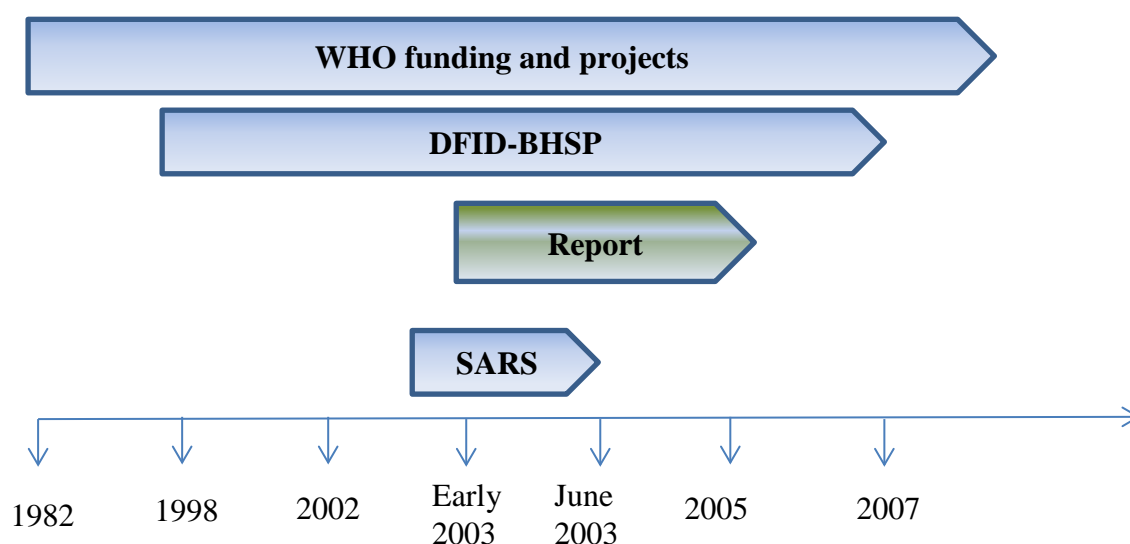
## **5.2 The full story: not all approaches worked**

The Report was a joint work by the DRC expert, the WHO and the DFID, because the WHO and the DFID have worked closely with the MOH on certain health projects in China. First, the World Health Organisation (WHO) had a long history of collaboration with the MOH even before SARS. The WHO had been conducting health projects to achieve the aim of improving health policy with the MOH, such as projects on different diseases (e.g., Sun et al., 2007, Kochi, 2001, Fu et al., 2003), projects studying different areas (e.g. Shi, 1993, Long-Shan et al., 2000), and projects on various other subjects (e.g. Helmer et al., 1997, Petersen, 2003). However, the research results did not have much influence on policy change (Wang and Fan, 2013). In particular, the joint work during the SARS outbreak gave an opportunity for Chinese government and the PEC to understand each other's working norms and ideas and build mutual understanding, which fostered trust and collaboration between them.

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<sup>124</sup> As discussed in Chapter 4, the government tends to seek suggestions from established experts first.





**Graph 5-1 Timeline of foreign projects in China and the Report**

Second, the DFID funded the Report via Basic Health Services Project (BHSP). Initially developed by the World Bank, the DFID stepped in the BHSP in 1998 in order to help the sustainable health for the residents of poor rural counties through a combination of supply- and demand-side by funding additional technical assistance and intensive innovation and lesson-learning (Bloom et al., 2009). From 1998 to 2007, the DFID offered technical skills (e.g. project design and implementation, quality evaluation and supervision) which contributed to other countries' success in rural area to the Chinese government officials and experts involved in the BHSP. Some experts trained in the BHSP actively involved in drafting China's New Rural Cooperative Medical System (NCMS) reform in 2002 (Bloom et al., 2009).<sup>125</sup>

After the SARS outbreak, the WHO and the DFID continued to conduct health projects in China. Graph 5-1 shows the timeline of the foreign projects and the Report. The DRC experts, the WHO and the DFID cooperatively evaluated the healthcare system and exploring the cause of the problems in early 2003.<sup>126</sup> The SARS outbreak fastened the speed of the research as the SARS outbreak made it more imminent to find solutions to the problems.

<sup>125</sup> Although the DFID greatly contributed to the NCMS, it was not a significant change in the overarching health policy direction at the time. In Chapter 3, I analysed overarching goal of health development in 2002, which clearly stated that the market played significant role in health while neglecting the role of government. But I do not exclude possibility that the NCMS could have led to a fundamental change in direction from marketization to government-led reform. However without external stimulus, it would take much longer to change, although the experience of the DFID project did offer valuable first-hand data in rural areas for the Report.

<sup>126</sup> Interview with 010, senior researcher at the China National Health Development Research Centre, 24/9/2013, Beijing.

The SARS outbreak exposed and evidenced problems in the healthcare system that were noticed by the WHO and the DFID over years of conducting projects. As a result, the WHO wanted to find a relatively independent research institution with a high-level research capability but still within the administrative system to conduct the health policy research.<sup>127</sup> The DFID agreed to participate and fund the research. The research proposal of the research coordinator, Ge Yanfeng, on evaluation of the healthcare system matched well with the research agenda of the WHO. Moreover, the DRC, where Ge worked, was the kind of research institute that the WHO was looking for. Although the funding for the project was very small (200,000 RMB) compared to most of the projects of the WHO and the DFID in China,<sup>128</sup> this research involved the WHO, the DFID as well as the experts from the DRC, the National Health Development Research Centre, the Beijing City Centre for Disease Control, the School of Public Health of Peking University, and Ministry of Labour and Social Security, along with external experts from outside China invited by the WHO.<sup>129</sup> The joint work of both external experts and China's experts brought results and experience from previous foreign projects in China, foreign healthcare systems in the world, and foreign research methods and ideas into the Chinese context.<sup>130</sup> It built consensus between external and Chinese experts. Although the external experts were not by-lined on the Report, the Report claimed that all the work was 'of collective achievements'.<sup>131</sup>

The research collaboration made very compelling arguments. The marketisation of the healthcare system made the medical resources unequal across the country. For instance, it is easier for citizens in urban areas to see doctors than for citizens in rural areas to do so, while most Chinese live in rural areas without health insurance. Furthermore, the health marketisation reduced government financial support and turned hospitals and doctors into business-oriented operations, which made it increasingly expensive to see doctors (Wang and Fan, 2013). The conclusion of the 'Report of Previous Health Reform' by the DRC

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<sup>127</sup> Follow-up interview with 014, MOH official, Beijing, 23/09/2013.

<sup>128</sup> Interview with 013, scholar of the Chinese Academy of Social Sciences, Beijing, 15/10/2013.

<sup>129</sup> According to the institutional reform plan of 2008 March, the Ministry of Labour and Social Security and the Ministry of Human Resource were combined to establish the Ministry of Human Resources and Social Security. However, I still use 'Ministry of Labour and Social Security' in reference to 2004 and 2005.

<sup>130</sup> The proportional contributions of the experts, the WHO, and the DFID to the Report are not clear.

<sup>131</sup> This might be the case because a by-line that includes external experts easily makes decision-makers suspicious about the 'interference of external forces' because of their ideology, as I discussed in Chapter 2.

(Wang, 2005f) was as follows: ‘The healthcare reform was basically unsuccessful’ (*yigai jiben buchenggong*). Although the Report did not generate new data of their own, it synthesised some existing data to make a compelling argument about the problems in the healthcare system. Moreover, even though the data were not new to the researchers, it might be still new to the decision-makers.

In the meantime, there were also voices within the MOH questioning the health policies towards marketisation. In August 2003, the MOH visited the city of Suqian, which led the health marketisation in the 2000s by privatising all public hospitals in the city (Southern Weekend, 2005). Although some officials of the MOH strongly criticised the marketisation in Suqian, there were also voices within the MOH calling for cities to ‘speed up the hospital privatisations’ (Mu, 2006).

### 5.2.1 Direct approaches

The Report was firstly delivered within the central government through direct approaches. In December 2004, the findings of the research project were sent to both decision-makers and the central departments as an internal reference (*neican*).<sup>132</sup> By the beginning of 2005, the Report had been disseminated broadly within the central government. Moreover, the DRC also sent the Report to international organisations such as the WHO, the World Bank, and the United Nations. But there was no response from governments.<sup>133</sup>

The Report was also published in a DRC internal journal, *China Development Review* (*zhongguo fazhan pinglun*) (March 2005, volume 7, issue A01).<sup>134</sup> The issue included nine papers on the research project analysing the healthcare system from different perspectives, including the change in the context of healthcare system since 1949, the input and performance of the healthcare system (Shi and Gong, 2005), public health (Ge and Wang,

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<sup>132</sup> The internal reference is up-to-date news and a report designed especially for policymakers beyond a certain level that is provided mainly by senior journalists with official news agencies, such as the Xinhua News Agency, *People's Daily*, and *Guangming Daily*. It has a long history that can be traced back to the *Yan'an* period. It serves as a special and crucial information channel for key policymakers for their decision making, so the information that appears in internal references will have a direct effect on the decision-making process. It functions as ‘eyes and ears’ and a think tank. Serving as eyes and ears means that journalists tell policymakers what they see and hear. Through the think tank function, the journalists suggest solutions to problems.

<sup>133</sup> Follow-up interview with 014, senior MOH official, Beijing, 24/09/2013.

<sup>134</sup> *China Development Review* is a DRC internal journal that publishes the organisation’s own research. The journal is mainly circulated within the central government.

2005), urban workers' medical insurance (Gong, 2005), rural healthcare (Wang, 2005j), epidemic disease prevention (Ge and Sun, 2005), and a framework design for a new healthcare system (Ge, 2005). The main conclusion was that there were serious problems in the healthcare system in terms of equality and performance (Ge et al., 2005). The commercialisation of the healthcare system and the state retreat undermined the financial foundation of the system, which led to the dysfunction of the system during the SARS outbreak (Ding, 2005, Lei et al., 2005). Therefore, the experts strongly suggested that a new healthcare reform focusing on equality and performance and bringing back government control should be initiated. Surprisingly, although the journal was a significant and direct internal reference for decision-makers of the CCP and the SC, there was no feedback on the project from the decision-makers.

In the same month, the Report was also delivered directly to the participants of the China Development Forum (*zhongguo fazhan luntan*),<sup>135</sup> including the Vice Premier, the Vice President of the Political Consultative Conference, the Minister of Foreign Affairs, the Director of National Development and Reform Commission, the Minister of Commerce, the Governor of the People's Bank of China, and the Vice Minister of Finance.<sup>136</sup> Me Ge also gave a presentation in the forum on the healthcare system problems and advocated for the reform. Perhaps because of the theme of the forum – China in the World Economy<sup>137</sup> – the Report was 'again neglected'.<sup>138</sup>

To get more attention, the research team published the results in a mainstream newspaper, the *China Economic Times* (*zhongguo jingji shibao*) in June 2005.<sup>139</sup> The newspaper is sponsored by the DRC and affiliated within the DRC's administrative system. Its subscription base includes mainly governments from the central to the county level, state-

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<sup>135</sup> The China Development Forum is a high-level dialogue platform for Chinese political leaders and foreign experts to talk about China's development. The China Development Forum 2005 was held in Beijing on March 20-21.

<sup>136</sup> For the full list of names, please see <http://www.cdrf.org.cn/plus/list.php?tid=161>, accessed in November 2013.

<sup>137</sup> The theme was 'China in the World Economy'. Five issues were discussed: China's macro-economic trend and the world economy, structural upgrading and technological innovation in China's manufacturing sector, China's public finance reform in the opening-up, China in the world trade system, the opening-up of China's financial market, and new trends in the international financial system. <http://www.cdrf.org.cn/2005cdf-cn/> accessed in November 2013.

<sup>138</sup> Interview with 013, scholar of the Chinese Academy of Social Sciences, Beijing, 15/10/2013.

<sup>139</sup> *The China Economic Times* is a daily newspaper focusing on economic issues. Its readers are mainly governmental and business elites.

owned enterprises, and public institutions. Judging from the audience of the newspaper, the newspaper had the potential to be influential in China's development. The paper published the research project for four consecutive days and interviewed Mr Ge. The newspaper laid out the problems of the healthcare system and solutions to the problems clearly as follows. First, given the scarce medical resources, the aim of the healthcare system should be to treat all citizens' basic health needs equally rather than prioritising some citizens' health needs or equalising all needs.<sup>140</sup> Second, the healthcare system was not equal because urban and rural citizens did not enjoy equal protection on healthcare, and, what is worse, both the urban and rural insurance systems failed to protect poor citizens' health needs.<sup>141</sup> Third, the new healthcare system should improve public health and the prevention of epidemic diseases.<sup>142</sup> Fourth, a good healthcare system should balance the input in healthcare and the performance of the healthcare system, and health development is not an accessory of economic development but should be considered a main part of the national development strategy.<sup>143</sup> Hence, the government should intervene in the distribution of health resources and the building of the healthcare system.

The first formal response of the central government was from the MOH. In May and June 2005, two senior officials of the MOH criticised the healthcare marketisation (Southern Weekend, 2005). On 1 July 2005, the then Minister of Health, Gao Qiang, made an openly critical speech of the previous healthcare reform towards marketisation (Gao, 2005). However, there were also different opinions within the central government. A senior official of the SC stated that state funding would be withdrawn from public hospitals, which was a strong signal of the deepening marketisation (Southern Weekend, 2005). The contradictory opinions of the central government showed that some officials favoured the new healthcare reform suggested by the Report, but it was still too early to reach a consensus within the government because some other officials still favoured marketisation.

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<sup>140</sup> The details of the interview can be found at [http://lib.cet.com.cn/paper/szb\\_con/93794.html](http://lib.cet.com.cn/paper/szb_con/93794.html), accessed in November 2013.

<sup>141</sup> The details of the Report can be found at [http://lib.cet.com.cn/paper/szb\\_con/114040.html](http://lib.cet.com.cn/paper/szb_con/114040.html), [http://lib.cet.com.cn/paper/szb\\_con/114039.html](http://lib.cet.com.cn/paper/szb_con/114039.html), accessed in November 2013. [http://lib.cet.com.cn/paper/szb\\_con/114039.html](http://lib.cet.com.cn/paper/szb_con/114039.html), accessed in November 2013.

<sup>142</sup> The details of the Report can be found at [http://lib.cet.com.cn/paper/szb\\_con/114038.html](http://lib.cet.com.cn/paper/szb_con/114038.html), [http://lib.cet.com.cn/paper/szb\\_con/102692.html](http://lib.cet.com.cn/paper/szb_con/102692.html), accessed in November 2013.

<sup>143</sup> The details of the Report can be found at [http://lib.cet.com.cn/paper/szb\\_con/102694.html](http://lib.cet.com.cn/paper/szb_con/102694.html), accessed in November 2013.

## 5.2.2 Indirect approach

### The CYD's articles

Since the direct approaches did not result in an agreement on healthcare reform within the central government, the DRC experts turned to an indirect approach which was outside the government.<sup>144</sup> A month later, the CYD publicised an edited version of the research Report 'in its own way' (Wang and Fan, 2013).<sup>145</sup> The CYD publicised the Report as a series of special articles. The CYD's special articles consisted of two interviews with Ge titled 'State Council Departments Say China's Healthcare Reform Is Basically Unsuccessful' (*guowuyuan jigou cheng, zhongguo yigai jiben buchenggong*) and 'It Is Just a Matter of System Design' (*zhishi zhidu shejide wenti*), two articles summarising the joint Report titled 'China's Health System Has Shown "American symptoms"' (*zhongguo weisheng xitong ranshang meiguobing*) and 'Three Prescriptions to Fix the Healthcare Problems' (*sanda yaofang zhiliao yigai bingzheng*), one interview with patients titled 'Pains of Four Families' Healthcare' (*sige jiatingde jiuyi zhitong*), one interview with a doctor titled 'Doctors Said That They Did Not Feel Fair' (*yisheng shuotamen bupingheng*), and one investigation report with numbers. I translated part of each article as follows:

'The ongoing healthcare reform caused four main problems', said Ge: 'equity of medical care services is decreasing, health investment is inefficient at the macro level, the direction of the healthcare reform towards marketisation and commercialisation is totally wrong, the urban medical insurance system has obvious defects on its own, and its prospects are not optimistic' (Wang, 2005f).

'Because of the characteristics of the basic medical health undertaking, neither the selection of basic security objectives nor the section of health intervention emphasis can be realised on its own by simply depending on the market. The only solution is to strengthen the government function. This is also the decisive factor to get great achievement in the medical health undertaking during China's planned economy period. The government responsibility should be mainly reflected in two aspects: one is to strengthen the government fund-raising and distribution function and the other is to intervene in the building and development of the health service system' (Wang, 2005d).

<sup>144</sup> So far, there is no evidence showing whether or not the DRC approached the CYD intentionally with the aim of agenda setting via the media. An interviewee told me that a CYD journalist approached the DRC about the Report publicity via her personal network. However, this statement has not been verified by other interviewees or the literature. Therefore, I do not address this issue here. No matter who approached them first, the DRC did not know about the CYD reporting in advance and worried about the CYD's publicity because of the great public debate it caused. Therefore, the DRC and the CYD were more likely to have 'collaborated' by accident instead of internally.

<sup>145</sup> The CYD is a quasi-liberal newspaper. It is ran by the state-run and associated with the Communist Youth League of China.

‘American symptoms’ have two basic characteristics. The first is low efficiency and the second is unfairness. Generally speaking, there are two reasons for low efficiency, i.e. waste of resources and utilisation of resources in programs or measures of low efficiency. Poor fairness is mainly because of the improper redistribution of resources. The following section is concerned with the direct reasons for the problems of low efficiency and inequality and even more with their underlying reasons’ (Wang, 2005a).

‘In future reform, we must break the boundary line between urban areas and rural areas and among different ownerships and build an integrated healthcare system covering all the citizens, which could not only better achieve the social equity and safeguard the basic health rights of all the citizens, but also avoid the vested interest group separation caused by system segmentation and the contradiction and conflict arisen from it’ (Wang, 2005i).

‘Shi Zhenjun is a migrant worker from Henan to Beijing. A few days ago, he fell from the 6th floor at work and was seriously injured. He has been in hospital for three days, which cost him over 20,000 yuan. His salary is only 40 yuan per day and he just started the work one month ago. He had no money to pay to the hospital. He could not tell his family because his wife is expecting a baby soon and his parents are too old and weak’ (Wang, 2005e).

‘Doctors take commissions for over-prescription and over-examination because our payment is too low. Two years ago, when I started the work here, my salary was just above 1000 yuan per month which was even less than a cleaner’s. Patients pay 5 yuan for diagnosis, but the doctors only take 10% maximum from this payment, which is too little. The commission of medicines and examinations could make up for the low salary. Moreover, the law of “Burden of Proof by defendant” [juzheng zeren daozhi] indicates that the doctors have responsibilities to provide medical evidence in order to prove that they treat the patients by following formal procedures. Therefore, the doctors have to protect themselves by examining the patients as much as possible. Otherwise, the patients may sue the doctors for not taking enough care of them’ (Wang, 2005c).

‘A World Bank Report shows that medicine cost is 52% of total health expenditure in China, which is only 15%-40% in most countries. 12%-37% of the health expenditure is wasted on over-prescription. From 1990 to 2002, the proportion of the examination fee for in-patient and out-patient service fees increased from 28% to 36.7%’ (Wang, 2005b).

The CYD publicised the Report in a critical tone supported by strong evidence, including the Report results, normal citizens’ real problems in the healthcare system, comparisons with other countries, and solutions. The evidence made the publicity vivid and compelling, which soon resulted in public sentiment criticising the healthcare reform because it reminded the citizens how increasingly difficult it was to see and afford a doctor.

There were reasons for the CYD to publicise the Report in a ‘challenging way’. First the CYD was a national semi-official newspaper with a strong tie with the Communist Youth

League that represents openness to reform within the CCP (Duckett, 2012). Therefore, the publications in the CYD were conventionally seen as the Communist Youth League's perspective, which tended to be critical and pro-reform. Moreover the CYD conventionally focused on social issues, such as health. For instance, as early as the 1990s, it reported that Chinese citizens feared being ill because they could not afford it (China Youth Daily, 1996). Second, the propaganda system might be not sure whether the Communist Youth League supported the CYD on publicising the articles. As discussed in Chapter 2, the functional differentiation and fragmented political system separated governmental departments from each other. Therefore the information flew within the separated departments sometimes lagged vaguely. Although the propaganda system controlled the media system, the system still separated from the Communist Youth League system. Therefore, the propaganda system was not sure whether the CYD's publicity of the Report was supported by the Communist Youth league (because of the close ties) or not (which meant that the then President Hu might also support it). Moreover, as discussed previously, there were officials' voices criticising the health marketisation publicly. The CYD took the advantage of this ambiguous situation. Therefore, although the CCP and the Chinese government had never overtly criticised their previous policies, regardless of whether or not these policies were internally acknowledged to be damaging, the CYD's critics of the healthcare reform did not bring the CYD further punishment.

### **The escalated discussions in the media**

The CYD articles and the government's tolerance on the report of health soon sparked a heated public debate in the media, and healthcare reform (*yigai*) became a hot topic. First, traditional media joined the discussion with massive reports. Some mainstream newspapers joined the healthcare reform debate, reporting pros and cons.<sup>146</sup> For instance, Duckett and Langer (2013) examined newspaper narratives of the healthcare reform from 2005 to 2009 which supported there was a continued growing media attention. Based on articles published in the three major national publications, *People's Daily*, *Beijing Youth News*, and *Caijing*, the coverage of healthcare reform in traditional media from 2005 to 2009 was continually growing. Though the distribution of articles on healthcare reform in the three mainstream newspapers fluctuated, starting in June 2005 when the Report was published in the CYD, the coverage of the healthcare reform in general experienced an upward

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<sup>146</sup> These ideas are discussed in detail in the next chapter.



movement and reached its peak in March 2009 when the healthcare reform policy was launched.

Those ‘anecdotal evidence reported by Chinese media points to ridiculously high expenditures on hospital care, poor quality of services, and use of fake or low-quality medicines’ (Tang et al., 2008). The increasing media reporting of tensions and violence between patients and doctors in China also drew public and government attention to the serious problems of the healthcare system and the consequences (Zhang and Sleeboom-Faulkner, 2011). Therefore, the media reports triggered citizens to join the discussion criticising the healthcare system and calling for a new healthcare reform on the Internet.

Second, the public discussion on the Internet was intense. I searched *Tianya* with the keyword ‘yigai’ and found 21,284 posts related to the healthcare reform.<sup>147</sup> I took the post with the most replies as an example to explain the public concern and focus. This post was published on 26 February 2008 with 82,016 reviews and 2,967 replies (which indicated the popularity of the post because the normal number of replies was between the tens and the hundreds).<sup>148</sup> The main post was titled ‘Chinese doctors are the cheapest’ (*zhongguode yisheng zuilianjia*). The post explained the cost and difficulties of a coronary bypass operation in China and compared a patient’s spending and the doctor’s income. It concluded that, although the cost was almost unaffordable for the patient, the doctor was paid much less. That is the reason that the doctors prescribe expensive medicines and take *hongbao*. As the *Tianya* main post said:

‘The cost of a coronary bypass operation in a provincial hospital is 63,446 yuan, which is a huge burden to most Chinese. However, the operation fee is only 2,000 yuan (which is the payment to the doctors). The operation needs six doctors and eight hours, which means that each doctor is paid only 42 yuan per hour. Where is the rest of the money going? Most of the money is spent on medicines and medical facilities. For instance, a roll of Johnson & Johnson sutures (M8737) costs 308 yuan, and the M88610 sutures cost 464 yuan. The coronary bypass operation usually uses five to six rolls of the sutures, which means that the payment for the six doctors’ eight hours of work is much lower than the cost of the sutures. The doctors have families as well who need to live. The doctors have to find other ways to earn money when they cannot earn what they deserve. Some doctors prescribe expensive medicines because the commission fee from pharmaceutical companies is good, while some doctors take patients’ *hongbao* as extra payment. The doctors know it is wrong, but they do not have other choices’.<sup>149</sup>

<sup>147</sup> I discuss *Tianya*’s information in Chapter 4.

<sup>148</sup> <http://bbs.tianya.cn/post-no01-379621-1.shtml>, accessed 16/3/2015.

<sup>149</sup> Ibid.

In the replies, the citizens expressed their opinions, which covered many perspectives addressed in the Report, such as medical insurance, community hospitals, unaffordability, and inaccessibility. Examples include the following: ‘It is a medical insurance problem. We need a well-designed and affordable insurance system’. ‘I queued three hours in a hospital. A doctor talked to me less than three minutes and prescribed very expensive medicines. My problem was even worse after using the prescriptions. I think we need reservations and community hospitals to split patients so the doctors have more time for each patient’. ‘Although doctors are low paid, taking bribes and making money out of patients is so wrong. The patients are ill already. It is both immoral and unethical’. ‘Most of the expensive medicines and medical instruments are imported from foreign countries because Chinese factories either cannot produce them or the quality is not good. We need to put more money into research on high-quality medicine and medical instruments and reduce the imports’. ‘The doctors also need to cover the loss of the hospitals when patients run without paying fees’.<sup>150</sup>

This themed post (both the main post and the replies) represented the heated discussion of the public opinion on the healthcare reform, because it was just one of the 21,284 posts on *Tianya* and *Tianya* was just one chat forum of the tens of thousands on Internet.<sup>151</sup> The heated discussion on the Internet indicated a public that was focused on the healthcare reform and expected the reform to address the healthcare system’s problems.

Third, the public showed their great interest in the healthcare reform by searching for the relevant information online. Figure 5-1 shows that, beginning in June 2006, citizens increased the debate on the Internet gradually.<sup>152</sup> I used *yigai* as the search keyword. The public debate started in July 2005 when the Report was published.

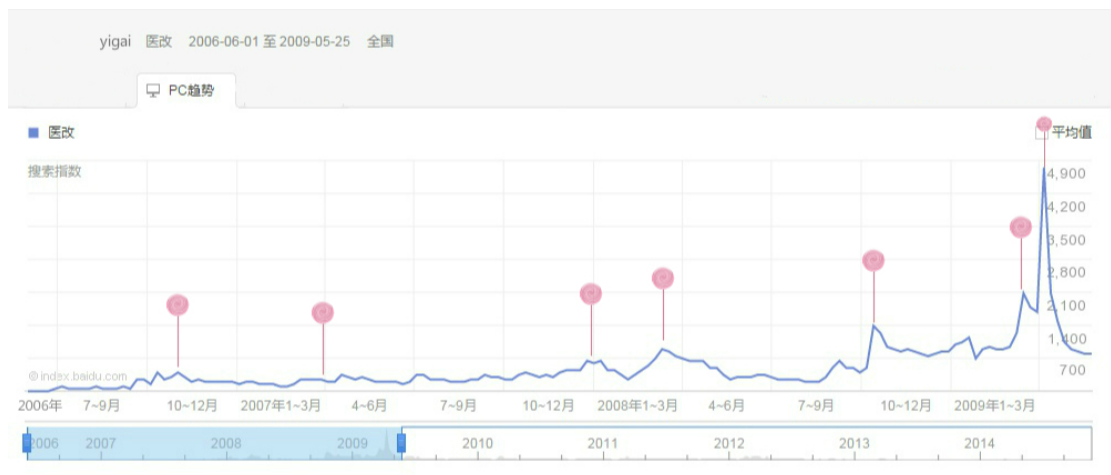
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<sup>150</sup> Ibid.

<sup>151</sup> Please see the other posts on *Tianya*, such as the posts with the second and third most replies: <http://bbs.tianya.cn/post-free-683081-1.shtml> (116,681 views and 2,439 replies) and <http://bbs.tianya.cn/post-free-619259-1.shtml> (33,443 views and 1,814 replies), accessed 16/3/2015.

<sup>152</sup> I use a figure from the Baidu (百度) index. Baidu is a leading and dominant Chinese-language search engine in China for websites, audio files, and images, which is similar to Google in the English-speaking world. 64.5% of Internet users in China use Baidu to search for information. In other words, around six out of ten Internet users in China use Baidu to search for information. Thus, by checking how frequently a keyword is searched on Baidu, the trend of public interest in the keyword can be estimated. For the details on the figure, please see <http://marketingtochina.com/china-seo/>, accessed in November 2014.

The time frame I considered was from June 2006 to April 2009,<sup>153</sup> when the healthcare reform policy documents were issued.<sup>154</sup> Each point on the wave is the average number of *yigai* searches per week. For instance, the first peak time of *yigai* searches was October to November 2006, which was around 430 times on average per week; another peak time was mid-March 2008, at around 930 times per week on average. Half a year later, the number of searches was around 1,430 on average in mid-October 2008; at the beginning of April 2009, when the medical reform policy was finally announced to the public, the average number of searches was 4,900 per week. Although the figures fluctuated, overall, the search trend was growing constantly and gradually, which indicates that, after the Report of the CYD was issued, citizens started to focus on and frequently discuss the healthcare system and reform.



**Figure 5-1 The frequencies of citizens searching for *yigai* on Baidu from June 2006 to April 2009.** Source: Baidu index.

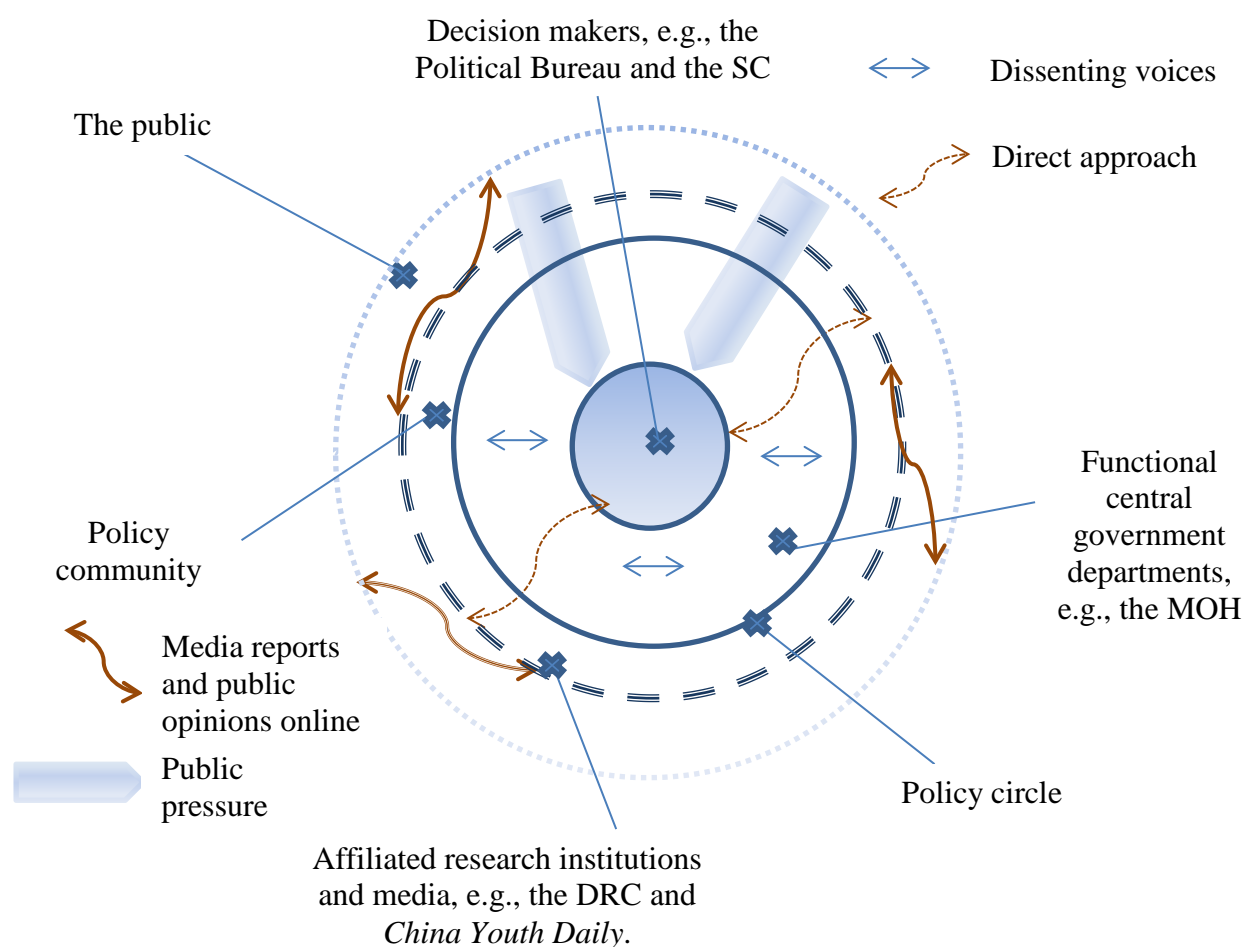
The CYD's article speeded the agenda setting of the healthcare reform by expanding the debate from within the government to the public. The follow-up media reports put public pressure on the decision-makers and facilitated the agenda setting of the healthcare reform. Although the MOH scrutinised the health policies right after the SARS outbreak when then Vice Premier Wu Yi was in charge (Duckett, 2010k), and some of the MOH officials'

<sup>153</sup> However, the Baidu index can only search for online information dating back to June 2006. It allows users to look up the search volume and trends for certain trending keywords and phrases. It can serve as a Baidu keyword research tool. See <http://chineseseoshifu.com/blog/use-baidu-index-for-chinese-keyword-research.html>, accessed in November 2014.

<sup>154</sup> Ideally, I wanted to see the period from June 2005, when the Report was published by *China Youth Daily*, to April 2009. However, since the Baidu index only started in June 2006, the earliest time I could get was June 2006. Even without the time from June 2005 to June 2006, a gradually and constantly growing trend of Internet searches for *yigai* is still shown. Another reason that I chose the period ending in April 2009 is that this was when the initiation and preparation of the medical reform was completed.

favoured the healthcare reform before the Report was published or even publicised in the CYD, there were always dissenting voices within the central government and even within the MOH. The decision-makers at the top level did not formally respond to the different voices until the CYD's articles, regardless of the DRC's initial direct approaches within the political system.

Graph 5-2 shows the pathway of the DRC's approaches. As discussed in Chapter 1, within the policy circle, both decision-makers at the top level (e.g., the Political Bureau and the SC) and in the functional departments (e.g., the MOH) are policy insiders who have a decisive role and veto power in deciding policies. Outside this circle is a loose policy community (discussed in Chapter 2) where the PEC exerted influence on the insiders. The public is the farthest from the policy circle. The DRC experts took the direct approach first by delivering the Report within the government. But it did not set the agenda, which was determined by the formal voices from the decision-makers, although some MOH officials supported the Report. The MOH's support could not set the agenda without the decision-makers' approval. While dealing with inter-departmental policies, the MOH has the decisive role. However, the healthcare reform was too big and significant, and it involves multi-departmental cooperation and thus cannot be decided by the MOH alone. The indirect approach which was the CYD's articles to the public, led the escalated media reporting of the problems with the previous healthcare reform, which triggered the public pressure placed on the decision-makers to respond to the Report formally.



**Graph 5-2 The pathway of the PEC's influence**

### 5.2.3 Results of different approaches

Although there was no evidence of how the top levels set the agenda within the government, the policy process of the new healthcare reform that was advocated by the Report was formally launched soon after the CYD's articles. One week after the CYD's publicity, the SC asked the DRC experts to provide a more detailed research report (Wang and Fan, 2013), although the research findings had been sent to the SC before as an internal reference. In response to the call from the SC, the research team prepared and sent a new report to the decision-makers of the SC and the CCP Politburo Standing Committee. The call for the detailed research report by the SC was a positive sign from the decision-makers, as it showed that they were interested in the suggestions of the experts for healthcare reform.<sup>155</sup> Soon after the call from the SC, the MOH took a series of actions to

<sup>155</sup> Interview with 004, CDC official, Beijing, 19/09/2011.

follow up on the research report. The MOH announced publicly that it was working with other departments to start a new healthcare reform program. The Health Minister also contacted the experts to schedule meetings with the MOH officials to discuss the problems of the healthcare system and to ask for professional inputs in the new healthcare reform.<sup>156</sup>

In March 2006, at the National People's Congress (NPC) and the Chinese Political Consultative Conference, the DRC research Report was the most heated topic, sparking a heated debate on the healthcare reform among the delegates (sohu, 2006). The result was a series of policy announcements in the Report on the Work of the Government (2007), which was delivered at the fifth session of the Tenth NPC on March 5, 2007:

‘...In order to solve the problem of unaffordable and inaccessible (*kanbingnan kanbinggui*) health service, we will accelerate reform and the development of public health programs. We will focus on four areas this year in our work to develop a system of primary healthcare services for both urban and rural residents. One is to energetically promote the new type of rural cooperative healthcare system. Two is to accelerate the establishment of a new type of urban healthcare service system based on community facilities. Three is to launch the trial of basic medical insurance for urban residents that covers mainly major illnesses, with the government providing necessary assistance to the poverty-stricken population. Four is to improve the prevention and treatment of major communicable diseases.’ (State Council, 2007d)

The four points correspond to the research findings and suggestions of the 2005 Report, which include rural and urban health insurance, rural and urban health services, medical reform, and epidemic disease prevention. The Report not only helped to initiate the new healthcare reform but also provided the decision-makers with new ideas and suggestions that ultimately became principles of policy change.<sup>157</sup>

Moreover, although the project experts were worried because the CYD used the name of the SC to criticise the previous healthcare reform without the SC's authorisation,<sup>158</sup> the SC recruited one of the experts into the MOH and promoted several other experts to different positions within the healthcare system.<sup>159</sup> This signalled that the DRC had become more highly valued by the SC and a more influential advisory institution in the national policy

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<sup>156</sup> I will discuss it in the next chapter.

<sup>157</sup> I do not mean that the DRC experts' idea was the only source of the reform policy or that they decided on the medical reform. Here, I discuss only the initiation of the reform process. I will explain more in the next chapter about how experts influenced the reform policy.

<sup>158</sup> Interview with 013, scholar of the Chinese Academy of Social Sciences, Beijing, 15/10/2013.

<sup>159</sup> Interview with 014, senior MOH official, Beijing, 08/09/2011.

process than it had been. This changing attitude of the decision-makers towards the DRC encouraged other experts to join the new healthcare reform policy.

### 5.3 Discussion

The PEC initiated the healthcare reforms. The experts and the international organisations conducted the research project collaboratively. The Report was covered by a traditional media outlet with large circulation that decision makers started to pay attention and eventually initiated the healthcare reform. In this process, the PEC identified problems, framed them in a way that the decision-makers could understand and accept, offered solutions, and generated a national mood by raising public opinion of the ideas of other actors in favour of the reform. This fits into Kingdon's multiple stream theory: when the problem, policy, and political streams meet, windows of opportunity open for policy change.

First, the DRC experts and the WHO identified the problems and worked out solutions via the collaborative research sponsored by the WHO and the DFID. Although there were other scholarly voices addressing the healthcare system problems from various perspectives, the DRC project systematically and comprehensively discussed the cause of the problems, the urban and rural medical insurance system, the epidemic disease control system, and the framework design of the healthcare system change. The Report gave an intuitive and overall view of the whole healthcare system problem historically, socially, politically, and economically in a well-reasoned way to call for a fundamental change in the healthcare system via healthcare reform. Moreover, the Report mentioned the unaffordability and inaccessibility problems from the citizens' perspective and in alignment with the leftist ideology and principles of President Hu Jintao, which focused on fixing social problems.<sup>160</sup> Opinions that are close to those of the decision makers are easy to accept.

However, problem identification alone is not enough.<sup>161</sup> The DRC also offered a systemic design for the healthcare reform as policy solutions. Therefore, the decision-makers could evaluate the Report and consider the suggestions from various perspectives, such as

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<sup>160</sup> I discuss this in Chapter 2.

<sup>161</sup> I discuss how Chinese governments value suggestions with solutions in Chapter 4.

technical feasibility and future constraints. This explained why the DRC's direct approach did not set the agenda initially. Because of the close link between the DRC and the SC, it is unlikely that the Report did not get to the decision-makers. That leaves us with one possible explanation: it would get to the decision makers but not be placed on the agenda immediately because of the complexity of the solutions.

Second, the problem identification and the policy solutions did not set the agenda until the CYD publicised the Report. This indirect approach via the media accelerated the agenda-setting process by arousing the public opinion, and the traditional media soon spread information about the problems of the healthcare system and the significance of the healthcare reform. The escalated media reports and public debate that followed the publishing of the Report helped to urge the government to face a problem that had been neglected for years and offered better public healthcare. The problems stream, policy streams and political streams converged which opened windows of opportunity for agenda setting and started the healthcare reform policy process.

Third, after the agenda setting, the Chinese government brought DRC experts into institutions. Some of them were recruited into the healthcare system as policy formulators. This institutionalisation is a double-edged sword with two consequences. On the one hand, bringing the experts in could increase support for healthcare reform within the political system and thus decrease the barriers to reform while pushing for reform policymaking. On the other hand, institutionalisation of the experts also inhibits their ability to call for radical change in the healthcare system, which could keep the healthcare reform in a stable scope.

Compare to the coalition during the outbreak of SARS, the experts, media and international organisations coalesced more intentionally this time, although it was not entirely a strategic collective action. First, the DRC experts, the WHO and the DFID did the research consciously. Second, the DRC experts initially tried to influence the policy makers and decision makers directly with the research report to a limited extent within the government without involving the public. But it did not work. Third, the CYD's publicity, although was an unintentional action, triggered the public sentiment criticising the health system and health marketisation. It eventually attracted the government's attention that the DRC experts previously failed to do and set the agenda. The coalition was then gradually turning from an unintentional collective action towards an intentional one.



Why the central government did not punish the DRC experts or the CYD for the critical and negative Report? First, although the Report criticised the previous healthcare reform, the main part of the Report was an objective articulation of solutions to the problem rather than blaming the government or the CCP. Second, the Report was circulated within the government exclusively for a while before it was made public. This indicated that the DRC experts did not aim to attract public attention initially but instead to seek government support. Third, despite the shocking title used by CYD that the DRC experts did not know in advance, the DRC experts did not want to challenge the authority of the government or the CCP but instead aimed to solve social problems and strengthen political stability, which in turn made them trustworthy to the government. Fourth, all the actors in the Report – the DRC experts, the WHO, the DFID, and the CYD – are credible to the Chinese government. The DRC experts have a strong established network within the political system. The WHO and the DFID have a long history of collaboration and thus have high authority in health matters in the eyes of the Chinese government. In particular, the cooperation with the WHO during the SARS outbreak made it trusted by the government. The CYD belongs to China's Communist Youth League, where China's leader at the time, Hu Jintao, used to work. It is a norm or invisible rule that the top leader's 'faction' (*paixi*) will not be punished when the top leader is still in power. Fifth, as I discussed in chapter 2, the ideas in the Report, such as social equality and people's livelihood, are aligned with the decision-makers' principles and ideology focusing on a harmonious society and leftism, thus making these ideas easy to be accepted by the government.

## 5.4 Summary

After influencing the SARS policy in 2003, the PEC set the agenda for the healthcare reform. By converging the three streams, namely the problem stream, policy stream, and political stream, the PEC opened the windows of opportunity that led to the initiation of the healthcare reform.

After the SARS outbreak exposed the healthcare system's problems, the DRC experts and WHO took the opportunity and conducted collaborative research with the funding from the WHO and the DFID to evaluate the healthcare system, investigate the problems, and analyse their causes. The outcome of the research was a comprehensive Report, which compelled a new healthcare reform. However, even though the Report was delivered directly to the decision-makers and the central government several times from 2004 to the

middle of 2005, it was repeatedly overlooked until a national newspaper, the CYD, reported the research findings in July 2005. The report of the CYD soon started a national debate and campaign for healthcare reform. The public appeal that resulted from the CYD report soon drew the attention of decision-makers. Starting then, the research Report was taken seriously by the central government and eventually taken into account in the healthcare reform plan. The healthcare reform plan of 2009 basically covered the policy suggestions made in the Report and changed health policy. As shown, the publication of the Report by the DRC experts and the WHO in a national newspaper set the agenda for the healthcare reform and initiated the health policy change.

The policy change during the SARS outbreak was mainly aimed at a change in infectious disease policy, while the healthcare reform was a fundamental policy change involving a number of health policies. It aimed at improving the healthcare system with a change in medical resource distribution and redistribution by changing health policy directions. As discussed in Chapter 2, the health policy of the healthcare reform re-adjusts the relations between the state, market, and community, changes the allocation of social capital and resources, and re-divides the interests of individuals and society.

After the agenda setting, the PEC continued its influence by joining the healthcare reform policy process broadly. After rounds of departmental debates, expert research demonstrations, public consultation, and policy review, the Chinese government finally published a new decision on the healthcare reform. The next chapter will look at this process.

## **6 The PEC's influence on policy change in healthcare reforms**

Chapter 4 showed that the influence of the Policy Entrepreneurial Coalition (PEC) on the SARS policy change occurred mainly within the Ministry of Health (MOH) system and under extraordinary circumstances, namely the SARS crisis, while Chapter 5 showed that even after the SARS outbreak, the influence of the PEC continued and reached the upper level of the Chinese government (e.g., the Political Bureau and State Council) by initiating the nationwide healthcare reforms in 2005.

After the initiation of the healthcare reforms, which occurred, the reform policymaking process from mid-2005 to mid-2009 went through a broad range of consultations that involved a wider scope PEC than the outbreak of SARS and the initiation. Tracing the timeline of this process, I argue that the PEC influenced the healthcare reform policy change with respect to the dynamics between the pro-market and pro-government directions, which reshaped the roles of the government and the market in the healthcare reform.

This chapter articulates how the PEC joined the healthcare reform policy debate and influenced the reform policy. From the agenda setting of the healthcare reform in mid-2005 to the reform policy launch in mid-2009, both stakeholders and the PEC embarked upon one political venture after another (Kornreich et al., 2012). They expressed their opinions in various ways to influence the healthcare reform policy, which made this process like a debate. The PEC took advantage of the debate and influenced the healthcare reform policy by shaping the pool of various policy options presented to the stakeholders and decision-makers. As a result, compared to the previous healthcare reform policy of the 1990s which marketised and commercialised health (Duckett, 2010a, Huang, 2013), this reform policy was a hybrid that restored the government's role and realigned both government and market roles in the re-distribution of medical resources.

Scholars have studied China's healthcare reform from different perspectives. Some have studied the reform by investigating the fragmentation of the reform policy process. Kornreich and his colleagues (2012) studied intra-bureaucratic bargaining within departments at the central government level and argued that the compromise between them

decided the final reform policy, while Ho (2010) argued that the decentralisation between the central government and local governments influenced the reform policy. In these two studies, the role of actors outside of government is overlooked.<sup>162</sup> Others have studied the role of different actors involved in the policymaking process of the reform. Duckett and Langer (2013) discussed the mainstream media reporting on the debate between the two factions and presented the dynamics of the debate. Bloom et al. (2008) presented a preliminary analysis of the health policy process and explained the ability of experts and international organisations to influence China's health policy. Zhu (2013) explained how think tanks influenced the new rural cooperative medical scheme and the new urban healthcare system, both of which are sub-policies of the healthcare reform. Wang and Fan (2013) explained how different actors interact with the government and influence the reform policy. Balla (2014) studied citizens' participation through online consultation regarding a proposed revision to China's healthcare system by the CCP and focused on how demographic characteristics and subjective motivations affect citizens' online participation.

Existing studies on China's healthcare reform have two limitations: first, the whole picture of the PEC's role in developing the reform policy has not been uncovered; second, we know little about the strategies used by the PEC in shaping the reform policy and the pattern of their influence. This chapter attempts to fill the gap in the existing studies in the following way. The first section reviews the different directions of the healthcare reform and introduces a general debate within the PEC and the government regarding the reform directions, which later led to the formation of two factions. The second section analyses the PEC's direct influence with governmental commissions, which shaped the policy pool for the reform policy. The third section explains the PEC's influence after the government coordinating the previous commissioned research. The fourth section discusses the influence of the PEC over the reform policy. The fifth section summarises the chapter and discusses a limitation.

## 6.1 General debate

According to existing research on the healthcare reform, there were two factions in the debate that advocated for contradictory reform directions: the government faction and the

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<sup>162</sup> Though Kornreich touched on some other actors, he focused on the debate within the department and saw other actors as bargaining tools rather than individual actors.

market faction (e.g. Wang and Fan, 2013, Ho, 2010, Duckett and Langer, 2013). Both factions agreed that there were serious problems in the healthcare system that needed to be fixed urgently, such as unaffordability and inaccessibility (China Research Center for Public Policy, 2008). However, they differed regarding the causes of the problems and how to fix them. The government faction thought that the problem was a result of the marketisation and privatisation of the healthcare system, through which the government lost the ability to regulate and guide the supply of public goods (e.g. Li et al., 2012, Bai, 2005). Therefore, the change in the healthcare system should bring back the command and control mechanism of the government in the health area (China Research Center for Public Policy, 2008) and let the government dominate and regulate healthcare services. In contrast, the market faction argued that the problems of the healthcare system could be attributed to too much government intervention in the previous healthcare reform, which inhibited market development. The government's excessive intervention in the health area disabled the market mechanism to balance healthcare and price through free competition; as a result, medical services became increasingly expensive (Zhou, 2008). To fix the problems, the government should completely retreat from the health area and fully marketise and privatise the healthcare system. These two opposing opinions resulted in the debate on the reform policy direction.

### **6.1.1 General debate within the PEC**

The debate on the two policy directions can be traced back to the end of the SARS crisis, when the government started to question the previous marketisation healthcare reform (*Southern Weekend*, 2005). However, the debate occurred mainly within the government, though 'critics of market-oriented, privatising healthcare system reforms apparently began to prevail over the market voices' in 2004 (Duckett, 2010k p.7). The DRC report of 2005 spilled over from the debate into the public and accidentally started a campaign for healthcare reform. Since then, 'various actors have deftly used diverse outlets to further their ideas and agendas throughout the process. Prominent Chinese academics in particular have been very vocal, appearing regularly on television and being quoted often in news articles. Analytical articles have been written by government economists, policymakers, and nongovernmental academics. Health bureau officials have been particularly vocal, indicated by frequent media interviews, press conferences, and policy speeches at conferences' (Thompson, 2009 p.65).

To draw on the wisdom of the masses, on 10 September 2005, *Southern Weekend* organised a forum and invited health experts to talk openly about their opinions of the healthcare reform (Zhao and Cao, 2005). The experts invited were Yu Zonghe, Professor Li Ling, Yu Hui, Professor Gu Xin, and Guan Zhiqiang.<sup>163</sup>

Focusing on the DRC report,<sup>164</sup> the experts discussed concepts and possible operational pathways for national medical insurance. Their opinions on the pathway for national medical insurance differed. Professor Li suggested a universal national health insurance system like the UK's NHS system, funded by national tax income. Yu Zonghe agreed with Professor Li and explained that, because of the decrease in government funding to hospitals since the 1990s, hospital workers relied on over-prescription to generate profits; therefore, the government should subsidise hospitals. In contrast, Professor Gu proposed a basic national insurance system covering limited medical services for both urban and rural citizens and suggested that the basic national insurance should be provided by private companies rather than the state. Yu Hui agreed with Professor Gu and stated that health services should be handled by market mechanisms in an environment of free competition. The government should not intervene much but fund insurance companies to pay medical fees. Guan Zhiqiang did not take a clear position between the factions but emphasised two points: first, supplemental insurance could address the affordability of serious disease treatment but not that of small diseases. Second, it was urgent to establish a high-level committee above various departments at the central government level to coordinate important public issues, such as health, education, and the environment.

Although all the experts agreed that, to change the healthcare system, the government needed to invest a huge amount of funding in the health area, there were tremendous

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<sup>163</sup> Yu Zonghe had previously worked for the MOH as Director of the Department of Medical Administration, in charge of reforming hospital classification and evaluation. He was retired at the time of the forum. Professor Li Ling was (and still is) a health economist at Peking University.

Yu Hui was (and still is) a social science researcher at the Chinese Academy of Social Sciences (CASS) and is also affiliated with other research institutions, such as China's Research Centre for Public Policy (RCPP) and the Unirule Institute of Economics.

Professor Gu Xin is also known as Edward Gu, a social science professor previously at Beijing Normal University and now at Peking University.

Guan Zhiqiang was a researcher at what was then called the Social Insurance Institute of the Ministry of Labour and Social Security (MOLSS). The MOLSS changed its name to the Ministry of Human Resources and Social Security (MHRSS) in 2008. However, in this chapter, I still use MOLSS because the organisation joined the reform before changing the name.

<sup>164</sup> For more information on the DRC report, please see Chapter 5.

differences of opinion on how and where to invest. Professor Li Ling and Yu Zonghe suggested that the government should invest on the supply side of health, such as in medical institutions, while Professor Gu and Yu Hui argued that the government should invest on the demand side, such as in insurance and pharmaceutical companies.

In addition to the *Southern Weekend* forum, the Unirule Institute of Economics (*tianze jingji yanjiusuo*) organised two forums to analyse the problems and difficulties of the healthcare reform and put forward its suggestions on the reform policy.<sup>165</sup> The first forum was held on 2 September 2005 (Unirule, 2005), which invited Professor Gu Xin to give a presentation titled ‘Towards Marketisation with Regulation: The Strategic Choice of China’s Medical System Reform’ (*zouxiang guanlide shichanghua: zhongguo yiliao tizhi gaigede zhanluexing xuanze*). Professor Gu explained that the cause of the affordability and accessibility problems was the fast-growing outpatient and inpatient fees as well as the low level of health insurance coverage. To solve the problems, the healthcare reform needed general practitioners (GPs) to take charge of primary care to control outpatient and inpatient fees. At the same time, mandatory insurance could increase the basic national insurance coverage, which can help citizens to afford medical services. Following Professor Gu’s presentation, Yu Hui and Zhao Jie further specified that marketisation was not the reason for the failure of the current healthcare system; rather, government intervention was.<sup>166</sup> Furthermore, support for free competition, such as privatising hospitals and allowing the free flow of medical workers, could solve the information asymmetry between patients and doctors. However, drawing upon health economics theory (e.g., Samuelson and Paul), Lei Haichao, the co-author of the DRC report, refuted Gu and Yu’s suggestion. He argued that the asymmetric information between doctors and patients made it impossible for patients to make rational choices like they do in a normal market and that this asymmetry cannot be solved using market mechanisms. Thus, the health area needed government regulation and control. Zhao Nong, though he agreed with health

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<sup>165</sup> The Unirule Institute of Economics (Unirule) is an independent, non-profit, and non-governmental (NGO) think tank that was jointly initiated in July 1993 by five prominent economists, Prof. Mao Yushi, Prof. Zhang Shuguang, Prof. Sheng Hong, Prof. Fan Gang, and Prof. Tang Shouning. Unirule focuses on research in economics, such as institutional economics, and maintains a highly prestigious status within academic circles.

<sup>166</sup> Zhao Jie was a social science researcher at the Central Party School of the CCP.

marketisation, insisted that the government and a third sector, such as medical associations, should regulate the health market.<sup>167</sup>

The second forum was held on 31 March 2006 (Unirule, 2006), where Professor Li Ling presented 'The Current Situation of the Healthcare System: Problems and Countermeasures' (*yiliao tizhide xianzhuang, wenti ji duice*). Professor Li compared different healthcare systems in Western countries and recommended the British NHS model as the direction for the reform. She pointed out six problems: weak public health caused by limited government funding, high medicine and medical instrument prices caused by insufficient government regulation, poor vertical hospital system, limited price control caused by the low level of commercial insurance coverage, poor social capital mechanisms to enter and exit the health market, and poor motivation mechanisms for medical workers. To solve the problems, the reform should be led by the government and supplemented by market mechanisms because the market alone cannot allocate public goods efficiently. The professor repeated and stressed the significance of health to the sustainable development of the state and supported more government input into health. Gao Shusheng agreed that the government should be in charge of medical resource allocation, but he also suggested that a primary care system involving GPs and commercial insurance should be set up, as it is more suitable to cover old people's health needs.<sup>168</sup> Guan Zhiqiang agreed with the government dominance approach and stated that the cause of the healthcare system problems was the revenue and tax redistribution system. The central and local governments have not determined how much they should share in the health inputs, and the medical costs thus fell on the patients. To fix the problems, the reform should make it clear that both local and central governments should share most of the cost. Lei Haichao largely agreed with Li's suggestions but disagreed with the point that introducing competition in health with external capital could lead to better healthcare provision. In contrast, Zhang Chunlin attributed the unaffordability and inaccessibility of health services to government control of hospitals and argued that the healthcare reform should adopt a marketisation strategy.<sup>169</sup> Zhao Nong again criticised the government hospital monopoly and cited the hospital privatisation in Suqian as the model for the marketisation of healthcare. Professor Mao Yushi and Professor Sheng Hong insisted that

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<sup>167</sup> Zhao Nong was a social science researcher of the CASS.

<sup>168</sup> Gao Shusheng was a social science researcher at China's Centre for Insurance and Social Security Research at Peking University and is now working at the Ministry of Finance (MOF).

<sup>169</sup> Zhang Chunlin was a World Bank representative in China.



healthcare is a private good instead of a public good, so the market should provide it and that only through privatising hospitals and pharmaceutical companies could better health services be provided.<sup>170</sup>

Furthermore, some experts also expressed their opinions of the reform directly in the media. For instance, leading economist Professor Zhou Qiren wrote a weekly series of special columns in *The Economic Observer* newspaper (*jingji guanchabao*) titled ‘A Series of Comments on Healthcare Reform’ (*yigai xilie pinglun*) (Cheung, 2007).<sup>171</sup> In over 40 articles, Zhou analysed the problems of the healthcare system and strongly recommended market-oriented healthcare reform. He argued that the problems included medical workers’ lack of motivation to focus on medical work and to provide health services; the government’s insufficient investment and excessive intervention; the health market’s lack of openness to external capital; and expensive medicine and medical fees caused by government price controls. The lesson we can learn from the hospital privatisation in Suqian is that the government should keep the public health service part, such as prevention and emergency treatment, but privatise hospitals.

The media reported not only on these experts’ ideas but also on the whole debate (Wang, 2009e). While broadly reporting the debate from 2005 to 2009, ‘the media took diverse positions, with narrative centring on market and state roles in health’ (Duckett and Langer, 2013 p.6). Through extensive coverage of the debate, the media contributed to an ongoing national discussion along with the policymaking process by maintaining the public debate’s high profile (Bloom, 2011), which built a policy environment that kept the healthcare reform on the priority agenda.

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<sup>170</sup> Professor Mao Yushi is a leading economist in China and the co-founder of Unirule.

Professor Sheng was (and still is) an economist, a member of Unirule, and a professor at Shandong University.

<sup>171</sup> Professor Zhou is a leading economist at China’s Centre for Economic Research at Peking University.

*The Economic Observer* was founded in 2011 by the Sanlian Group, a diversified state-invested company based in the Shandong province. It publishes information on China’s market liberalisation and reports on socioeconomic and political events.

Pro-government	Pro-market	Mixed
Professor Li Ling	Professor Gu Xin	Zhao Nong
Yu Zonghe	Yu Hui	Guan Zhiqiang
Lei Haichao	Zhao Jie	Gao Shusheng
	Zhan Chunlin (World Bank)	
	Sheng Hong	
	Mao Yushi	
	Professor Zhou Qiren	
	Professor Liu Guo'en <sup>172</sup>	

**Table 6-1 Experts and international organisation representatives of the pro-government faction and the pro-market faction<sup>173</sup>**

The experts and international organisation representatives expressed different ideas for the reform policy on various forums and via the media. The debate was nascent, but the division between the two factions became clear. Table 6-1 shows the respective experts and international organisation representatives in each faction.<sup>174</sup> Both Professor Li Ling and Professor Gu Xin became the leading symbols of their respective faction because of their contradictory ideas. They continued to express their ideas on various occasions. Although they were distinguished in their opinions on who should take the dominant role in the reform at the macro level, the government or the market, they did not entirely deny the role of the other in the reform. The debate that followed addressed in depth at the micro level how to separate government and market responsibility for health, such as insurance, hospital reform, and medicine distribution.

### 6.1.2 The differentiation within the central government

At the same time, the function and area differentiation of the departments within the central government contributed to the internal debate. The departments within the central government rely on a division system, within which ministries and affiliated agencies only take charge of issues within their own areas. For instance, issues related to insurance belong to the MOLSS; hospital and issues related to medical workers and patients belong

<sup>172</sup> Professor Liu Guo'en is an economist at Peking University and is mentioned later in this chapter.

<sup>173</sup> Because of time and space constraints, I cannot list all the citizens who presented their ideas during that time. Here, the citizens who represented the two factions are listed.

<sup>174</sup> I list only the leading figures among the experts and international organisation representatives who joined the debate.

to the MOH; and funding and financing issues belong to the MOF. This division of labour is efficient in the sense that each department can concentrate on the governance of its own area with the limited resources it possesses. However, even though all departments are technically under the control of the CCP, each department can only understand the issue from its own perspective based on its working experience in the area it is responsible for. Hence, when an issue is linked to a few areas and goes beyond the jurisdiction of one department, it becomes difficult to develop a policy that can satisfy every department.

‘The healthcare reform was such a big issue that linked more than 10 departments’, said the Minister of Health at the ‘Two Meetings’ of 2006 (Liu, 2007).<sup>175</sup> ‘Besides the MOH and the State Administration of Traditional Chinese Medicine, medical security is in the charge of the MOLSS, medical infrastructure construction is in the charge of the National Development and Reform Commission (NDRC), medical price is in the charge of the Price Bureau, hospital subsidies and expenses are in the charge of the MOF, medical salvation is in the charge of the Ministry of Civil Affairs, medical workers’ education is in the charge of the Ministry of Education, and medicine quality control is in the charge of the State Food and Drug Administration’ (Liu, 2007).

Furthermore, even within one department, the understanding and idea of the reform varied. For instance, an MOH official told the *21st Century Business Herald* that the health reform would adopt the British NHS model and offer free medical services (Beijing News, 2006), which was strongly recommended by the pro-government faction.<sup>176</sup> However, another MOH official criticised the dual track of revenues and expenses (*shouzhi liangtiaoxian*) at the Chinese People's Political Consultative Conference (CPPCC) meeting even though it was a significant part of the reform that the MOH strived for (Wang, 2009d).

To coordinate the work related to the reform within all departments, the Health Reform Coordination Group (RCG) was established within the SC in September 2006. The RCG consisted of 16 governmental departments and was led by both the NDRC and the

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<sup>175</sup> ‘Two Meetings’ is a common Mandarin Chinese abbreviation for the annual meetings of the National People's Congress (NPC) and the Chinese People's Political Consultative Conference (CPPCC).

<sup>176</sup> The *21st Century Business Herald* is sponsored by the Southern Media Group, which is famous for being critical.

MOH.<sup>177</sup> However, it did not change the ‘communication problem’ within the government (Liu, 2007).

‘There was very limited communication between the four sub-groups within the RCG. The MOH led a few departments within a group and the MOLSS led another group. Although they all discussed issues within each group, the groups did not communicate with each other. Even within each group, citizens clearly separated issues based on the original area. For example, when I discussed medical insurance within the MOLSS group, as long as it was related to medical services, citizens stopped me and said that this topic belonged to the MOH group and we should not discuss it’.<sup>178</sup>

The differentiation and communication problem led to two opposing designs for the reform envisioned by the two factions within the central government: ‘the MOH favoured a supply-side solution, under which the majority of government financing would be channelled directly into public hospitals – primarily rural and urban community medical facilities ... while the MOLSS ... advocated a demand-side solution, under which the government, acting as insurer, would purchase health services from health-care providers rather than funding the services directly’ (Kornreich et al., 2012 p.182).

### 6.1.3 Interaction between the PEC and the government

The debate extended beyond the PEC and the government. The government officials, experts, and international organisation representatives met on several occasions to discuss and debate the reform. The media covered the debate extensively. The interactions between the PEC and the government broke the boundaries of the inter-governmental differentiation and led the debate into a broader and deeper area, in which citizens discussed both macro and micro designs for the reform.

The hospital privatisation in Suqian was discussed frequently in the debate. Suqian sold most of its public hospitals beginning in 2000 (Mu, 2006), which was a milestone of the previous marketisation healthcare reform. To determine the reasons for the healthcare

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<sup>177</sup> The government did not publish an official list of the departments involved in the RCG. Even the media reports of the RCG departments varied. Administrative reform in 2008 also changed the members of the RCG. Therefore, I list 16 initial RCG members here which changed slightly as time passing by: the NDRC, the MOH, the MOF, the MOLSS, State Commission Office for Public Sector Reform, Ministry of Education, Ministry of Civil Affairs, Ministry of Personnel, State Population and Family Planning Commission, Legislative Affairs Office of the State Council, the DRC, China Insurance Regulatory Commission, State Food and Drug Administration, State Traditional Chinese Medicine Administration, State-owned Assets Supervision and Administration Commission of the State Council, All-China Federation of Trade Unions.

<sup>178</sup> Interview with 001, a professor of the CASS, 09/03/2011, Beijing.

system's problems, Professor Li Ling conducted independent research along with her team using first-hand data in Suqian in April 2006. The output of the research was a report titled 'Report of Healthcare Reform in Suqian' (*suqian yigai diaocha baogao*). In the report, Professor Li stated that the marketisation did not solve the problems of 'unaffordability and inaccessibility' but made things worse by increasing the burden on ordinary people. The report was sent to the MOH and published by the *China Youth Daily* in June 2006 (Li, 2006a).<sup>179</sup> Afterwards, the MOH and Policy Research Office of the CCP Central Committee (ROCCP) met with Professor Li several times to talk about her understanding and research for the reform plan. The ROCPP even asked her for a more detailed research report (Wang and Fan, 2013).

In the meantime, different governmental departments invited experts to attend meetings, lectures, and workshops to talk about their opinions regarding the reform and asked for their suggestions. For instance, the MOH invited Professor Liu Yuanli;<sup>180</sup> the MOH, the MOF, and the MOLSS invited Professor Wang Hufeng.<sup>181</sup> These experts were the leaders of the market faction.<sup>182</sup>

The interactions of the debate sharpened the differences between the two factions with respect to their opinions on the reform and turned the debate focus from general principles to more specific areas. Table 6-2 shows the key points of each faction. These key points were very high profile and incorporated into the policies later.

In June 2006, the NDRC published 'Guidance of Medical Industry Development during the Eleventh Five Year Plan' (*yiyao hangye shiyiwu fazhan zhidao yijian*). It pointed out the two key problems of the current healthcare system: 'medical insurance cannot guide the use of drug effectively in hospitals; over-prescription is rampant and competition in the health market is in disorder.... in the meantime, hospital pharmacies still monopolise the supply of drugs in the drug consumption market' (NDRC, 2006). Although this policy document did not state in detail the direction of the reform, it was the first policy that specified the two key areas of the healthcare reform – medical insurance and medicine

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<sup>179</sup> Interview with 013, researcher in the CASS, 09/10/2013, Beijing.

<sup>180</sup> Professor Liu Yuanli works for both Tsinghua University and Harvard University.

<sup>181</sup> Professor Wang Hufeng is an economist. He worked for the MOLSS (2002-2005) and has been a professor at Renmin University since 2005.

<sup>182</sup> Interview with 013, researcher in the CASS, 09/10/2013, Beijing.

distribution. These two key areas were not new to the NDRC, as they were at the centre of the debate between the two factions before the publication of the policy document. As indicated here, the heated debate and the interactions between the PEC and the government guided the central government to focus the reform on these two key areas.

	<b>Pro-government</b>	<b>Pro-market</b>	<b>Consensus</b>
Cause of the problems	Marketisation and privatisation of healthcare system	Not enough marketisation and too much government intervention	Limited government funding
Medical resource allocation	Led by the government	Led by the market	
Insurance model	Universal health insurance funded by the government covers all citizens' healthcare needs (like the NHS)	Basic health insurance provided by commercial insurance covers a limited number of diseases, such as serious and common diseases, e.g., heart disease	Solve rural and urban inequality in healthcare provision
Insurance coverage	'Small' diseases, such as common and frequent diseases	'Big' diseases, such as serious and uncommon diseases	
Hospital reform	Government-funded hospitals	Privately funded hospitals, more privatisation of hospitals, introducing competition	
Primary and community care			Setting up the GP system
Medicine production and distribution	Government regulation, such as price controls	Free competition and privatisation	

**Table 6-2 The opinions of each faction**<sup>183</sup>

<sup>183</sup> Here is a summary of the general debate by each faction. However, this does not mean the ideas in each faction were the same. Actually, in each faction, the ideas varied in terms of the level of government and market involvement. For instance, in the market faction, Gu suggested a market-led reform with government regulation, while some experts (e.g., Mao Yushi) suggested the complete privatisation of the health market without government control. It was the same in the government faction. Li suggested a government-led reform with market supplementation, while some experts (e.g., Yu Zonghe) suggested a completely government-funded hospital system without external capital.

## 6.2 Governmental response

After nearly a year of debate and communication among experts, international organisations, and different departments, there was finally a formal response from the decision-makers. On 23 October 2006, Professor Li Ling and Liu Jun were invited to give a lecture to Political Bureau members at the 35rd Routine Group Study.<sup>184</sup> The topic was healthcare systems in foreign countries and the development of healthcare services in China (*Xinhua*, 2006a). In the lecture, drawing upon the British NHS model as an example as well as her research in Suqian, Professor Li suggested a universal insurance system that would cover all citizens' healthcare needs, including basic healthcare, disease prevention, public health, health education, and environmental health. 'Only when this system is built by the government can it really function', Professor Li Ling suggested directly to the Political Bureau (China Health Vision, 2007).

In the lecture, then President Hu Jintao formally stated the principle of the reform: 'to enable universal access to healthcare services, we need to keep the welfare nature of the healthcare system, to strengthen the government's responsibility in supervision and regulation, to construct a healthcare system covering urban and rural residents with the focus on disease prevention and providing community healthcare in both urban and rural areas, to deepen the reforms in the following areas – the medical and health management system, the public hospital operating system, the medical insurance system, and the pharmaceutical market supervision system, to strengthen the public service function of public hospitals, and to establish an essential medicine system that provides citizens affordable basic medicines' (*Xinhua*, 2006a).

Since the initiation of the healthcare reform in 2005, this was the first time that decision-makers had indicated the direction of the reform. The phrases 'welfare nature', 'government responsibility', and 'public hospital' symbolised the pro-government direction. Furthermore, although the governmental departments approached the experts to exchange ideas and discuss the reform plans, until then, only the leading experts of the pro-government faction were chosen by the decision-makers to give lectures directly to the Political Bureau. This suggests that, in the heated debate between the two factions, the decision-makers preferred the direction suggested by the pro-government faction. In other

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<sup>184</sup> Liu Jun was the vice president of the Chinese Medical Association (CMA).

words, the government and the decision-makers followed the debate closely, and, at this time, the pro-government faction took an advantageous position in the sense that the direction of the reform followed their suggestions.

On the same day of the Group Study, China's Health Policy Support Project (HPSP), a cooperative project by the MOH, the WHO, and the UK Department for International Development (DFID), opened bidding for nine research projects (MOH, 2009).<sup>185</sup> The HPSP (2005-2012) aimed to develop China's health policies and build an efficient and equitable health system by enhancing the research and policy making ability of the Chinese health department (International Development Committee of Great Britain, 2009). It focused on human capacity building by means such as training and forums for decision makers with the DFID's 6 million pounds funding -- 4.8 million pounds to the Chinese government and 1.2 million to the WHO (*Xinhua*, 2005). Compare to Basic Health Service Projects launched in 1998,<sup>186</sup> which focused on basic health delivery at low level in rural China, the HPSP centred on China's health policy making of holistic system at the decision making level and 'provided innovative concepts and methods - particularly in knowledge management and, with the rapid response facility, policy research, exposure to international technical assistance through training and study tours and a policy space for cross-sectoral dialogue' (Barr et al., 2010). It brought concepts of evidence-based decision-making and the practice of rapid response policy advice and also highlighted the challenge of the healthcare reforms was less about increased spending and more about ensuring that improved systems of accountability and incentives which allow existing resources to be used more wisely (Guo et al., 2010). Not surprisingly, six of the nine open bidden projects concerned the design of the medical security system (China Health Vision, 2007). For instance, one project addressed the health financing and insurance system and studied how to share the costs of health and medical services among citizens, the society, and the state. But the DFID's role was more on training policy makers and facilitating dialogues between stakeholders and experts in a neutral way rather than 'trying to take a share of powers or resources which was a usual concern [of the Chinese government]' (Bloom et al., 2009 p.52).

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<sup>185</sup> Since 2012, the MOH, the DFID, and the Ministry of Commerce launched a bigger cooperative project, named the China UK Global Health Programme (GHSP) which aimed to improve global health policy and outcomes, as well as to help China improve its contribution to global health and achieve the potential of its health cooperation. Officially launched in January 2013, GHSP is a five year programme (2012-2017) with a £12,000,000 financial contribution from DFID.

<sup>186</sup> I discussed his projects in Chapter 5.



### 6.2.1 Commission of independent research

After the previous heated general debate and interactions between the PEC and various departments within the government, the debate between the two factions finally escalated to a more formal and influential level after the RCG brought it to a senior platform. Since the end of 2006, the RCG had commissioned experts and international organisations to conduct independent research and provide policy suggestions for the healthcare reform. The RCG promised that the government would consider their research results and policy suggestions seriously in designing the reform plan. It was at this time that the PEC became able to provide their opinions directly to the decision-makers and entered the policy process.

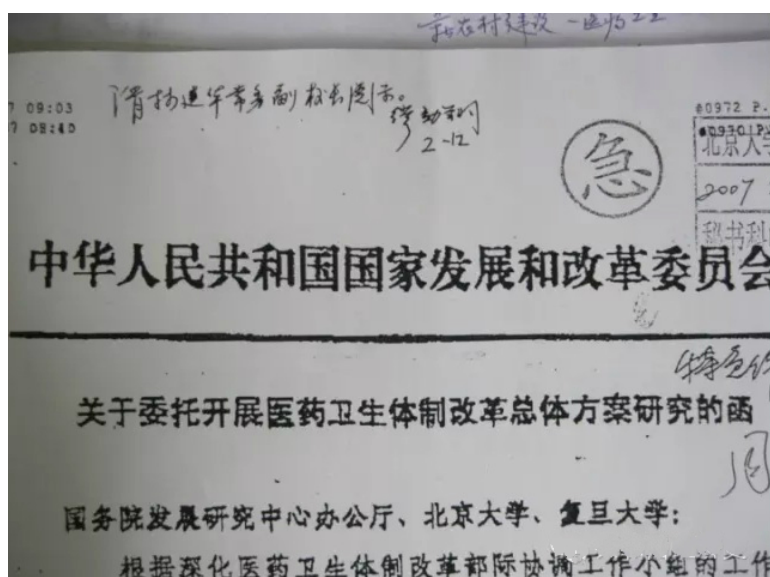
However, research teams entered the policy process at different times. At first, the NDRC, the MOH, and the leading departments of the RCG commissioned six research institutions in February 2007 to conduct research. The six research institutions were the DRC, Peking University, Fudan University, the WHO, the World Bank, and the McKinsey Company.<sup>187</sup> Picture 6-1 shows the commission letter to the DRC, Peking University, and Fudan University. Two more research institutions joined the mission at the end of March 2007, Beijing Normal University and Renmin University.<sup>188</sup> Although Beijing Normal University and Renmin University were not asked to join the first call for independent research, the PIs from the two universities, Professor Gu Xin and Professor Wang Hufeng, had conducted relevant research before. Professor Gu's research report was recommended by the MOH and the MOLSS to the RCG; while Professor Wang's report was recommended by the NDRC (Wang and Fan, 2013).<sup>189</sup>

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<sup>187</sup> Professor Li Ling was a co-principal investigator (PI) of the Peking University commission.

<sup>188</sup> Professor Gu Xin was the PI of the Beijing Normal University commission, and Professor Wang Hufeng was the PI of the Renmin University commission.

<sup>189</sup> After finishing their research, the Renmin University research team organised several workshops to discuss the report and asked for feedback. The guests at the workshops were health experts and economists as well as officials from different departments. The workshops not only helped with communication and information exchange among experts and the government but also promoted the idea of the research team to the government. The NDRC soon recommended the research by Professor Wang for the eighth plan.



**Picture 6-1 The Commission letter to the DRC, Peking University and Fudan University.**<sup>190</sup>

The addition of the latter two research teams was intended to diversify the suggestions for the reform and to add new and different ideas. The research by Peking University, Fudan University, and the DRC was said to be ‘unusually’ similar: government should dominate the reform by providing healthcare financing and operating hospitals (Wang, 2007). They rejected the marketisation and privatisation of the health market; instead, they advocated a dual track of revenues and expenses (*shouzhì liangtiaoxian*) through which hospital income would be remitted to the government first and the government would redistribute the revenue back to the hospitals. After joining the mission, the researchers at Peking University and Fudan University organised several meetings to discuss research plans and spoke openly in the media about their suggestions: the government must dominate the reform using regulation to maintain the welfare nature of the healthcare system as a public good; separating government administration from hospital operation could not solve the problem (Wang, 2009b). This opinion was considered too close to the MOH’s proposal – in which the government would lead and fund the supply side. Experts and government departments with different opinions asked for a different voice in the mission.<sup>191</sup> The RCG then commissioned the latter two research teams with a pro-market inclination to join the mission.

<sup>190</sup> Source: Interviewee 012, professor of Peking University, 9/22/2011, Beijing.

<sup>191</sup> Interview with 010, researcher from China’s National Health Development Research Centre, 10/03/2011, Beijing.

In addition to the plans by the two teams from Beijing Normal University and Renmin University, sponsored by Johnson & Johnson, Tsinghua University and Harvard University conducted a study on the reform without joining the mission, and their plan was delivered to the RCG as the ninth plan in June 2007, after the RCG's evaluation of the first eight plans (sohu, 2008).<sup>192</sup> Similarly, the Chinese Academy of Sciences (CAS) and Sun Yat-sen University also conducted independent research, and their plan was delivered to the RCG as the tenth plan in February 2008.<sup>193</sup>

In addition, without joining the commission, the CASS also conducted a study on the reform with China's Society of Economic Reform (*zhongguo jingji tizhi gaige yanjiuhui*).<sup>194</sup> The CASS delivered the research report to the RCG and was invited to the plan evaluation meeting held in May 2007. The CASS was the only institution that was commissioned to evaluate and integrate all eight plans after the meeting (Shaoguang Wang & Fan, 2013) by the RCG. At the end of 2008, the CASS delivered the final evaluation to the ROCCP, the SC, the Reform Leading Group (RLG), the Political Bureau, and various departments at the central and provincial levels.<sup>195</sup>

## 6.2.2 The evaluation meeting

At the end of May 2007, all eight plans as well as an oral report from the China International Capital Corporation were evaluated by internal experts from China and external experts from other countries (e.g., Professor William Hsiao from Harvard University, Professor Ann Mills from the London School of Hygiene and Tropical Medicine, and Professor Alan Maynard from the University of York). Members of the Political Bureau and officials from 16 governmental departments also attended the meeting. There were two sessions: the plan presentation and evaluation and a general discussion. In the presentation and evaluation session, each plan was assigned one principal expert to evaluate (external experts evaluated plans from Chinese research teams, and internal experts evaluated plans from outside China). This session consisted of three

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<sup>192</sup> Johnson & Johnson is an American multinational medical device, pharmaceutical, and consumer packaged goods manufacturer.

<sup>193</sup> Academician Zeng Yixin was the PI. His team members included clinical doctors, pharmacists, medical professors in Guangdong, and researchers from the Health and Social Security Bureau.

<sup>194</sup> Established in February 1983, the China's Society of Economic Reform (CSER) is a research association focusing on economic system reform and offering references for the policymaking of enterprises and governments.

<sup>195</sup> The RLG will be discussed later in this chapter.

parts, the presentation of each plan (30 minutes), an expert evaluation of each plan (10 minutes), and free discussion on each plan (30 minutes), and government officials were not supposed to talk during the meeting (Wang and Fan, 2013). During the general discussion session, government officials and experts had an open discussion. However, the media were excluded from the meeting. Moreover, all participants and institutions signed a confidentiality agreement to ensure that the content, discussion topics, and research plans addressed in the meeting would not be released (Wang and Fan, 2013).

The external experts were mainly invited to join the meeting by international organisations. For instance, Professor Ann Mills and Professor Alan Maynard were invited by the DFID because DFID and the MOH cooperated in the HPSP.<sup>196</sup> The external and internal experts not only evaluated the research plans but also provided comments on advantages and disadvantages of different research papers.<sup>197</sup> The conclusion was that there was not a single and universally correct way to proceed with the reform.<sup>198</sup> Through the presentation of the plans and the discussion, the experts and international organisations exchanged their ideas regarding the healthcare situation in China.

Although no information was provided at the end of the meeting on what policy decision would be made based on the ideas and suggestions from the plans, it was clear that the government became more interested in some issues than in others.<sup>199</sup> For instance, citizens debated a lot on whether the government should channel funding to the supply side or the demand side, which was the key point in the previous general debate and the main disagreement between the MOH and the MOLSS. However, when one scholar mentioned the problem of hospitals raising revenues by means of over-prescription and excessive medical testing, it was not further addressed in the discussion.<sup>200</sup> Moreover, at the end of the meeting, Professor Hisao was asked by all the external experts to do a summary speech that suggested six main points that the reform needed to address: market dysfunction in medical insurance and services, government-led equalisation in health, medical prevention and primary care, the high prices of medical services, medical worker motivation mechanism, and commercial medical insurance as compensation (Jiang, 2014). Some of

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<sup>196</sup> Skype interview with 023, an external expert, 09/01/2015, UK.

<sup>197</sup> Ibid.

<sup>198</sup> Ibid.

<sup>199</sup> Ibid.

<sup>200</sup> Ibid.

the points were addressed in the final reform plan, such as insurance, prevention, and primary care, while some were not mentioned, such as medical worker's motivation.

The meeting presented to the government the whole picture of the healthcare reform at the macro level and details of the healthcare system that needed to be changed at the micro level, such as insurance, medicine, and hospitals. Though experts suggested two main directions for the reform in the debate, namely pro-government and pro-market, the detailed design of the reform went beyond the scope of the two factions' ideas. Most of the final research results in the mission included suggestions from both factions rather than advocating a single dominant way of implementing the reform. For instance, the Peking University team initially suggested that funding should be channelled to the demand-side, but they later changed their opinion, and part of their research suggested that funding should be directed towards the supply side. In the end, the Peking University team presented two plans, with one from Professor Liu Guo'en proposing marketisation and the other from Professor Li Ling stressing the government's leadership. The Renmin University reform plan suggested that both the government and the market should bear the responsibility of providing health service. Table 6-3 summarises all proposals. These institutions are listed in order from the earliest to the latest to join the commission.

Though, initially, a majority of the first six teams involved in the mission had a pro-government inclination, the final reform proposals certainly did not. One proposal from Peking University and the DRC proposal still strongly advocated a government-dominant approach, while the WHO and Beijing Normal University proposals advocated a market-oriented solution. The remaining proposals suggested a mixed approach that combined the government-dominant solution and the market-oriented solution, as shown in Table 6-3. Some of the PIs of these mixed-approach leaning proposals were initially leading figures belonging to one of the two factions, but the proposals turned out to be different from what the PIs had previously advocated publicly. For instance, the PI of the Renmin University research team, Professor Wang Hufeng, was a leading expert in the pro-market faction, but instead of promoting a market-oriented approach, he proposed a mixed approach for the reform.

There were two interesting patterns in the proposals. First, a few research teams with leading figures supporting either the pro-government faction or the pro-market faction changed their original position to promote a mixed approach. Second, a majority of the

research teams that joined the mission at a later stage favoured the mixed approach. Among the last four proposals, only the Beijing Normal University proposal supported a single force in the reform, namely the pro-market approach, while all others advocated a mixed model with the government and the market sharing responsibility. These two patterns could be explained by the change in the strategies used by the experts to promote their ideas and reform proposals for adoption in the final reform policy.

<b>Institution</b>	<b>Macro design</b>	<b>Micro design</b>	<b>Faction</b>
Peking University	The government should dominate the health area		Pro-government
		Public health should be covered by the government; basic healthcare should be paid for by commercial insurance; advanced care should be paid for by individuals	Mixed
Fudan University	Social path: the government should dominate medical financing; market mechanisms should be introduced on the supply side		Mixed
The DRC	The government should dominate the health area to maintain the public welfare nature of health services		Pro-government
The WHO	Market mechanisms should dominate supply and pricing; should encourage the private sector to join the health area	Target of the reform: equality, efficiency, and quality.	Pro-market
World Bank	Final goal: NHS model and free healthcare	Temporary goal: commercial insurance	Mixed
McKinsey			N/A
Beijing Normal University		The government should purchase healthcare. Patients do not pay hospitals; instead, they should purchase medical insurance from the government. The government should then purchase medical services according to the demand for insurance. Therefore, the financing of hospitals relies on medical insurance.	Pro-market
Renmin University	The government and the market should share responsibility. Health services, medical services, medicine, and medical insurance should not be simply separated into two dichotomous solutions, either the government-dominant solution or the market-dominance solution.	Near-term target of the reform: everyone can afford and have access to healthcare; price of medicine becomes reasonable. Long-term target: equality, efficiency, and sustainable development of healthcare.	Mixed
Tsinghua	A combination of government regulation and market	Different reform plans in different areas based on	Mixed

University	mechanisms and a national medical credit system	economic and social conditions	
CAS	A primary care system and a comprehensive medical security system	Primary care should be mandatory, and the fees will be covered by national insurance; comprehensive medical insurance should include a) basic insurance for low-income citizen paid for by central and local governments; b) medical insurance for urban workers paid for by enterprise and public institutions; and c) commercial insurance paid for by the enterprise, public institutions, and citizens.	Mixed

**Table 6-3 10 Commissioned proposals of the reform<sup>201</sup>**

<sup>201</sup> For the details of the proposals, please see <http://news.163.com/08/0108/20/41NBID5P0001126S.html> regarding command-and-control versus regulated marketization.



During the period of the general debate, when there was not yet an idea regarding the direction of the reform, experts focused on publicising their ideas and proposals and on getting the attention of decision-makers. Once ideas and proposals were selected for the policy pool, the debate entered a senior level. The key aim of experts is to promote their ideas and proposals for adoption in the final policy. However, at this stage, they changed their strategies. When there were various policy suggestions in the policy pool, the ideas close to the preferences of the decision-makers would be relatively easy to spot among other policy suggestions, so it is easier for the proposer of the idea to sell the whole design of the reform to the decision-makers. Thus, experts would need to speculate about the preferences of the decision-makers based on the actions of the decision-makers and then tailor their original proposals to bring them closer to those preferences. Only in this way could they directly influence the final policy.

Figure 6-1 presents the correlation between experts' idea changes and signs of decision-makers' changing preferences. During the general debate about the healthcare reform policy, experts openly discussed and presented their proposals and ideas to attract the attention of the decision-makers. The first clear signal of the potential direction of the reform emerged when a leading figure of the pro-government faction was invited to the Political Bureau Group Study in October 2006; on the same day, Hu's speech mentioned the principle of the reform: the welfare nature of the healthcare system and government responsibility.

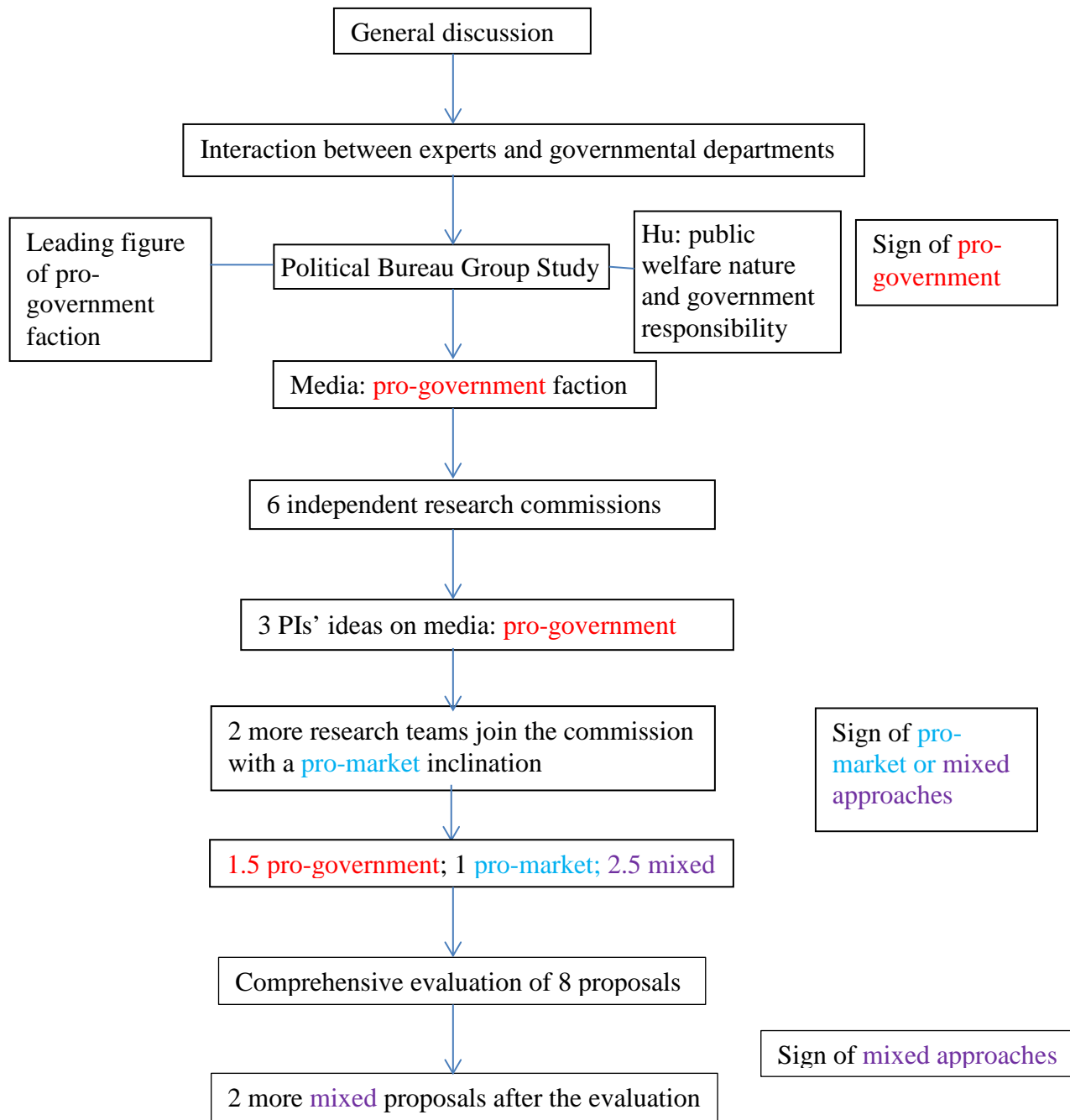
At that time, the media broadly reported that the pro-government faction had won (Xinhua, 2006c). In the next stage, although the commissioned research teams did not release the details of their proposals because of confidentiality concerns, the PIs of the three Chinese teams publicly spoke in the media about their inclination towards the pro-government approach. However, the second signal regarding the direction appeared when the RCG commissioned two more research teams whose PIs were leading figures in the pro-market faction at the last minute to join the mission. The media then published an interview with one of the PIs, who said that the government wanted a different idea (Tan, 2007). In addition, it was said that the MOH was leaning towards the pro-government faction and the MOLSS towards the pro-market faction; it was in the decision-makers' interest to balance the power between the MOH and the MOLSS in the internal debate within the

government.<sup>202</sup> Although there was no official explanation of the last-minute move by the RCG, it showed that the decision-makers had yet to decide to take up a government-dominant approach as the media had previously advocated. It also showed that the decision-makers did not consider that the two solutions proposed by the two factions were mutually exclusive. Nonetheless, this move signalled that the government might prefer a mixed-approach. Not unexpectedly, when the five Chinese research teams completed their research, only one and a half proposals supported a government-dominant solution, one proposal supported a pro-market approach, and the remaining two and a half supported a mixed approach.<sup>203</sup> The goal of the evaluation meeting was to combine all eight plans into a single reform policy, and two final reform proposals submitted after the meeting discussed the reform beyond the scope of the two factions. They also took into account regional differences in the design of insurance plans rather than focusing on discussing who should pay for the insurance and on designing a universal plan to apply in China.

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<sup>202</sup> Interview with 013, researcher in the CASS, 09/10/2013, Beijing.

<sup>203</sup> I excluded three proposals from the international organisations because none of them was released before or during the commission, so it is difficult to tell whether they changed or not. Furthermore, they were commissioned at the very beginning, so I cannot know whether their perception was influenced by other proposals.



**Figure 6-1 Experts' idea changes and signs of decision-makers' changing preferences**

### 6.3 Targeted debate

The mixed proposals showed consensus as well as disagreement among the PEC and government officials. They reached consensus on the following areas: increasing public spending on health; promoting a reform proposal that combines a government-dominant approach and a market-dominant approach; equity as the prioritised long-term goal but not without efficiency; and universal coverage of healthcare security. The disagreement centred on how the government and the market should share responsibility in the health area, in particular, medical insurance. The PEC then targeted those disagreements in the debate between the two factions.

Two months after the evaluation meeting, the SC published a new policy for medical insurance trials – ‘Guiding Opinions Concerning Developing Urban Residents’ Basic Medical Insurance Trials’ (*guowuyuan guanyu kaizhan chengzhen jumin yiliao baoxian shidiande zhidao yijian*), which signalled that the healthcare reform was entering the experimental stage. This trial policy aimed at covering medical insurance for unemployed urban residents, including students, children, and jobless adults who were not covered by the urban workers’ medical insurance. Seventy-nine cities and towns were selected for the trial, and if the trial proved that the policy worked in these places, it would then be implemented throughout the country in 2010 (State Council, 2007a). The core of the policy was that the central government, the local government, and individual residents would share the medical insurance cost. The policy encouraged local working units to finance medical insurance by providing tax relief. Though the medical insurance was meant to cover serious diseases and inpatient fees, the policy encouraged local governments in well-developed areas to cover outpatient fees. The policy also took into account the uneven economic development between east and west and suggested that the share of different levels of government and individuals in health provision should differ.

The trial policy also reflected the fact that the government intended to balance the power and ideas of the two factions and preferred a mixed approach in carrying out the healthcare reform. In this trial policy, the government chose to channel the funding to subsidise the medical insurance companies on the demand side; responsibility for medical insurance was shared by the government, the society, and the individual rather than the market alone, as some of the proposals suggested (e.g., Tsinghua University).

However, it was still unclear who should take a leading role in the reform. Around the same time that the SC launched the trial policy, the MOH invited the leading figures of the pro-market faction, Professor Gu Xin and Professor Liu Guo'en, to discuss two possible changes for the reform (Wang, 2009e). The MOH suggested centralising the procurement of medical facilities and adopting a dual track of revenues and expenses. More specifically, the MOH proposed that they would purchase medical facilities for all hospitals and be in charge of the revenue generated by hospitals and the allocation of revenue to cover expenses. If this suggestion had been added to the reform policy, through controlling the supply side of healthcare, the MOH would have significant control over the reform. However, the two invited experts strongly criticised the proposal directly to the MOH and publicly in the media. Professor Liu publicly questioned the MOH in the *21st Century Business Herald*: 'how could the government know the real needs of over 17,000 hospitals?' (Jiangnan Times, 2007). Professor Gu also commented that the two measures proposed by the MOH would lead China to a rent-seeking planned economy (Wang, 2009e). These two points were not included in the final policy documents launched in 2009.

In October 2007, at the 17th National Congress of the CCP, the leader of the CCP, Hu, addressed the healthcare reform, citing the need to

'Establish a basic medical and healthcare system and improve the health of the whole nation... maintain the *public welfare nature* of public medical and healthcare services, always put disease prevention first and centre in rural areas... We will *separate government administration from medical institutions*, management from operation, healthcare from pharmaceuticals, and for-profit from non-profit operations. We will *increase government responsibilities and spending*, improve the national health policy, and encourage greater *participation of nongovernmental sectors* to develop systems of public health services, medical services, medical security, and medicine supply to provide both urban and rural residents with safe, effective, convenient, and affordable medical and health services. We will enhance our capacity to prevent and control the outbreak of major diseases and respond to public health emergencies. We will improve the three-tier rural healthcare network spanning the county, township, and village and the urban community-based healthcare system, and deepen reform of public hospitals. We will set up a national system for basic pharmaceuticals to ensure their supply...' (Hu, 2007a).

This policy document indicated the principles of the reform. Although it stressed the public welfare nature of the public medical and healthcare services and the government's responsibility, it also addressed the importance of separating government administration from medical institutions and that of involving non-government sectors in the healthcare system, which was suggested by the pro-market faction. This report was then seen as an

internal consensus between the two factions and indicated that the reform would take into account both the demand and the supply sides (Wang and Fan, 2013).

Since then, to understand the local context and design a practical reform plan, the central governmental departments conducted internal consultation and organised a series of symposia to meet local government officials and experts familiar with local conditions and to discuss their ideas and opinions of the reform. In October 2007, the NDRC held two symposia in Nanchang and Tianjin and met provincial and city-level officials who were in charge of the local NDRC, health, finance, and insurance sectors and asked for their opinions on the reform (Li, 2007). The decision was made at the symposia that the final reform policy would be a combination of all the commissioned proposals and that it would be adapted to fit the context of different localities. In January 2008, the NDRC held another symposium and invited experts from both factions (e.g., Professor Li Ling and Professor Bai Chong'en) to discuss the internal draft of the reform plan (Wang, 2009b).<sup>204</sup> In April 2008, Prime Minister Wen Jiabao held a symposium and invited experts, medical workers, and ordinary citizens to discuss the reform. Starting in July 2008, the Counsellor's Office of the SC spent months conducting research on the public hospital reform – a significant part of the healthcare reform – and the research aimed at assisting the development of the reform policy (State Council, 2010).<sup>205</sup> In September 2008, the MOH sent 10 teams to investigate and consult the feasibility of the internal draft plan in different areas together with local policy research institutions. Starting as early as 2006, at the 'Two Meetings' in March, the National People's Congress (NPC) representatives and CPPCC members working in the medical sector provided ample feedback and suggestions to the government. For instance, at the 'Two Meetings' in 2007, the MOH received 866 suggestions (MOH, 2007).

After over three years of debate, the SC unveiled the first formal draft of the reform to solicit feedback from the public on 14 October 2008, 'Opinion on Deepening the Healthcare Reform: Seeking Views' (*shenhua yiliao weiseng tizhi gaige zhengqiu yijian*). This policy drew a blueprint at the macro level, which adopted opinions from both factions. It emphasised the development of primary care by expanding the infrastructure of grassroots-level clinics, as suggested by the pro-government faction, while it also proposed

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<sup>204</sup> Professor Bai is an economist at Tsinghua University.

<sup>205</sup> The Counsellor Office of the SC is a ministry-level agency that offers research and consultation to the SC.

channelling the funding into medical insurance as suggested by the pro-market faction (State Council, 2008). It embraced some key ideas from the WHO proposal, such as the WHO framework of basic healthcare services and universal access to these services. It also endorsed the idea from the CAS proposal that suggested increasing the insurance compensation rates. However, it did not resolve all disagreements. For instance, it did not lay out clearly how to manage rural and urban insurance or how to implement public hospital reform.

This policy was open for a month to solicit feedback from the public, and broader public participation on both the Internet and in the mass media was witnessed. There were nearly 30,000 online comments and 6,000 emailed feedback messages (Balla, 2014). Moreover, the pharmaceutical industry and medical personnel also joined the discussion through participating associations, a Web portal, workshops, and seminars and tried to influence the reform in a direction that favoured their interest (Kornreich et al., 2012, Wang and Fan, 2013). The discussion was massively reported in the media (Duckett and Langer, 2013).

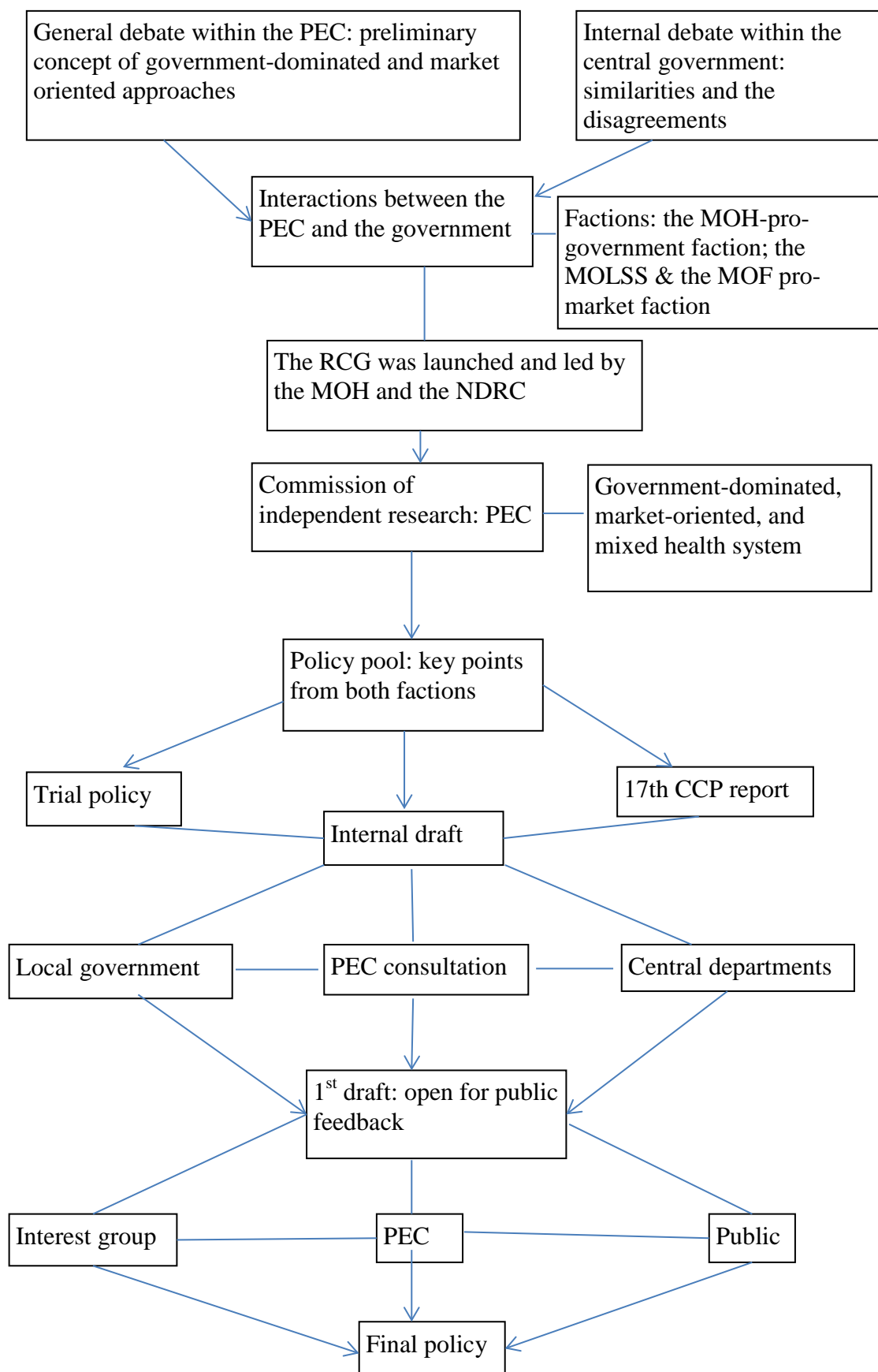
In December 2008, the Healthcare Reform Leading Group (RLG) led by the NDRC was established within the SC. According to the feedback, comments, and suggestions gathered, the RLG commissioned the Policy Research Office of the CCP and the Research Office of the SC to formulate the final policy. In April 2009, the SC announced the final reform policy, titled ‘Opinion on Deepening the Healthcare System Reform (New Blueprint: Final Draft)’ (*Guanyu shenhua yiyao tizhi gaige de yijian: xin fang’an, zui zhong gao*) and an additional implementation document titled ‘Blueprint for Implementation of the Key Points of the Health-care Reform in the Near Future: 2009–2011’ (*Yiyao weisheng tizhi gaige jinqi zhongdian shishi fang’an*).

There were some differences between the final policy and the draft one. The final policy included some of the points addressed during the feedback period. For instance, in response to the pharmaceutical industry’s concerns, the final draft added amendments to the essential medicine plan so that all enterprises could bid openly and there would be no price limits on medicine. In response to the public’s concerns about the unaffordability and inaccessibility of healthcare, the final policy added four more goals on top of the original single goal of the draft policy to speed up the reform (Kornreich et al., 2012).

## 6.4 Discussion

Figure 6-2 shows that the PEC influenced the policy in five stages. First, the general debate within the PEC formed a preliminary concept of the two approaches, namely the pro-government approach and the pro-market approach. At this stage, the media not only reported the experts' ideas about the reform but also organised seminars for both the experts, international organisations, and the government to exchange and to communicate their ideas. Research institutions and think tanks also organised this kind of seminars. Through the general debate, a rough understanding of the differences between the two approaches formed. Second, both the experts and the governments engaged in an in-depth exchange of opinions. In the meanwhile, the media further reported the experts' idea. For instance, *Caijing* engaged in reporting pro-market ideas. Through the interactions, the experts, the government, and the media formed alliances sharing similar ideas for the reform, and a clearer division of factions formed. Third, the experts and international organisations took advantage of the commissioned research and the later evaluation meetings to shape the formation of the policy pool. The two factions debated on the key points, such as medical insurance, medicine production and distribution, and public hospital reform. Each commissioned research proposal contained a detailed design of the reform. In the meanwhile, the media reported the experts' idea which influenced their final research. The analysis, evaluation, and comparison of the proposals sharpened the key points of the debate at both the macro and the micro levels. The later combination of the proposals that integrated the opinions from the two factions formed the policy pool that served as the foundation of the trial policy, the 17<sup>th</sup> CCP report, and the internal draft. Fourth, in the internal consultation stage, the experts offered suggestions and feedback on the internal draft at the NPC and CPPCC meetings and other formal seminars organised by the government. Departments at the central level and local governments also tried to influence the policy through communication with the PEC and promoting the research results of the PEC to the decision-makers. Based on the internal consultation, the SC launched the first draft to solicit feedback from the public. Fifth, in the public feedback stage, in addition to the PEC, more actors became involved in the process, including interest groups (e.g., pharmaceutical companies) and the public. They provided suggestions and asked for a change in the draft policy on the Internet and through the reports delivered by the PEC to the government. Based on the suggestions and feedback, the SC finally launched the formal policy.



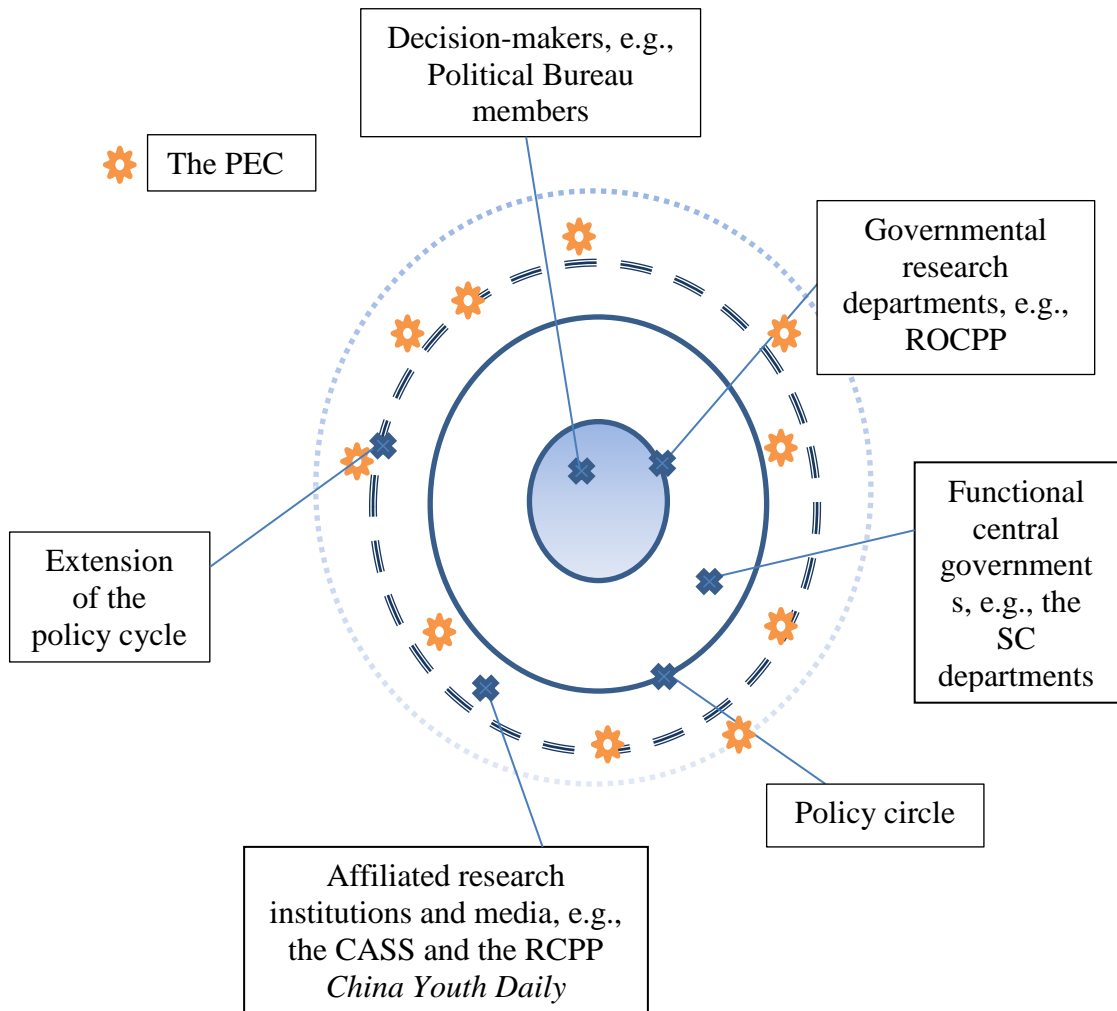


**Figure 6-2 Summary of the healthcare reform policy process**

Compare to the collation during the outbreak of SARS and the initiation of the healthcare reforms, the experts, media and international organisations coalesced deliberatively. First, the media intensively covered the experts' idea of the two factions. Some media showed strong ideological preferences in their report and allied with the experts with similar preferences. For instance, *Caijing* and *The Economic Observer*, two rightism media strongly advocated pro-market direction with the pro-market experts' ideas. But there are also media reporting both factions comprehensively, such as *China Youth Daily* and *Southern Weekend*. The media report formed a policy environment, in which the government made the reform policies. Second, the international organisations were more independent and did not make obvious coalition with the other two actors, although the media still reported and international organisations' ideas and the experts exchanged ideas with the international organisations. Because the healthcare reform policies were more fundamental than the policies during the outbreak of SARS and involved more critics, doubts and opposite ideas. Allying with anyone or the factions would put the international organisations in a risky position that they may try to intervene China's domestic policies for their own purpose. Because compare to the media and the experts, the international organisations were external forces. Moreover, it was because of their neutrality that the Chinese government invited the international organisations to evaluate the commissioned research.

Figure 6-3 shows the interactions between the PEC and the government. The filled circle surrounded by a solid line is where the policy is made and is usually considered a 'black box', as we know very little about how policy is made inside the circle. However, this circle is not as closed as most citizens believe. The central government has affiliated agencies, which include research institutions, the media, and associations. These agencies have links to the PEC. The central government is thus linked to the PEC through the affiliated agencies. The PEC are not totally excluded from the policy process. Some experts are working at the affiliated research institutions of the establishment, such as the DRC, and they can deliver research reports directly to the department with which they are affiliated. Some international organisations, such as the WHO and the DFID, cooperate with the government on health, so they can influence the policy by providing funding, training staff, providing support for evidence-based policymaking design, opening policy dialogues between the government and the PEC, offering health education, providing laboratory techniques, and conducting collaborative policy research. Some media affiliated with the government are also active in delivering experts' ideas. For example, the *China*

*Youth Daily* reported on the Suqian report issued by a leading expert, Professor Li Ling, and after that, Professor Li was invited to meet with the MOH and give a lecture to the Political Bureau. As indicated, the boundary between the government and the PEC is not solid, and the PEC can find various ways to influence the decision-makers.



**Figure 6-3 Interactions between the PEC and the government**

The media, experts, and international organisations collaborated with each other and entered the policy process. First, the experts who were directly invited by the government to offer opinions and draft proposals published their ideas in the media, especially leading figures such as Professor Li Ling and Professor Gu Xin. There was massive media coverage of their interviews during the development of the reform policy. They published their policy suggestions and reform designs along with research evidence in media affiliated with the government. For instance, the *China Youth Daily* is affiliated with China's Communist Youth League, where President Hu rose to power. Research reports

that advocate positions aligned with Hu's principle of a 'harmonious society' are relatively easy to publish in the *China Youth Daily* and to reach the decision-makers with a similar understanding. It was through the media coverage that the decision-makers and senior officials came to know the experts' suggestions. The decision-makers and senior officials, in this case those involved in setting the reform policy, then invited experts for meetings and detailed explanations.

The experts also published their work and opinions in non-governmental media belonging to famous media groups. For instance, the *21st Century Business Herald*, which reported the reform extensively, is sponsored by the Southern Media Group, a very influential media company in Guangdong that is famous for being critical on social and public issues. The coverage of experts' opinions in such influential media increased the experts' exposure and attracted more attention from other media to do follow-up reports and spread the experts' ideas. The broad media coverage of the experts' ideas also attracted more citizens to join the debate and helped make the reform a salient issue in the society.

Second, unlike experts, international organisations do not usually promote themselves in the media on their own; rather, they normally do so together with the government, government-affiliated agencies, or other research institutions. Throughout the period from the SARS outbreak to the making of the reform policy, the types of international organisations working with the Chinese government and entering health policymaking expanded from only health authorities (e.g., the WHO) to international consultancy companies (e.g., the McKinsey Company) and foreign governmental departments (e.g., the DFID). The cooperation and collaborative work was also expanded from mainly laboratory and research training to inviting external experts to design and evaluate the reform policy. The Chinese government was willing to collaborate and needed help from international organisations. However, to maintain relationships and trust, the international organisations had to sign a confidentiality agreement with the Chinese government, to prevent the release of any information to the media without the consent of the Chinese government. This is an essential condition that international organisations must meet to collaborate with the Chinese government. For instance, unlike the Chinese experts who talked about the reform and their proposals openly in the media, McKinsey and the DFID did not release any information about the commissioned research proposals. Compared to the experts, these international organisations are established authorities with good reputations and resources. They do not need the media to increase their profile. In contrast, high exposure in the

Chinese media might risk their relationship and established trust with the Chinese government. Therefore, keeping a low profile in the media is important for international organisations to maintain their relationship with the Chinese government.

Third, the Chinese experts, especially those with a foreign education, have access to international resources, e.g., external experts and funding. These external experts, in collaboration with the Chinese experts, provide advanced techniques and help to produce high-quality research; the Chinese experts act as a bridge between the external experts and the Chinese government. For instance, sponsored by Johnson & Johnson and funded by Harvard University, Professor Liu Yuanli conducted independent research at Tsinghua University without joining the RCG commission. However, the reciprocal relationship between Chinese experts and external experts is limited to the top world-class research institutions. Most of the leading experts are from top Chinese universities, such as Peking University, Tsinghua University, Fudan University, and Renmin University; it is rare to see experts from other universities or research institutions. Similarly, the external experts who entered the policy process are also mainly from world-class institutions, such as Harvard University and the London School of Hygiene and Tropical Medicine. This indicated that, although other experts and international organisations were studying China's healthcare system, the Chinese government were more willing to cooperate with the top-notch ones. Nonetheless, international organisations and external experts who do not have direct access to the Chinese government can approach domestic experts and research institutions that have connections with the Chinese government or with affiliated agencies, through which they can open a window of opportunity for collaboration.

The types of PEC experts affect the ways in which they can influence policy change. There are two types of experts based on the nature of their work units: established experts and non-established experts. Those working at agencies affiliated with the government and research intuitions are established experts because they operate within the policy circle, the immediate circle outside of the filled circle of decision-makers in Figure 6-3. Because of their status in the political system and relationship with the government, they can influence the decision-makers by delivering research reports, making policy suggestions, or even submitting draft policies to the government via their institutions. For instance, the DRC delivered its report to the SC and other departments via the internal SC system. The category of established experts also includes those who used to work at affiliated agencies because they can deliver reports directly via the existing network. For instance, Professor

Wang Hufeng used to work at the MOLSS as a researcher. He was invited to participate by the MOLSS during the general debate and then had an opportunity to deliver his ideas to the RCG.

Those working in units outside the policy circle (see Figure 6-3) do not have such an institutional channel through which to influence policy directly. However, they can take an indirect approach using their own social networks. These social networks can be built by attending seminars either organised by the government and affiliated agencies or involving government officials and established experts; by joining research projects conducted by the government and affiliated agencies; or by publishing ideas and research results in affiliated media. If the government is interested in an idea that the experts deliver, they will ask for a detailed report directly from the experts. In fact, as this chapter makes evident, a majority of the experts who influenced the policy process directly are not established experts, and they entered the policy process by taking an indirect approach.

There are also two main types of experts who influenced reform policy based on their expertise: economists and social scientists. During the SARS policy change, it was mainly medical experts who influenced the policy; after the SARS outbreak, it was mainly social scientists in the field of social and public policy who initiated the reform. Unlike the previous two periods, during the development of the reform policy, more experts with diverse expertise entered the reform policy process, among which most of the leading figures are economists, such as Professor Li Ling, Professor Liu Guo'en, and Professor Wang Hufeng. Even the external experts are mainly health economists. Although healthcare is a social and public issue, health is also very important for the sustainable economic development of the state. Economists' joining the reform policy process helped to put the significance of the health issue into a bigger picture and goal – maintaining sustainable economic development and a balanced national development – which made the health policy a top priority. This indicates that it is easier to set an issue on the agenda and make it a national policy if it is related to economic development than if it is just a social issue.

Table 6-4 shows that the PEC's influence on health policy is institutionalised along the development of the reform policy. First, the PEC act from the outside as a bridge between different departments and bureaus and offer different angles that significantly complement the one-sided views of the departments and bureaus. As mentioned above, there is a rigid

boundary between different departments at the central level, and it is difficult for employees in each department or even bureaus within one department to view an issue from a broader perspective. There are also communication problems between departments or even bureaus because of the lack of a common understanding of issues. The PEC facilitates communication and fosters a common understanding between different departments at the central level. They also bring the departments together to join the debate and create platforms for them to communicate. The exchange of ideas benefits the forming of key points and directs the final policy to focus on those key points.

Second, the PEC join the policy process directly by offering research based policy options and evaluating the previous policies and providing feedback and comments. The final reform plan is based on combinations of the 10 research results as well as the comments and evaluations. The PEC's influence thus becomes a formal procedure of the policy making. The involvement of the PEC's into the policy process changed from an ad hoc in the SARS policy to de facto in the reform policy. Although, the PEC's involvement is not de jure yet, a wider range of PEC's debate, research and policy suggestions become a norm in the formal policy process.

Time	PEC	Government action
2000		<i>Health marketisation trial: Suqian</i>
2002		<i>New Rural Cooperative medical system</i>
2003	Influence on SARS policies	
July 2005	DRC Report	Setting on agenda
Sep. 2005	Unirule/Southern Weekend forum	
March 2006	Unirule forum	
April 2006	Li Ling's Suqian report	<b><u>RCG</u></b>
June 2006		<b><u>NDRC</u></b> : 'Guidance of Medical Industry Development during the Eleventh Five Year Plan'
July 2006-2007		<b><u>ROCCP and MOH</u></b> met Li Ling <b><u>MOH</u></b> met Liu Yuanli <b><u>MOH, MOF, and MOLSS</u></b> met Wang Hufeng
Oct. 2006	The HPSP	<b><u>The Politburo</u></b> invited Li Ling for a lecture
End of 2006-early 2007	Commissioned research of experts and international organisations	
May 2007		<b><u>Sixteen ministry-level departments</u></b> and foreign experts joined a meeting on the evaluation of the commissioned research proposals.
July 2007		<b><u>SC</u></b> : 'Directing Opinions on Developing Urban Residents' Basic Medical Insurance Trials'
		<b><u>MOH</u></b> announced the building of a new government-led medical equipment purchase system in 2-3 years.
Aug.-Sep. 2007		<b><u>MOH</u></b> encouraged hospitals to be spared from the management of revenues and expenditures.
July to Dec. 2007	Gu Xin and Liu Guo'en strongly opposed the MOH opinion	
Oct. 2007-2008	Internal consultation between the PEC and the government	<b><u>The 17<sup>th</sup> National Congress of the CCP</u></b> <b><u>NDRC</u></b> , then Premier Wen, MOH, Counsellor's Office of the SC with PEC, central departments, and local governments
Oct. 2008		The draft reform program was launched views
Octo. 2008-April 2009	Broad consultations among public	
April 2009		Final policies
Ongoing		

**Table 6-4 Timeline of PEC and government actions<sup>206</sup>**

<sup>206</sup> I did not list media in the table because media's reports of the two factions were full of the period from 2005 to 2009.



Third, internal consultation among the PEC, central departments, and local governments helps to unify thoughts and reach a consensus, which facilitates the implementation of a reform policy. Throughout the policy process, the local government was mainly involved after the internal draft was developed. Although the central government might have asked for local governments' ideas about the reform previously, there is no evidence showing that the local government played a bigger role than the PEC before the internal draft was developed. However, after the internal draft was issued, the local governments formally joined the discussions between the central government and the PEC and were asked for suggestions on the feasibility and possible adaption of the policy. The local government mainly contributed to the development of the reform policy from the implementation perspective.

## 6.5 Summary

After initiating the healthcare reform, the PEC influenced the reform policy through the debate between the two factions within the PEC and the interaction with the government. First, the formation of the two factions, the pro-government and pro-market factions, emerged in the general debate, and the debate between the two factions attracted the government's attention. Second, through interactions between the PEC and the government, the distinguishing difference between the two factions formed, and the key focus of contention was sharpened. Third, the PEC delivered their research and policy design directly to the decision-makers, forming the policy pool. The final policy was developed based on the design and policies in the policy pool, and the internal consultation and public participation played a role in the making of the final policy. The reform policy finally redistributed medical resources by restoring the dominant role of the government in public health, changing the previously marketised health sector. However, it maintained the role of the market in medical insurance.

However, there are several caveats in interpreting the healthcare reform policy process in China. First, although the PEC were active in creating and opening windows of opportunity to influence the policy change, the government had the final say on the extent to which an idea would be accepted. The government also designed the formal institutional channels for the PEC to get involved (e.g., the commission and evaluation). Second, although the media reported intensively on the reform and tracked the whole process, which aroused a big discussion in the public, there is no direct evidence showing that the

public discussion directly influenced the policy before the final draft was issued. Furthermore, the public was only offered the opportunity to provide feedback for a month, and this call for public engagement was only made after the formal draft was issued. It is in this sense that the influence of the public on the reform policy is considered limited. Third, the PEC still belong to the elite circle, as they employ citizens with higher education and/or senior positions. There is limited space for the public to engage in the policy process.

Although the final reform plan was implemented, the debate between the two factions is far from over. In this chapter, to understand the interactions between the PEC and the government and how the interactions affect policy change, I study only the period up to the point when the final reform plan was launched. The healthcare reform is still an ongoing process. The debate between the two factions will certainly continue with the implementation of the reform. The continued debate and the influence of this debate and the PEC on the implementation of the reform policy and the possible revision of the reform policy is worth studying in future research.

## 7 Conclusion

By using Kingdon's multiple streams framework (Kingdon, 2003), theories of policy entrepreneurship (e.g. Roberts and King, 1991, Weissert, 1991, King and Roberts, 1992, Mintrom and Vergari, 1996, Roberts and King, 1996), and fragmented authoritarianism (Lieberthal and Oksenberg, 1988, Mertha, 2009a), this thesis explained how and why health policies changed between 2003 and 2009. I argue that the policy process is not as exclusive as some scholars have argued and that policy outsiders such as experts, media, and international organisations influence China's health policy change since SARS as a policy entrepreneurial coalition (PEC).

This chapter is divided into five sections. The first section summarises the PEC's influence on the health policy change that occurred from 2003 to 2009. The second section compares the influence of the experts, media, and international organisations in the three cases, namely policy change during the outbreak of SARS, the initiation of healthcare reforms, and the making of reform policy. Based on the PEC's experience of influencing health policy change, the third section discusses how the PEC's influence added to the understanding of policy process. The fourth section then explains empirical implications on how to influence policy in China. The fifth section sets out the development of healthcare and politics in China and assesses the PEC's influence since 2009.

### 7.1 The PEC's influence on health policy change

During the 2003 SARS outbreak, the PEC influenced the change in SARS treatment and information policies by converging the problem, policy, and political streams and opened windows of opportunity for policy change. The government attitude towards SARS changed from passive to active. First, experts in Guangdong identified problems: the existence of SARS as an unknown epidemic disease. A leading expert, Zhong Nanshan, indicated that the cause of its fast spread was the fact that disease information was limited within the government and almost blocked to the public. Second, another leading expert, Zeng Guang, advocated policy suggestions: treatment with corticosteroids instead of rifampicin, opening media reportage of SARS to warn the public, and building a disease surveillance system to report the infection situation within the government. In the meanwhile, some local traditional media and new media pushed for disease information disclosure. The World Health Organisations (WHO) worked with the experts to control the SARS spread and also asked for the open of disease information. Third, the three actors

pressured the government as a coalition by changing the national mood, constituting the political stream.

A series of policies changed in accordance with the PEC's influence. The SARS treatment policies changed from using rifampicin to using corticosteroids with supplementation with traditional Chinese medicine. The SARS control policies changed in three policy areas: infections control within hospitals, medical workers protection and motivation, and control policies in the society. The media reportage policy not only changed to open reportage in the middle of the SARS outbreak but also opened more widely after the outbreak in the sense that information about all public emergencies and natural disasters was opened to the public and media. The government also greatly improved and upgraded the epidemic disease surveillance system to a comprehensive health information system.

After the SARS outbreak, the PEC's influence continued and went beyond the epidemic disease policies within the Ministry of Health (MOH). First, the PEC helped set the healthcare reform on the government agenda by converging the three streams in 2005, which opened windows of opportunity for a fundamental health policy change. The experts and the WHO and the UK Department for International Development (DFID) identified problems in the healthcare system, unaffordability and inaccessibility, and analysed the causes of the problems based on a comprehensive analysis of previous health marketisations. They offered correspondent policy solutions to the problems, which called for another healthcare reform to bring back the leading role of the government in health. The publicity of their research result on China Youth Daily, a traditional media, triggered the national mood of citizens criticising the health system. The Government then set the healthcare reform on the agenda and started a formal policy making process.

Second, after opening windows of opportunity for policy change, the PEC influenced the policy dynamics of the healthcare reform from 2005 to 2009. The PEC actively joined debates between the two factions based on the different directions of healthcare, government-dominant or market-leading. The experts and the media then interacted or allied with the stakeholders within the two factions. The experts and a few international organisations directly joined the policymaking process with their policy research and suggestions, which became the foundation of the healthcare reform plan. The experts also joined the discussions between central governments and local governments. The public joined the policy consultation via Internet in the end.

Not only did a series of policies change during this period in accordance with the debate that the PEC joined but the health policy direction also changed from marketisation to a mixed approach involving both government and the market. During this process, the overarching goals of health development changed from being seen as inferior to economic development to being made a significant part of the national development strategies, which indicated a paradigmatic shift in the health policy.

Moreover, the coalition of the experts, media and the international organisations went from unconsciousness to deliberation. At first, during the SARS outbreak, the coalition was unintentional. The three outsiders happened to target the same policies and influenced the policy change. However, the three outsiders intentionally initiated the healthcare reform together, although the experts and the international organisations changed a few media to collaborate. During the process of the healthcare reform policy making, the three actors coalesced deliberatively. The experts actively express their ideas on the media. Some media allied with experts with similar ideology. Although some international organisations criticised the health marketisation, they did not make obvious coalition with the pro-government faction in order to maintain neutrality.

Besides, although the particular actors varied in each case, along the process of influencing policy change, the PEC expanded with more diverse members. There were more experts from different areas. The areas expanded from medical science to social policy, political science, and health economics. The traditional media that reported health issues expanded from few media to a broad range of media. The media's critics went beyond pressing for open SARS information to criticising the health policies openly. The new media was more open for citizens to discuss the health issues during the reform policymaking process than during the SARS outbreak. The types of international organisations that entered the policymaking process expanded from mainly cross national organisations to foreign governmental departments.

In accordance with the PEC's influence, there were two changes in policy making. First, the health policy change was from fine tuning to fundamental change. The fine tuning was partially adjustment of a few policies or areas without touching fundamental problems; while the fundamental change was significant change of the whole health system. Compare the health policy change during the SARS outbreak and that during the reform policymaking, the health policy change started with initial small adjustment within the SARS area; it then expanded to the whole disease prevention and control system, and at

last to the health system. Second, the government's attitude to the health policy change was different. The government was initially quite passive to the change of health policies during the SARS outbreak and changed the policies because of the fast spread of the disease and increasing pressures from the PEC. However, the government's attitude started to change during the initiation of the healthcare reform in the sense that the government realised the PEC and the public strongly advocated for the healthcare reform. During the reform policy making process, the government actively interacted with the PEC members and eventually invited the experts and the international organisations to join the policy making process directly.

## **7.2 Distinguished actors in the PEC**

Although the PEC influences health policy change, the methods of influence by experts, the media, and international organisations differ. The experts offer technocratic expertise, but how they offer it differs depending on whether the experts are within the political system or not. The media facilitate information delivery among the government, experts, and the public. However, the way in which they deliver information differs depending on the type of media: traditional media, new media, or non-official media. International organisations use a carrot-and-stick strategy to approach the Chinese government but at the same time must cope with the Chinese government's rules to build trust.

### **Experts**

Whether or not experts work within the political system determines the initial relationships between the experts and the government. Therefore, there are different paths for experts to influence policy change.

Established experts have direct and close links with the government, which enables the government to trust the established experts and their policy research. Established experts are those who work in research institutions within the political system. Therefore, they have direct access to the government, although they cannot draft or formulate policies directly. For instance, the experts of China's Centre for Disease Control (CDC) and Development Research Centre (DRC) are established experts of the MOH and the State Council (SC). However, being within the political system is a double-edged sword. Because the established experts share the same administrative ranks as their governmental departments, they are also under direct control of the government, and their research must

follow the government's mind-set or political restrictions. For instance, although the Guangdong experts opposed the CDC experts' findings on SARS and continued conducting research on their own, the China CDC experts did not verify their findings with more scientific research because the Chinese government formally confirmed them.

In contrast, non-established experts enjoy a wider range of research 'freedom' than the established experts because they are outside the direct restrictions of the political system. The non-established experts do not have direct access to the government or are further from the political system than the established experts. For instance, the experts in Guangdong medical institutions, universities, and commercial research institutions are non-established experts. They cannot influence policies as directly as the established experts can.

Therefore, the established experts have more privilege than the non-established ones do to influence policy changes because the former is initially trusted by the government. For instance, during the SARS outbreak, the central government preferred the opinions of established experts to those of non-established experts twice. First, although the non-established experts in Guangdong opposed the CDC experts' rifampicin treatment suggestion, the central government still insisted on promoting it. Second, the decision-makers choose a CDC expert, Zeng Guang, to meet directly for consultations regarding SARS prevention and control, even though the non-established experts proved the CDC experts wrong in their treatment suggestions.

However, non-established experts can remedy the weaknesses of their position with the 'freedom' to collaborate with other actors. During the SARS outbreak, a non-established expert, Zhong Nanshan, conducted SARS research and resisted the central government's treatment policy with support from Guangdong's provincial government and his own network of international research community members. In the process of the healthcare reforms, more non-established experts joined the policy process with support from the media and the governmental departments. The decision-makers even directly consulted a non-established expert, Li Ling, regarding the healthcare reforms.

Moreover, non-established experts play bigger roles than the established ones in influencing healthcare reform policies because the non-established experts do not have direct links with the stakeholders. The healthcare reforms concern the stakeholders because the reforms relate directly to their interests. The policy suggestions of the established

experts thus easily favour the stakeholders with whom they have close links. However, policy research conducted by non-established experts can avoid bias more easily than research performed by established experts because the non-established experts do not have direct links with the stakeholders. Therefore, the Chinese government commissioned one established expert team and four non-established expert teams to conduct policy research. Although the research still falls into two factions, it at least avoids preferences based on interests.

One thing that both established and non-established experts have in common while influencing policy change is that they always identify problems while making policy suggestions. First, the problem stream decides which policy alternatives and solutions will be chosen to enter the policy stream. However, a single issue could be identified as exhibiting different problems from various angles, which in turn influences the policy chosen. For instance, SARS could be identified as a public health issue that requires health policy, it could also be identified as an emergency issue in need of a crisis management policy, and it could be identified as a social security issue that needs social policies. The different problem identifications require different policies and thus exclude policy measures that do not fit into the problem stream. When an issue emerges, various experts crowd into the 'policy pool' with the policy alternatives and possible solutions based on their own professional experience and area, but which policy is chosen largely depends on who can influence the problem identification of the decision-makers. In this circumstance, the policy that fits the problem identification could be set on the agenda. Second, the problem identification alone is not enough. The Chinese government has achievement-oriented standards (Kau, 1969) that value practical and feasible policies that can solve problems. Well-designed policy suggestions that indicate how to solve an identified problem add value to the whole analysis as an integrative and comprehensive package. When facing massive policy suggestions, the Chinese government tend to take into account problem identifications with suggested policy solutions.

Established experts have a greater initial privilege of policy influence than non-established experts because of their direct links to the government within the political system. However, being within the political system may also constrain research that has a different mind-set from that of the government. Non-established experts thus make up for the weakness with their network. To influence policy change, both established and non-established experts offer both problem identifications and policy solutions.



## Media

Conventionally, the traditional media in China are for propaganda purpose: guiding the public and making the citizens follow the policies (e.g. Brady, 2010, Chang et al., 1993, Shambaugh, 2007). The traditional media are those that use conventional ways to deliver information, such as newspaper, TV, and radio. Traditional media in China has a long history of state control and thus has a strong role in spreading propaganda, which mainly delivers information from the top down from the government to the public. For instance, when the Chinese government banned media reporting of SARS in the beginning, most of the traditional media kept silent;<sup>207</sup> while since the government lifted restriction of the media reporting of SARS in late April, most of the traditional media followed the propaganda rules to report positive stories about SARS being under control and how hard the government and medical workers fought against SARS.

The new media development based on information technology (Zheng, 2007) challenges the traditional type of reportage by offering spaces for the public to express their opinions. Although the media in China still do not have the same freedom as their counterparts in the West, the government tolerate the new media because the upper-level government uses it to monitor lower-level governments and social issues (King et al., 2013, Stockmann and Gallagher, 2011). Therefore, the new media can influence policies as long as they do not challenge the one-party system of the CCP's control (Zhao, 1998b). For instance, during the SARS outbreak, rumours spread via mobile messages caused public panic that pushed the Guangdong local government to confirm the existence of SARS. The information of medical worker's motivation on the Internet triggered a series of related policy changes. The broad public discussion on the Internet of the health system problems formed a policy environment which facilitated push of the public for the healthcare reform.

Media commercialisation also challenges government propaganda by encouraging the media to report news from the bottom up. Since the media commercialisation in the 1980s, the state loosened control of the traditional media because of funding cuts (Yu, 2009). Therefore, most of the traditional media depend on commercials and circulation, which pushes the media to attract as many readers as possible by reflecting their difficulties and problems or even by criticising the government on social issues. For instance, Southern Media Group bases in Guangdong and is one of the most commercialised media groups in

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<sup>207</sup> There were very few traditional media in Guangdong reporting SARS, but the reports were mainly spread in Guangdong and thus did not reach all the Chinese citizens.

China. Its newspaper and magazines, such as *Southern Weekend*, *Southern Metropolitan News*, actively reported SARS in Guangdong when most of the media reporting was banned. Their reports finally pushed the Guangdong government to admit the existence of SARS. After the SARS outbreak, a semi-official media that are partly sponsored by the government but partly commercialised, *China Youth Daily* publicised the research report in a very critical way. This publicity generated a broader discussion among both the public and the government, and eventually initiated the healthcare reform. During the reform policy making process, lots of commercialised (or partly) media joint the debate by supporting directions of pro-government, pro-market, or the mixed. *China Youth Daily* favoured pro-government direction; *Caijing*, one of the most commercialised magazines, strongly advocated for pro-market (Duckett and Langer, 2013). Those media allied with the experts and the government sharing similar ideas and interests influenced the dynamics of health policies.

To enhance the value of media reports, commercialised traditional media tend to add experts' ideas to reports, which also shortens the distance between experts, especially non-established experts, and the government. Because of the media coverage of the experts' ideas, the reports that draw more public attention are more likely to attract the government's attention than reports without public attention. For instance, the initiation of the healthcare reform occurred because of a critical publication that cited evidence supported by expert research in semi-commercialised media.

Commercialised traditional (or partly) media compete with each other for the market and thus push the media to focus on controversial topics that attract readers. Information technology enables new media to circulate information to a large audience in a very short time. Therefore, traditional media have to report on the controversial topics that new media report on as well. The frequent coverage of controversial topics by both new media and traditional media form a policy environment that makes the government aware of the issues concerning at least part of the public. When media coverage reaches a certain degree, the government is pushed to envisage the topic and thus may set it on the agenda (Cook et al., 1983, Wallsten, 2007). For instance, the broad media coverage (both traditional and new media) of healthcare reforms and critics of the health system between 2005 and 2009 formed the policy environment targeting the healthcare reform from both pro-government and pro-market perspectives. It not only set the agenda for the healthcare reforms but also continues to influence the policy direction by facilitating reports on both sides' ideas.

Although the media in China do not have the same freedom as their counterparts in the West, they can influence policy change by facilitating information delivery. While the traditional media produce information on their own, new media deliver information as a channel. The former mainly offer space for the opinions of government and elites, while the latter provide space for ordinary people's voices. However, it is more possible to influence policy when both of them focus on the same issue (though with different voices from elites and the public) than on different issues. For instance, during the SARS outbreak, it took months for the central government finally to confirm the existence of SARS and to provide infection information. Although some experts asked for information disclosure and the public asked for information on the Internet, most of the traditional media were silent. However, after the SARS outbreak, both traditional media (official and non-official) and new media actively reported different ideas regarding the healthcare reforms, which initiated the reform and influenced the reform policies.

Although the traditional media have conventional propaganda functions, conveying the government's voice from the top down, its commercialisation and the development of new media give voice to both elites and the public, forming the policy environment and pushing the government to face social issues. The more vocally and focally the different types of media report an issue, the more likely it is that the issue will be set on the agenda.

### **International organisations**

Compared to experts and the media in China, international organisations are not only outside the political system but also external to China. On the one hand, the international organisations are not under the same control of the Chinese government as the other two actors. On the other hand, these organisations are not trusted by the government as much as the other two actors. Therefore, international organisations influence policies using two different approaches: carrots and sticks. In other words, they provide assistance to or exert pressure on the Chinese government.

First, international organisations offer funding, technical assistance, and the innovative experience of other countries to the Chinese government. During the SARS outbreak, the WHO confirmed the findings of the Guangdong experts and influenced the change in the national treatment policies. After the SARS outbreak, the WHO and the UK Department for International Development (DFID) funded the DRC's research and offered techniques and experience based on other projects in China, which initiated the healthcare reforms.

Moreover, the WHO, the World Bank, and the McKinsey Company offered policy research independently of the healthcare reform consultancy. It was the first time in history that the Chinese government officially considered an international organisation's policy suggestions.

International organisations also bridge the gap between the Chinese government and external experts in the health area. The cooperation between international organisations and the Chinese government build trust; therefore, the international organisations are allowed and asked to bring external experts from other countries directly into China's policy process. During the SARS outbreak, the WHO organised external experts from different countries to conduct field trips in China to offer technical guidance and evaluate SARS control in different areas. In the healthcare reform policy process, the DFID invited external experts to evaluate independent policy research as referees.

Second, international organisations pressured the Chinese government to open access to information by conveying pressure from the international society. During the SARS outbreak, foreign embassies and the WHO both pressured the Chinese government to release SARS information. The foreign embassies asked their home countries and informed the WHO about the disease situation, while the WHO contacted the Chinese government with increasing frequency, in strong tones, and in direct ways. Furthermore, the WHO listed China's provinces as SARS-infected areas with increasing warnings. Eventually, the Chinese government released information bit by bit.

However, there is a difference between pressure from foreign governmental departments and pressure from intergovernmental organisations because the Chinese government may doubt neutrality and intentions depending on the relationship between the international organisations and the foreign countries. Direct pressure from foreign governmental departments may lead to suspicions of governmental interference in China's domestic issues or an 'ill-intentioned anti-China move' (Zheng and Liang, 2004 p.67). In contrast, pressure from intergovernmental organisations makes the Chinese government less suspicious because they do not belong to any country. For instance, although foreign embassies asked the Chinese government for SARS information before than the WHO did, the Chinese government did not respond to their enquiries until the WHO stepped in. The Chinese government even asked a consultancy company for policy research instead of the DFID, which have more experience conducting health projects in rural China and other developing countries, because the DFID belongs to the UK government. However, this

does not mean that the Chinese government will not trust foreign governmental departments such as the DFID. On the contrary, the Chinese government trust the DFID's expertise, its international research network, and its neutrality with respect to China's bureaucratic interests, experts' debates, and ideological context. Therefore, the Chinese government asked the DFID to invite external experts to review independent policy research and values their comments. However, compared to the influence of independent research conducted by non-governmental organisations, the DFID's influence via review and evaluation is less and indirect.

To build and maintain trust, international organisations respect the Chinese government's basic rules while cooperating with them, even at critical moments. For instance, while the WHO was pushing the Chinese government for information disclosure, the organisation stayed in contact with the Chinese government regarding press releases and did not release information without acknowledgement from the Chinese government. While conducting commissioned policy research in the healthcare reform policy process, although other domestic research teams released information to the media, international organisations kept strict confidentiality based on their agreement with the Chinese government.

Moreover, the international organisations build trust with collaboration and cooperation in research, field trips, and projects in China with Chinese experts and health officials. For instance, during the SARS outbreak, the WHO worked with Chinese experts and health officials towards SARS control. The WHO and the DFID also worked with Chinese experts on the DRC report that initiated the healthcare reforms. Moreover, the DFID cooperated with China's experts and health officials via two upgraded health projects, the Basic Health Services Project (BHSP, 1998-2007) and the Health Policy Support Project (HPSP, 2005-2012) to increase the availability, quality, and equality of evidence-based health policymaking. The collaboration and cooperation that occurred via the upgraded projects was a mutual learning process that opened a dialogue. On the one hand, the international organisations deepened their understanding of Chinese culture and values and learned how to adapt to China's context. On the other hand, the Chinese experts and health officials benefitted from advanced techniques and innovative concepts, gradually developing trust in the international governments commitment, intelligence, and resources. Therefore, the BHSP and the HPSP not only influence basic policies by delivering practical health services in some rural areas but also influenced national policies at the central level.

Based on the trust building, the international organisations were able to bring China into the international society, which pushed China to follow international rules in dealing with domestic health issues. During the SARS outbreak, the WHO brought China into the Global Network, which shares health information and research with other countries. It pushed the Chinese government to release SARS information and to open to international cooperation.

International organisations use a carrot-and-stick approach to influence China's policy change. They offer assistance and exert pressure from the international society to push Chinese government to change their health policies. However, the relationship between the international organisations and countries determines the extent to which the Chinese government respond to their assistance and pressure. By respecting the Chinese government's basic rules, the international organisations deepen and broaden their influence on China's health policy change.

### **7.3 Theoretical contribution: policy outsiders' influence on the policy process**

This thesis contributes to understanding the policy process by adding to both theories of the policy process and understanding of policy entrepreneurs. In relation to theories of policy process, this thesis modifies Kingdon's theories about the 'multiple streams framework' (MSF) and policy cycles (Kingdon, 1995).

First, the MSF indicated that when the problem stream, the policy stream and the political stream converge, windows of opportunity open and policy change takes place. Kingdon argued that three streams flowed independently before finally converging. However, my analysis of the first case of this thesis, policy change during SARS, showed that problem identification could influence policy suggestions. The different problem identifications of the government could influence the government's decision when choosing policy suggestions. The SARS crisis was identified as three different issues. From November 2002 to January 2003, SARS was identified as an unknown epidemic disease that only existed in a few areas in Guangdong. Therefore, the central government did not make national policies to control it. From February to April 2003, SARS was identified as a fatal disease that could be cured by scientific research. Then the central government made national treatment policies focusing on the SARS treatment based on scientists' policy suggestions. From late April to July 2003, SARS was identified as a serious infectious

disease with a fast-growing number of cases. The government therefore took policy suggestions from epidemiologists and public health experts and changed the principle of national policies from treatment to control. Policy changes during the SARS crisis thus showed that when there were various policy suggestions in a ‘policy pool’, the government picked the policy suggestion based on problem identification. Therefore, the problem stream and policy stream are not necessarily independent of each other.

Second, besides the MSF, Kingdon made another contribution to the explanation of the policy process by dividing it into four stages: agenda-setting, considering alternatives and specifications, decision-making and policy implementation. After implementation, the policy process starts again with agenda-setting, and goes through the whole process stage by stage. Thus, the policy process is like a cycle. If there is any policy change, the policy change happens in the next cycle after the implementation. However, scholars criticised Kingdon’s policy cycle, because in real world, the policy process rarely has clear separation of the stages (Sabatier 2007). The policy change does not always happen after the implementation either. The third case of this thesis, policy change during the healthcare reform policy making, I showed that the policy making process in China’s authoritarian state could be divided into two stages – interactions between the government and the PEC and view-seeking from the public. Policy change happened mainly at the stage of the interactions between the government and the PEC. After the initiation of the healthcare reform in 2005, the government made several policies in accordance with the PEC’s suggestions. The policy directions changed between the pro-government and pro-market approaches before the final reform policies was made in 2009. I thus show that policy change does not necessarily happen after the implementation stage, but could happen during policy making.

This thesis also expands theories of policy entrepreneurs. First, it shows that policy entrepreneurs are active and influential in the health policy area. Most of the research on policy entrepreneurs focus on environmental policy (Han, Swedlow et al. 2014)(e.g. Mertha, 2009; Crow, 2010; Han, Swedlow et al., 2014). However, there is little research on other policy areas. Mertha (2009) implied that environmental departments ‘invited’ or ‘were open’ to the NGOs because they were relatively lower status within the political system, and thus had to draw support from outsiders to frame the issue and set the agenda. Like the environmental policy area, the health policy area was for a long time a low status policy area within the political system, because the drive toward economic growth in the post-Mao era marginalised public health issues (Ruan et al., 1994). Therefore, the public

health needs outsiders' help to make the government recognise and formally address health issues (Huang, 2004). Since the theories of policy entrepreneurs are used in different areas, because of the spill over effect,<sup>208</sup> it is reasonable to argue that policy entrepreneurs could play a role in broader policy areas.<sup>209</sup>

Second, this thesis expands the scope of policy entrepreneurs from individual actors to suggest that they can act as a coalition of different actors. Mertha (2009) used 'policy entrepreneurs' to explain that peripheral officials, non-governmental organisations and the media functioned as policy entrepreneurs to influence the Chinese hydropower policy. He considered policy entrepreneurs to be individual actors who '.....successfully entered the political process precisely by adopting strategies necessary to work within the structure and procedure' (Mertha, 2009 p. 996). However, this thesis shows that the entrepreneurs could coalesce with each other and take a group action as the PEC in the face of common problems. Although the PEC was not a unitary actor in the first case, along with health policy change it gradually came to act in an increasingly coordinated way. This thesis traces the evolution of the coalition and explains how policy entrepreneurs behave strategically as a group by using each entrepreneur's expertise. For instance, in the second case, the initiation of the healthcare reform, experts and international organisations cooperated consciously on the health research and used the media to draw the attention of both public and government. In the third case, the coalition was even clearer. Different policy entrepreneurs formed two factions based on two main opinions of the healthcare reform approaches and influenced the policy change.

Third, although the theories of entrepreneurs originated in democratic countries, this thesis argues that policy entrepreneurs could influence policies in the setting of an authoritarian state. In democratic states, there are formal institutional channels for policy entrepreneurs to influence public policy, such as elections, lobbying, and campaigns. However, in authoritarian states, where the institutional barriers are high and rigid, there are limited channels for policy entrepreneurs to exercise their influence. In authoritarian states, the

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<sup>208</sup>The 'spillover effect' means the learning from one situation could be transferred to others that are thought to be similar. The spillover can be in the same sector, but in a different country MINTROM, M. & VERGARI, S. 1996. Advocacy Coalitions, Policy Entrepreneur, and Policy Change. *Policy Studies Journal*, 24, 420-434, IKENBERRY, G. J. 1990. The international spread of privatization policies: Inducements, learning, and policy bandwagoning. In: SULEIMAN, E. & WATERBURY, J. (eds.) *The political economy of public reform and privatization*. Boulder, CO: Westview., or in different sectors but within the same country ZAHARIADIS, N. 1992. To sell or not to sell? Telecommunications policy in Britain and France. *Journal of Public Policy*, 12, 355-376.(Sabatier 2007)

<sup>209</sup> I do not mean that the theories of policy entrepreneurs could apply to all policy areas. There are still some policy areas need further study, such as internal security or defence.



policy entrepreneurs should pay heed to political guidelines (Steiner, 1959). Otherwise they can be ‘... easily shut out, especially in an authoritarian political system like the People’s Republic, and they do rely on the degree to which they can fit their ideas or arguments to a particular policy agenda at a given time’ (Hammond, 2009 p.223). For instance, while the advocacy coalition framework focuses on technical information, the PEC understands the political context and the logic of its operation, and also uses its expertise and strategy to promote policy change. Therefore, compared to policy entrepreneurs in the democratic states, the PEC is a new form of outsider influence in the authoritarian state.

## **7.4 Empirical implication: strategies to influence policy change**

With new qualitative evidence, this thesis has been able to unravel the strategies used by policy outsiders to influence policy in China. However, before detailing the narrative of the strategies, a few things must be clarified. First, the strategies are based on the PEC’s influence on health policy, which belongs to the social policy area concerning public goods. Therefore, the strategies introduced will probably influence social policies more easily than other policies that conventionally are not affected by the PEC. Second, the PEC’s influence on policies is associated with not-for-profit activities, so strategies drawn from these activities might not be applicable to the profit-driven activities of commercial organisations. Furthermore, the strategies used by actors that are intended to influence policies on behalf of commercial interests might lead to corruption, which is beyond the scope of this thesis. Third, the strategies drawn based on the findings of this thesis proved useful in the cases I studied. There is no guarantee that the use of these strategies will definitely lead to policy change because of the constraints of the contextual conditions mentioned in Chapter 2, such as political fissures in the fragmented authoritarian state, the functional differentiation of institutional design, and ideological transition. These contextual conditions vary among cases and over time. Fourth, the strategies can be applied to influence policy at the level of the central government rather than at the level of local government. Although China is an authoritarian country with one ruling party, the local governments have leeway to set their own policies and how to implement the policies set by the central government, which is referred to as authoritarian decentralisation, as mentioned in Chapter 2.

Policy outsiders can influence policies in China by adopting the following strategies. First, the policy outsiders need to identify problems and suggest policy solutions accordingly,

usually resulting from policy research. Problem identification includes recognising the problems that the policy needs to solve and the hierarchy of the policy. The problem identification determines how the policies are made. The hierarchy of the policy determines the nature of the policies, such as the policy principles of decision-makers, practical policy set by ministry-level departments, and technical policy set by divisions within the ministries. Although a higher-level policy has stronger legal and political power, the setting of such a higher-level policy also means more obstacles because of the different interests involved, as a higher-level policy focuses on broader subjects and is related to a wide range of different interests. A lower-level policy focuses on very specific problems. For instance, the SARS treatment policy issued by the disease prevention and control department of the MOH addresses only SARS, but the healthcare reform policies set by the SC solve various types of problems relating to the different interests of the departments and stakeholders with different ideologies. The more interests the problems are related to, the more difficult it is to set a policy that will satisfy every interest involved. Therefore, lower-level policy is easier to influence than higher-level policy, although a change in higher-level policy usually indicates a fundamental change.

Second, policy outsiders need to know the governmental departments that are in charge of the policy area and the governmental functional departments that are related to the policy. Departments with similar interests and ideas regarding a given problem and policy are a good starting point for actors to influence policymaking and policy change. Because of the fragmented authoritarian system and the functional differentiation of the institutions, there are different bureaucratic interests. To influence policies, the following key information is essential for actors to exert effective influence: the main department in charge of the policy area, the interests of the department, the angle of the policy that would benefit the interests of the department, other departments with different interests, and the difference among these conflicting interests. It is important to know the state of the art and to make a rational move. For a policy solution to be accepted by the decision-makers, an important step is to propose a policy that would satisfy at least one department within the government so that at least the proposal would have a supporter, even though this means that the policy proposal would inevitably be opposed by a department with a different interest.

Third, after finishing the problem identification and selection of policy solutions and identifying the related governments, the next step is to approach the governments. Of course, the easiest way would be to approach the policymakers directly. However, such a direct approach is limited. In most cases, as shown in this thesis, an indirect approach via

the policy community could also work. The policy community is a loose and informal community that is open to a broad range of actors. Within the policy community, unestablished experts are usually easier to approach than established ones because they are outside the political system. Therefore, the actors should approach unestablished experts first, such as those who work for universities and think tanks. A useful way to identify unestablished experts is to check academic journals for publications related to the designated policy area. Because unestablished experts, established experts, and policymakers connect with each other within the policy community, via the unestablished experts, the actors can eventually approach established experts or even policymakers. Another way to be connected with the policy community is to join discussions that usually involve different experts and policymakers and to publish policy research in academic journals or even in internal government journals.

Moreover, publicising the problem identification and advocating for policy change in the media is a useful way to attract the attention of both the public and the government. To achieve this end, the media should be chosen carefully. Regarding traditional media, a mainstream media outlet that is influential and shares a similar understanding with the policy proposal should be chosen. For instance, *Caijing*, an influential rightist traditional media outlet, published many articles in support of pro-market healthcare reform. A policy proposal that fits the stand of *Caijing* would be easily accepted and promoted by the media outlet. Concerning new media, websites with larger numbers of users should be chosen to attract the attention of the public. However, it is risky to arouse discussion on the Internet, as it is difficult to predict the public segmentation that a policy idea might lead to. If a policy idea causes criticism of the political system, going beyond the policy level, the criticism might negatively affect the potential influence of the idea on the policy change.

In addition, international organisations could also provide a good avenue to have an effective influence on policy. However, this approach is not without limitations. On the one hand, although, in theory, international organisations should be easy to approach because they are external to the Chinese government, it is not always easy to approach them, as their limited staffs are busy conducting projects with the Chinese government and do not have much time to focus on other business that is not related to their projects. On the other hand, approaching the international organisations while bypassing the Chinese government might have a negative impact on the policy suggestion that an actor proposes to influence policy change because the Chinese government might be suspicious about the actor's intention. Therefore, it would be better to approach international organisations with

good reputations, a history of successful cooperation with the Chinese government, and projects and plans related to the policy outsiders' ideas.

## 7.5 Future research: can the PEC's influence be sustained?

This thesis takes early 2009 as the endpoint because the healthcare reforms formally began with the launch of the policies. The healthcare reform policies are periodical results of the PEC's influence, but this influence does not stop at that point. In fact, the PEC members themselves are undergoing great development. Furthermore, the contexts of policymaking change as well. All changes shape the extent of the PEC's influence and affect the implementation of the healthcare reforms.

The profound development of the PEC members diversifies the influence. First, the government formally institutionalises the experts' influence. In January 2015, the SC issued a policy document, 'Opinions on Strengthening the Construction of New Types of Think Tanks with Chinese Characteristics' (*Guanyu jiaqiang zhongguo tese xinxing zhiku jianshe de yijian*), to confirm formally the consultancy role of experts and encourage the development of policy research. It indicates that the experts' influence will be more diversified because the government will put effort into policy research. Moreover, the policy community will be further confirmed as a norm because of the institutionalisation of the experts' influence.

Second, the media have developed greatly, especially the Internet. Since 2009, two important new media outlets, Sina Weibo (a Chinese microblog combining features of Twitter and Facebook) and Wechat (a Chinese version of WhatsApp), have begun to be used by most Chinese Internet users. Weibo was launched in 2009, and, as of December 2014, its numbers of 'monthly active users were 175.7 million and daily active users were 80.6 million on average [with] an increase of 31% year over year'.<sup>210</sup> Wechat was launched in 2011, and it had 1.1 billion registered accounts as of January 2015 and 500 million active users by March 2015, among which 100 million users are outside China.<sup>211</sup> The massive number of users and fast information delivery via new technology offer a platform for the public to express their opinions. Moreover, it brings the government to the

<sup>210</sup> For more information, please see <http://www.chinainternetwatch.com/12670/weibo-q4-2014/>, accessed 4/20/2015.

<sup>211</sup> For more information, please see <http://expandedramblings.com/index.php/wechat-statistics/>, accessed 4/20/2015.

same level as the public (from mainly top-down control) and to respond to those opinions directly (although not always). The new media are important for experts and other policy outsiders to advocate their ideas. For instance, normal medical doctors who almost lost their voice in the previous policy reform stage express their difficulties in their work on the Internet, try to ease tensions between doctors and patients, and ask for the government's input to improve the doctors' quality of life and work

The Internet is not only a platform for different voices but also a channel for different actors to challenge the health reforms. Alibaba, China's biggest e-commerce company whose business was based on Taobao, a Chinese version of Amazon and eBay, entered China's medical market with e-prescription and e-medicine services (later named AliHealth) after it began trading on the New York Stock Exchange in 2014.<sup>212</sup> According to AliHealth's plan, it will use big data analysis (also called Ali yun) to build a comprehensive health information system that includes doctors and hospitals. It will allow every citizen to choose doctors, hospitals, medicines, and medical suppliers equally and freely online. It is a challenge to China's original healthcare reform plan with the government leading because it not only brings a strong market mechanism to health but also brings foreign investments into the Chinese health market.

Third, the cooperation between international organisations and the Chinese government has been upgrade to the global level. For instance, the DFID has expanded its input into China's healthcare system with a new project, the Global Health Support Programme (GHSP). This project not only trains Chinese health officials and researchers on how to make health policies based on evidence and research but also encourages the Chinese government to contribute to global health by aiding developing countries in Africa and offering the Chinese healthcare reform experience. Via this cooperation, the international organisations could influence China's health or even foreign relations policies deeply and broadly by encouraging the Chinese government to take on international responsibilities.

However, the changing contexts do not seem to favour the criticism of policy outsiders all the time. The CCP has had its fifth-generation leadership, Xi Jinping and Li Keqiang, in place since 2012, which implies a possible shift in agendas. As many scholars have observed, the fifth-generation leadership has set anti-corruption as the top priority, together with a series of economic development strategies. Although this does not imply that they

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<sup>212</sup> For more information, please see <http://www.irasia.com/listco/hk/alihealth/>, accessed 4/20/2015.

will not continue the healthcare reforms, it seems that they may not see them as important as the fourth-generation leadership did. Hu and Wen, in May 2010 invited pro-government experts, Ge Yanfeng and Rao Keqian, to attend the 20th Political Bureau Group Study and ask for the implementation of the reform policies and suggestions for possible change.<sup>213</sup> However, the fifth generation does not show the same interest in holding the Group Study on the healthcare reforms.

With the existence of the factors favouring and impeding the PEC's, it is hard to predict how it will go. However, certain factors need to be considered in future research. First, the PEC's influence on central governments is not enough. The implementation of healthcare reforms is more complicated than the policymaking process in the central government because it involves different levels of local governments. As discussed in Chapter 2, the lower-level governments have some leeway to decide how to implement policies with their own understandings, which greatly affects where the reforms go and their success. Therefore, to implement healthcare reform policies, the PEC needs to influence local governments in the implementation. Second, besides the experts, the media, and international organisations, more outsiders are trying to influence the policy change, such as medical doctors, hospital managers, pharmaceutical industries, and foreign investors. These diverse actors will provide complex opinions and interests regarding the healthcare reforms. It will be a great challenge to the Chinese government to coordinate these different opinions and interests, as Lampton (1977) predicted decades ago. Therefore, I think that the PEC's influence will be sustained, but its extent depends on the PEC's strategies and the Chinese government's response.

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<sup>213</sup> For more information, please see <http://politics.people.com.cn/GB/1024/11729994.html>, accessed 3/12/2015.

## Appendix: list of interviewees

001	Scholar of Chinese Academy of Social Sciences	9/4/2011
002	Technician of China Centers for Disease Control	9/5/2011
003	External expert of World Health Organisation	9/18/2011
004	Senior Official of China Centers for Disease Control	9/19/2011 & 9/23/2013
005	Journalist of Xinhua News Agency	9/25/2010
006	Senior journalist of <i>Health Times</i>	9/21/2011
007	Representative of World Bank Beijing Office	9/21/2011
008	Senior expert of China Centers for Disease Control	9/27/2011
009	Senior journalist of <i>Beijing Evening News</i>	9/28/2011
010	Senior official of China National Health Development Research Center	9/13/2011 & 9/24/2013
011	Researcher of China National Health Development Research Center	9/24/2013
012	Scholar of Tsinghua University	10/16/2013
013	Scholar of Chinese Academy of Social Sciences	10/14/2013
014	Official of Ministry of Health, Department of Law and Legislation	9/8/2011 & 9/24/2013
015	Senior official of Ministry of Health, Department of International Cooperation	9/27/2013
016	External expert of World Health Organisation	11/12/2012
017	Citizen of Guangdong Province	6/9/2012
018	Senior manager of Traditional Chinese Medicine Hospital of Guangdong Province	9/20/2012
019	Senior journalist of <i>Guangzhou Daily</i>	9/23/2012
020	Scholar of Peiking University Health Science Center	9/22/2011
021	Senior journalist of <i>Health Times</i>	2011.9.29
022	External expert of health	9/19/2013
023	External expert of UK Department for International Development	1/9/2015
024	Senior journalist of Xinhua News Agency	10/2/2013
025	Senior journalist of <i>Jinwanbao</i>	9/14/2011
026	Senior journalist of Xinhua News Agency	9/15/2011

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