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Strong state, weak system: social health insurance in rural China 1956-2007

Abstract

A question of great interest to China watchers is whether or not central mandates are successfully implemented, and how. The issues surrounding this question are at the heart of the analysis in this thesis about China's attempts to institute social health insurance schemes in rural areas from 1949 to 2007.

The thesis looks at central government attempts to institute social health insurance schemes between 1949 and 2007 and tries to explain the significant variation in enrolment in social health insurance across this experience.

The study shows that implementation of social health insurance schemes in rural China, measured in terms of their widespread uptake, succeeded on two occasions. There also have been a number of failures and collapses of social health insurance schemes in rural China.

To explain the variation, the thesis first constructs a framework of how rank and authority of decrees work in the Chinese Communist Party. This framework allows an evaluation of how implementation decrees are transmitted down from the centre to local areas (who implement policy).

The thesis argues that the issuing of a central decree holding the local Party secretary to account for high enrolment is the necessary and sufficient condition for the central government to ensure high enrolment in social health insurance schemes. The issuing of a central decree is shown only to be a necessary condition, but not a sufficient condition. And the holding of the local Party secretary to account must occur through the Party governance system rather than through the health governance system.

The thesis shows that the rise, fall, failure to rise, and then unexpected rise of social health insurance can be explained by the systems of coordination and control used to hold the local Party secretary responsible for ensuring high levels of enrolment in health insurance. It shows that only the local Party secretary can mobilise the local state sufficiently to meet central decree. And only certain central decrees can motivate the local Party secretary sufficiently to mobilise the local state.

The thesis concludes by applying this framework to broader questions of health system reform in modern-day China. It draws tentative conclusions as to how wider health system reform can be understood through the thesis' analytical framework and suggests testing this framework in other policy contexts.

Acknowledgements

Thanks to my supervisor, Professor Winnie Yip, whose work remains an exemplar to all working in the field. Thanks also to my co-supervisor, Professor Peter Drysdale, who — again! — saved the day. Peter, I'm proud to be a member of the seventy-plus strong group of people whose dissertations have been rescued by your wit, wisdom, strength, and support. Thank you.

Thanks to the Rhodes Trust (especially the wonderful Mary Eaton), Merton College, the Crawford School of Public Policy and the Australian Centre on China in the World at The Australian National University for financial and other support for this thesis.

Thanks to the inimitable Dr. Graeme Smith for his mentorship and laughter and to Professor Geremie R. Barmé and Professor Richard Rigby for their thoughts and erudition. Many thanks to Dr. Luke Hurst — without doubt, the world's greatest office mate — and to my teacher Dr. Li Zelin for their patient assistance and counsel. 君子可谓好学也已.

Thanks to the many people who have helped along the way. These include, but are not limited to:

Adelaide: Professor Denise Bradley, Professor Byron Sharp and the Ehrenberg-Bass Institute, Dr. Terry O'Callaghan, Liam Golding, Ben Payler, Adam Richards, Jenny Richards, Simon White, Magda and the Halt family, and Amy and the King family.
Oxford: Merton College Library staff, the Medical Sciences Graduate Office, Professor Sasha Shepperd, Professor Christine Wong, Professor Vivienne Shue, Professor Ray Fitzpatrick, Dr. Sarah Eaton, Dr. Rachel Murphy, Dr. Claire Leaver, Dr. Karl Gerth, Dr. Linda Yueh, Dr. Patricia Thornton, Jing Fang, Shio-Yu Kan, and Christelle Kervella.
Many thanks also to Jono Bono and the Jar Kids, Jono Webb, Amia Srinivasan, Daniel Rothschild, Selby Marshall, Rosara Joseph, Katie Rivkin, Robbie Coleman, and Ben Papps.
China: Professor Cai Fang, Professor Ran Tao, Professor Gordon Liu, the Transition Institute and Gu Junsheng, Zhengzhou Medical University, Dr. Chris Buckley, Dr. Tao Kong, John Garnaut, and many people who cannot be named here for obvious reasons.
Canberra: Professor John Braithwaite, Dr. Benjamin Penny and everyone in the CIW and Morrison Project teams, Dr. Shiro Armstrong, Dr. Nicholas Farrelly, Dr. Anthony Garnaut, Dr. Sarah Logan, Dr. Anna Oldmeadow, Alex Grey, David Hume, Julia Hurst, Alison Jenkins, Anastasia Kapetas, Sarah Kirlew, Jo Lennan, Anna Mitchelmore, Andrew Nolan, Sean Starmer, Julia Talbot-Jones, Gillian White, Kyle Wilson, and Matt Wise.

Finally, thanks to my parents, my family, the Foster-Thorpes, and my friends for their constant support. Thanks to Carl and Mum for always guiding me safely through the darkest of times. And thanks to Francie, for everything.

Ryan Manuel
September 2015

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Chapter 1: The Issues

The question of how institutions work in both strong or weak states, and how institutions then affect the provision of public goods to citizens is of considerable interest to modern studies of political economy.[1] Within this literature, the paradox of how Chinese institutions have greatly improved economic growth and aggregate welfare, but have also failed to improve other social welfare goals of the state, is of great importance. Yet this paradox is relatively rarely addressed.[2]

This thesis outlines how bureaucratic politics and political organisation affect the implementation of social health insurance schemes in rural China; it aims to shed some light, if only a certain slant, on the question of how the Chinese institutional environment affects the implementation of policy within China. The thesis argues that the structure of the Chinese political system constrains actors at the local level in a way that makes some central commands far more likely to be followed than other central commands. China's political structure and command has had a particularly large impact on the implementation of rural social health insurance (SHI) schemes. There have been a number attempts by the central government to institute SHI schemes, with varied success. But there

[1] Although there are many examples, perhaps the most discussed recently is Daron Acemoglu and James Robinson (2012) *Why Nations Fail*, Crown Business: New York, which builds on Daron Acemoglu, Simon Johnson, and James Robinson (2005) 'Institutions As A Fundamental Cause Of Long-Run Growth' in Phillippe Aghion and Steven Durlauf (eds) *Handbook of Economic Growth*, pp. 386-464, Elsevier: Amsterdam.

[2] See for example the importance given to explanations of China in recent *tours d'horizon* such as Acemoglu and Robinson (*ibid*), or Francis Fukuyama (2014) *Political Order and Political Decay: From the Industrial Revolution to the Globalization of Democracy,* Farrer, Straus and Giraux: New York.

is currently no explanation as to why some schemes succeeded and others failed over a period of Chinese Communist Party ("Party") rule. Based on a comprehensive and unique analytical framework of how the rules of the Chinese state function, the thesis argues that the variation in successful SHI scheme implementation and SHI enrolment is due to variations in how the central state has held local leaders accountable for the levels of enrolment in their jurisdiction.

The thesis takes the approach that a general explanation of *how* the Chinese system implements social health insurance policy may provide a framework to explain the successes and failures of different attempts to create a social health insurance scheme by the Chinese state. The thesis begins with an examination of the internal rules, documentation, and regulations governing behaviour within the Chinese system. There are certain regularities within China's political structure and system of command that, due to the Leninist nature of the political structure, apply to all actors within the system and can affect behaviour of individual actors nationwide. The political structure gives local party secretaries almost complete power and control over policy implementation within the formal Chinese governance system. The relationship between the government and the Party within China provides incentives to local leaders that make implementing some policies far more attractive than implementing other policies.

An application of this generic framework to the empirical evidence of different attempts to implement social health insurance further supports the hypothesis that successful implementation relies on the centre targeting local Party secretaries and holding

them and only them accountable for social policy successes. Successful implementation in this way appears less a commitment to broader social goals ("health care", or "welfare") than a commitment to maximising one's performance on targets decreed and measured from above.

But the initiation and successful implementation of a national social health insurance scheme is an enormously impressive feat of governance. Social health insurance schemes are considered among the 'most difficult of policy reforms', even in countries with high-performing health systems.[3] While accurate comparative claims are difficult,[4] the United States, Mexico,[5] Vietnam,[6] Ethiopia,[7] Indonesia,[8] Nigeria,[9] Nicaragua,[10] Georgia,[11] and

[3] Jacob Hacker (1998) 'The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy', *Studies in American Political Development*, vol. 12, no. 1, pp. 57-130.

[4] The Chinese system, for example, has far less comprehensive reimbursements or financial protection than other schemes.

[5] Mexico's *Seguro Popular*, for example, launched in 2003 is the health ministry's semi-SHI scheme that operates in parallel to the social security institute's SHI scheme, and is aimed at the informal sector. The poorest two deciles are exempt from contributions. The remainder of the population contributes according to assessed income. In spite of an extensive enrolment campaign, public funding and attempt to boost participation, treatment clusters could only enrol 44 percent of households participating in the program, compared with 7 per cent in control communities. See for example: Gustavo Nigenda (2005) 'El seguro popular de salud en México: Desarrollo y retos para el futuro', *Nota Técnica de Salud*, No. 2/2005, April, Banco Interamericano de Desarrollo: Caracas. Example case also listed in Michael Kremer and Rachel Glennerster (2012) 'Improving health in developing countries: evidence from randomized evaluations', in Pedro Barros, Thomas McGuire, and Mark Pauly (eds) *Handbook of Health Economics*, Elsevier Publishing: Amsterdam, p. 242.

[6] In Vietnam, about 40 per cent of those who ought to have received health insurance coverage (or a free health care card) by virtue of being poor had actually done so in 2004. And non-poor families that are not in the formal workforce (which a high proportion of rural China falls into) are even less likely to enrol. World Health Organisation (2006) 'Health service utilization and the financial burden on households in Vietnam: the impact of social health insurance', Discussion Paper No. 6, *World Health Organisation*, available online: http://www.who.int/health_financing/health_service_utilisation_Vietnam_dp_e_06_6.pdf.

[7] See for example, World Health Organisation (2014) Improving health care financing in Ethiopia, *Evidence Base for Policy Paper*, available online: http://www.who.int/evidence/sure/esimprovinghealthcarefinancingethiopia.pdf.

[8] Sparrow R, Suryahadi A, Widayanti W (2008) Public health insurance for the poor: targeting and impact of Indonesia's Asheskin Programme. The Hague: Institute of Social Studies.

[9] J. Van de Gaag (2013) A Short-Term Impact Evaluation Of The Health Insurance Fund Program In Central Kwara State, Nigeria. Amsterdam Institute for International Development: Amsterdam.

Colombia[12] have all experienced difficulty implementing wide-scale insurance programs. Indeed, aside from China, only Rwanda appears to have had some success in implementing a nationwide social health insurance program, and the Rwandan scheme targeted a much smaller population group.[13]

A major problem for social health insurance schemes is that for any insurance scheme to succeed, it needs an adequate rate of up-take.[14] Generally speaking, the more people enrolled in a health insurance scheme, the better. A high enrolment rate — even one short of universal coverage —makes it more likely that all members of society will be able to access health care, ensures the sustainability of risk pools and obviates some of the problems of adverse selection.[15] It is a necessary step to improving overall welfare.[16] The bigger the risk pool, the more likely that the scheme can bear the consequences of health shocks rather than the individual. And a high enrolment rate is essential to any future health financing reform, because an insurance body formed by a scheme with high

[10] Only around 20 percent of eligible workers took up a voluntary health insurance program. Rebecca Thornton and E Field (2010) Social security health insurance for the informal sector in Nicaragua: a randomized evaluation. *Health Economics*, vol. 19, pp. 181-206.
[11] S Bauhoff, R Hotchkiss and O Smith (2011) The impact of medical insurance for the poor in Georgia: a regression discontinuity approach, *Health Economics,* vol. 20, no. 11, pp. 1362– 1378.
[12] 10 years after the schemes initiation less than 50 per cent of the principal poor target group was actually enrolled in the non-contributory scheme. Alejandro Gaviria, Carlos Medina & Carolina Mejía (2006) 'Evaluating The Impact Of Health Care Reform In Colombia: From Theory To Practice,' Working Paper (Documento CEDED), vol. 002647, *CEDE*, Universidade de los Andes: Lima.
[13] A Shimeles (2010) *Community-based health insurance schemes in Africa: the case of Rwanda*, mimeo. University of Gothenburg, School of Business, Economics and Law: Gothenburg.
[14] See, for example, David M.Cutler (2002) 'Equality, Efficiency, and Market Fundamentals: The Dynamics of International Medical-Care Reform', Journal of Economic Literature, Vol. 40, No. 3, pp. 881-906.
[15] J Gruber (2008) *Covering the Uninsured in the US*, Report No. w13758, National Bureau of Economic Research: New York.
[16] Universal health coverage is "the single most powerful concept that public health has to offer" Margaret Chan (2012) *Best days for public health are ahead of us, says WHO Director-General.* Address to the 65th World Health Assembly; Geneva, Switzerland; May 21, 2012.

enrolment has much larger economies of scale and political clout, and is better able to be an efficient purchaser of services and representative of patient interests.[17]

As a result, major global organisations such as the World Bank and the World Health Organisation have long encouraged SHI schemes to aim to provide all members of the population with sufficient financial risk protection against the costs of health care service. The benefits of widespread insurance enrolment are well-described.[18] Ensuring everyone is covered by insurance is vital in ensuring that everyone is able to afford treatment.[19] So the long-held goal of "universal health care"[20] has in recent times become the goal of "universal health coverage",[21] as global bodies push many developing countries to improve their health care access through improving their health financing.[22] Improving the availability of health financing[23] can allow citizens to access greater amounts of health services and

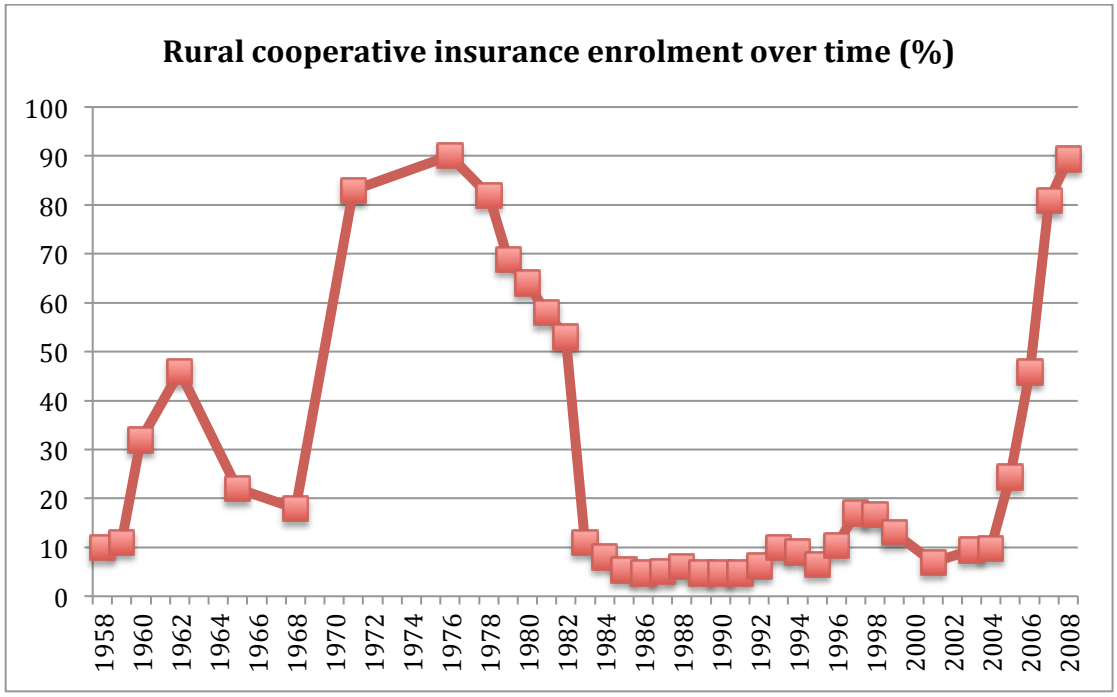
[17] See for example William Weissert and Carol Weissert (2012) *Governing Health: The Politics of Health Policy*, Johns Hopkins University Press: Washington DC, fourth edition.
[18] See various reports from the World Health Organisation (WHO). WHO (2010) *World Health Report 2010 (Health systems financing and the path to universal coverage)*, WHO: Geneva.
[19] As it 'entitles all people to benefit from health services funded by publicly organised insurance': see F M Knaul, E González-Pier, and O Gómez-Dantés (2012) 'The quest for universal health coverage: achieving social protection for all in Mexico.' *The Lancet*, vol. 380, no. 9849, p. 1263.
[20] Guy Carrin and Chris James (2005), 'Social health insurance: Key factors affecting the transition towards universal coverage'. *International Social Security Review* vol. 58, no. 1, pp. 45–64.
[21] The World Health Organisation (WHO) defines universal coverage as being the access of all people to comprehensive health services at affordable cost and without financial hardship through protection against catastrophic health expenditures. WHO (2010) *World Health Report 2010 (Health systems financing and the path to universal coverage)*, WHO: Geneva, p.3.
[22] The term 'Universal Health Care' has most frequently been used in describing policies for care in high-income countries, while Universal Health "Coverage" (UHC) has most often been applied to low- and middle-income countries; hence, the fact that population coverage may not guarantee a sufficient breadth of care services among the poorest countries (merely achieving basic coverage of the populace) is an important consideration that is often overlooked. For a broader overview see D. Stuckler, A.B. Feigl, S. Basu, and M. McKee (2010) *The political economy of universal health coverage,* World Health Organisation: Geneva.
[23] For a more comprehensive framework of the interaction between financing and insurance, see X. Scheil-Adlung and F. Bonnet (2011) 'Beyond legal coverage: assessing the performance of social health protection'. *International Social Security Review*, vol. 64, pp. 21–38.

reduce unexpected health care "shocks", or unanticipated health costs.[24] Achieving universal health coverage is seen as a 'truly immense landmark', and a 'remarkable feat'.[25]

Rural China's social health insurance enrolment rates have fluctuated wildly over the past sixty years, but within this fluctuation there have been not one, but two successful implementations of social health insurance schemes achieving almost universal health coverage. Figure 1 below provides a review of the insurance enrolment rates in rural China after 1958. It reveals that two periods had particularly high enrolment rates — one period following the introduction of the Cooperative Medical Scheme (introduced in 1968) and another period following the introduction of the New Cooperative Medical Scheme (introduced in 2002/3).[26] Both of these schemes were government-initiated and run social health insurance schemes. But there were also a number of other government-initiated and run schemes that failed, including many attempts at lower levels of government as well as major central government decrees in 1987 and 1997.

[24] Adam Wagstaff and Eddie van Doorslaer (2003) 'Catastrophe and impoverishment in paying for health care: with applications to Vietnam 1993-1998', *Health Economics,* vol. 12, no. 11, pp. 921-34.
[25] 'Earlier this year, Mexico reached a truly immense landmark in its pioneering journey of health reform: achieving universal health coverage (UHC) for its 100 million citizens. This remarkable feat has been realised in less than a decade' F M Knaul, E González-Pier, and O Gómez-Dantés (2012) 'The quest for universal health coverage: achieving social protection for all in Mexico.', *The Lancet*, vol. 380, no. 9849, p. 1263.
[26] Announced in November 2002, but no trials, documents or work took place on the scheme until 2003.

Figure 1: Percentage of rural residents enrolled in cooperative insurance schemes in China 1958-2008



Source: Ministry of Health China Health Statistical Yearbook; Wang Shaoguang (2009) 'Adopting by Learning: The Evolution of China's Healthcare Financing', *Modern China*, vol. 35, no. 4, pp. 370-404;[27] Transition Institute (2010), '新农合作医疗：问题与展望' [NCMS: Questions and Prospects] pg. 3.

Given this variation, we need an explanation that covers both the rise and fall in enrolment across different time periods. The thesis distinguishes itself from other works — which often concentrate on the successful Cooperative Medical Scheme (CMS)[28] and the

[27] Please note that Professor Wang's data, while slightly more comprehensive than the state data or the Transition Institute's data, are based on the number of villages that have SHI schemes, rather than based on the percentage of rural citizens that are enrolled in SHI schemes. Hence, where there is any conflict in the data, the thesis has used the official state data, if only to ensure consistency. This methodological issue is discussed in further depth in Chapter 4.

[28] A Smith (1974) 'Barefoot doctors and the medical pyramid' *British Medical Journal*, vol. 2, no.5916, pp. 429–432.; Liu Xingzhu and Cao Huaijie (1992) 'China's Cooperative Medical System: Its Historical Transformations and the Trend of Development' *Journal of Public Health Policy*. vol. 13, no. 4, pp. 501-511; Cao Pu (2010) '1978-2002：关于农村合作医疗存废的争论与实证性研究的兴起' ('1978-2002: The rise of debate and evidentiary study on the retention or removal of rural cooperative health'), *Zhonggong Yunnan sheng*

New Cooperative Medical Scheme (NCMS)[29] — by examining all attempts to achieve widespread insurance coverage within rural China.

Yet looking at all the attempts during the period of Party rule in China further highlights how little current theories explain the varying enrolment rate in insurance schemes. For example, current theory tells us that: the success of social health insurance enrolment during parts of the Mao period of government was due to Mao's 1968 decree and barefoot doctors;[30] that the retreat of the state in the 1980s did not occur locally (although this is more disputed);[31] and that health care reform mooted in 2007 and implemented in 2009 led to a 'return to health'. These statements are consistent with the Ministry of Health being a weak actor in China's 'fragmented authoritarian' political system, and then becoming a stronger actor leading health care reform. Moreover, they are consistent with the idea that pilots (often supported by international assistance) are first trialled, then chosen by the centre, and finally rolled out nationwide in a process of 'guerilla policymaking'.[32]

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weidangxiao xuebao (The Journal of the Central Party School, Henan), vol. 4, available online: http://www.cssn.cn/shx/shx_shflybz/201310/t20131026_584601.shtml.

[29] There are studies in both international and Chinese journals on the efficacy and impact of the NCMS, and some studies of the design of the NCMS. See for example: Xuedan You and Yasuki Kobayashi (2009) 'The new cooperative medical scheme in China.' *Health Policy*, vol. 91, no. 1, pp. 1-9. 揭建旺 (2005) 全面建设小康社会进程中的农村合作医疗制度的研究. 武汉大学: 武汉 (Jie Jianwang (2005) A study of the rural health system in the process of building a comprehensive well-off society, Wuhan University Press: Wuhan); 胡绍雨(2010) 新型农村合作医疗制度的执行评估与完善对策，农村经济, no. 7 (Hu Shaoyu (2010) 'An assessment of the implementation and policy improvements of the New Cooperative Medical Health System', Rural Economy, no. 7).

[30] David Lampton (1977) The politics of medicine in China: the policy process, 1949-1977, Westview Press: Boulder, Colorado.

[31] This is the debate between Jane Duckett and Sascha Klotzbücher, discussed in Chapter 5.

[32] Sebastian Heilmann and Elizabeth Perry (2011) *The Political Foundations of Adaptive Governance in China*, Harvard University Press: Cambridge, MA, pp 1-33.

But a cursory examination of the ups and downs of social health insurance invalidates almost all of these statements as useful explanations of experience with implementation of health insurance schemes. Mao was halfway to universal coverage by the end of 1961, before decreeing through the Central Committee that control of social health insurance be passed to the Ministry of Health,[33] against the idea that social health insurance was just a one-off event in the Cultural Revolution. Moreover, Mao sent down barefoot doctors in 1965 — three years before decreeing the reintroduction of social health insurance — which makes it hard to draw inferences on the links between social health insurance and the barefoot doctors. Data on the 1980s shows that the centre did not retract local incentives to keep social health insurance schemes until 1983; and then the schemes collapsed dramatically. Almost all the countryside was enrolled in SHI schemes by the time the 2007 health reforms were even announced, and the whole countryside was enrolled before the 2009 increases in the health spending budget. And finally, while the centre did appear to encourage schemes in 1968 and 2002, it had made similar exhortations (including through rare central *jueding*) in 1959, 1963, 1987 and 1997; not to mention nearly a dozen pilots, many internationally-led and funded, that were tried between 1985 and 2002 but the evidence from which appear to have all been ignored in the design of the 2002 reforms.

Evidence from international studies seems similarly contradictory to Chinese experience. For example, many analyses emphasise the importance of government intervention — rather than price — in ensuring high up-take rates of health insurance

[33] See chapter 4, or Central Committee and State Council (1962) 政务院关于统一处理机关生产的决定, (Decision on Unifying Activities of Productive Organs), clause 10.

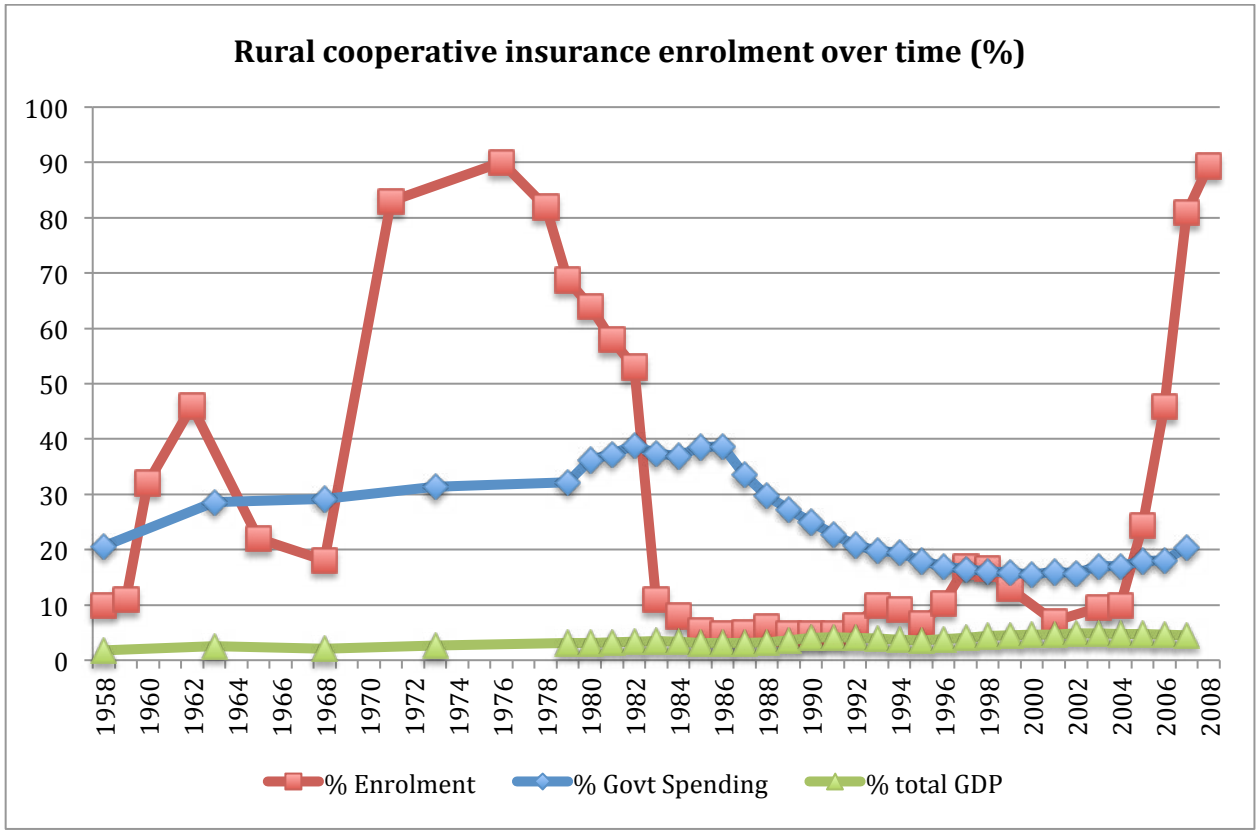
schemes.[34] Hence, they emphasise the importance of the owner of the health insurance scheme (usually the state) possessing high, sustainable and constant rates of funding for the health insurance scheme.[35] But these conditions were not present in the case of the schemes launched in China, particularly for the successful scheme launched during the Cultural Revolution.

Similarly, another factor often associated with success in developing social health insurance schemes is that of the amount of money devoted to them. China's success seems notable for the limited amount of public monies devoted to implementing the program. While China's rural GDP per capita has improved vastly, it was low enough at the launch of both of the successful health insurance schemes under study (RMB9540 in 2002 and RMB 223 in 1968)[36] that China could still be classified by the World Bank as a low-to-middle income country.[37] And while China's GDP has undoubtedly been rising rapidly during the past 30 years, the rise and fall of enrolment does not seem to correlate with the linear increases in GDP. As Figure 2 below shows, the jumps in enrolment do not seem to be matched with increases in the amount spent on health care as a percentage of GDP. Neither do these jumps in enrolment match with increases in the amount of money spent

[34] 'Even if the insurance is offered at no cost, enrolment may still be an issue' — Adam Wagstaff (2007) *Health insurance for the poor: initial impacts of Vietnam's health care fund for the poor*, Policy Research Working Paper 4134. Washington, DC: World Bank.
[35] A Acharya, S Vellakkal, F Taylor, E Masset, A Satija, M Burke and S Ebrahim (2012) Impact of national health insurance for the poor and the informal sector in low- and middle-income countries: a systematic review. EPPI-Centre, Social Science Research Unit, Institute of Education, University of London: London.
[36] Data taken from table 1.2 in National Bureau of Statistics (2015), *China's Quarterly Statistics*, available online: http://219.235.129.58/welcome.do.
[37] On GDP per capita alone, China currently ranks 121st in the world. The World Bank thus still calls it a 'middle income' or 'developing' country — see for example the most recent World Bank global growth statistics, discussed in Shawn Donnan (2015) 'Developing nation growth slowing, warns World Bank', *Financial Times,* June 10, available online: http://www.ft.com/intl/cms/s/0/2a19f5ca-0ef7-11e5-848e-00144feabdco.html#axzz3gPoJVtSx.

by the government within total health care expenditures. Rather, rural social health insurance appears to have achieved nearly total coverage without the state needing to divert vast sums of public monies to restructure the delivery of health services.

Figure 2: Percentage of rural residents enrolled; health spending as part of GDP and government share of total health spending 1958-2008



Source: Ministry of Health China Health Statistical Yearbook; Wang Shaoguang (2009) 'Adopting by Learning: The Evolution of China's Healthcare Financing', *Modern China*, vol. 35, no. 4, pp. 370-404; Transition Institute (2010), '新农合作医疗：问题与展望' [NCMS: Questions and Prospects] pg. 3.

The lack of analogous international evidence makes the successful implementation of two SHI schemes in rural China yet more a mystery. Studies of health insurance schemes often emphasise that a well-run health system is a good predictor of a health insurance scheme with broad coverage.[38] In this argument, high insurance up-take is indicative of a health system that people want to join, and more broadly, is indicative of an effective governance system and or effective "institutions".[39] Yet, both successful implementation efforts occurred in very similar institutional and structural contexts as the unsuccessful efforts listed above (including the international evidence reviewed above). And, this coverage succeeded — contrary to the normal methods of ensuring universal coverage through using compulsory enrolment[40] — by using *voluntary* schemes organised by the state. How do we explain such a departure from conventional models of what institutional environments will lead to successful implementation, an achievement once being described as a "miracle"?[41]

[38] S Alkenbrack (2008) *Extending health insurance to the informal sector: a summary of approaches*, mimeo. London School of Hygiene and Tropical Medicine: London.

[39] Although this is argued more in the negative than the positive — see for example X Gine, D Yang (2007) *Insurance, Credit, and technology adoption: field experimental evidence from Malawi,* Policy Research Working Paper 4425. Washington DC: The World Bank, pp. 2-3

[40] Classically, there are two types of national schemes — general tax revenue schemes and social health insurance (SHI). General tax revenue schemes use tax revenue to create funds that citizens can use. SHI schemes, traditionally, are compulsory and have participants in the scheme make contributions (often through employers) with the government contributing into the fund for the unemployed. Finally, there are mixed national schemes which combine elements of both of these schemes. But in all these schemes, there is usually some form of compulsory behaviour, or mandate.

[41] 'In just over three years, China launched a basic medical insurance system to cover all its residents, the largest of its kind in the world, and the move was praised as a "miracle" by the international community. "Medical insurance reform is China's greatest achievement of the past decade," declared American scholar Robert Lawrence Kuhn. Margaret Chan, director-general of the World Health Organization, noted, "It is a hard-won achievement to ensure that more and more people, especially rural residents, can enjoy medical insurance." John Langenbrunner, the World Bank's chief health economist, described the results of China's medical insurance reform as "unprecedented."' Quotes taken from China Central Television (2012) *Profile of Li Keqiang*, available online: http://english.cntv.cn/special/newleadership/likeqiang01.html.

The thesis argues that this unusual variation in ensuring coverage is a byproduct not of China's health system, but of China's governance system. It will show that the key factor in whether or not social health insurance schemes were implemented or not — and citizens enrolled or not — across time is whether the Party leadership in Beijing prioritised social health insurance by holding local leaders accountable for high enrolment. It will show this using formal representations of the Party's own systems of documentation and rank. Party incentives, in essence, trump welfare and health system incentives. While there are many other factors affecting enrolment — including *inter alia* the economic production system, peasant and local government resources, and Ministry of Health actions — these factors only explain certain periods of success or failure in implementation. A systematic analysis over time, and over multiple attempts to establish health insurance schemes, shows that the state holding the local Party secretary accountable for enrolment is both a necessary and sufficient condition to ensure national implementation of a SHI scheme.

This claim is based on a new analytical framework that shows the power and authority of the actor/s held responsible for any given decision. This analytical framework treats 'governance' as the byproduct of not only individual choice, but also of the power and authority held by an individual in a given position within the Chinese political system. The comprehensive system of rank and authority within the Chinese political system provides an extensive guide to the power and authority held *ex officio* by various actors in the Chinese system. Using this information to outline the formal range of powers and authority available to individuals within the Chinese system shows whether or not a given actor is able to carry out implementation decrees from above. Similarly, outlining the

formal range of powers and authority that can be decreed through formal documentation shows whether or not a given decree may have significant force or effect to compel lower-level actors to follow central will.

In this way, the thesis directly addresses literature that claims that national health insurance schemes require highly capable states and, as is usually assumed, well-functioning institutional environments. A governance based approach has previously been applied to analyses of low-to-middle-income countries (LMICs) health systems[42] and to the broader Chinese health system,[43] as well as to other policy problems in China.[44] This wider research shows that state-run rural health insurance schemes require the bodies implementing the reforms to have sufficient authority and skills for fund collection and risk transfer.[45] A particularly large problem for LMICs like China is ensuring that these implementing bodies have this authority and skill.[46] The development of strong

[42] Mills, among others, argues that using a capacity-based framework draws attention to the wider institutional factors that may hamper the effective functioning of health systems. Original framework in M Hilderbrand and M.S Grindle (1994) *Building Sustainable Capacity: Challenges for the Public Sector*, Harvard Institute for International Development, Pilot Study of Capacity Building, no. INT/92/676; see also Anne Mills (2012) 'Health Systems in Low- and Middle-Income Countries' in Sherry Glied and Peter C. Smith (eds) (2012) *The Oxford Handbook of Health Economics*, Oxford University Press: Oxford, available online: http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199238828.001.0001/oxfordhb-9780199238828-e-3.

[43] 朱幼棣 (2009) *大国医改*, 社科历史: Beijing (Zhu Youdi (2009) *Major Health Reform,* Social Science History Press: Beijing) for example.

[44] 'administrative capacity refers to the ability of states to deliver public goods, and services such as education and public health and to carry out the normal administrative functions of government such as government regulation, revenue collection and information management'. Peter N. S. Lee and Carlos Wing-hung Lo (2001) *Remaking China's Public Management,* Greenwood Publishing: Northboro, NC, p.44.

[45] Feng Xueshan, Tang Shenglan, Gerald Bloom, Malcolm Segall, and Gu Xingyuan (1995) 'Cooperative medical schemes in contemporary rural China', *Social Science & Medicine*, vol. 41 (8) pp. 1111-1118.

[46] Anne Mills (2012) 'Health Systems in Low- and Middle-Income Countries' in Sherry Glied and Peter C. Smith (eds) (2012) *The Oxford Handbook of Health Economics*, Oxford University Press: Oxford, available online: http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199238828.001.0001/oxfordhb-9780199238828-e-3.

institutions is often thought to be an essential step in creating these implementing bodies.[47] This suggests that, by definition, the less 'developed' a country, the weaker its political, economic, and social institutions tend to be.[48] Institutions can 'form the backdrop to the relationships within health systems that help promote efficiency and equity'.[49]

Within this literature, the difficulties in ensuring high enrolment (let alone universal coverage) noted above are often seen as institutional,[50] with national schemes suffering from various problems including: weak or ineffective political institutions;[51] a lack of administrative and political capacity; [52] historical influences; [53] inappropriate policy formulations;[54] and problems within the political structure of the state attempting to institute the social health insurance scheme.[55]

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[47] See for example Avner Grief (1993) 'Contract Enforceability and Economic Institutions in Early Trade: the Maghribi Traders' Coalition' *The American Economic Review* vol. 83 no. 3, pp. 525–48.
[48] Daron Acemoglu and James Robinson for example — Daron Acemoglu and James Robinson (2012) *Why Nations Fail: The Origins of Power, Prosperity, and Poverty*, Profile Books: London.
[49] Anne Mills (2012), *op cit*.
[50] Or, in plainer English, it is seen as a failure of political process, which the thesis treats as based on institutions. For example: M. McKee, D. Balabanova, S. Basu, W. Ricciardi, and D. Stuckler (2013) 'Universal Health Coverage: A Quest for All Countries But under Threat in Some', *Value in Health*, vol. 16(1, Supplement), pp. S39–S45, and especially: 'many countries, both developed and developing, have pursued the quest to achieve universal health care. This has been an explicitly political process.', p S40.
[51] Stein Steinmo and Ian Watt (1995) 'It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America', *Journal of Health Politics, Policy and Law*, Vol. 20, no. 2, pp. 329-372; Ryozo Matsuda and Monika Steffen (2013) 'Learning from variations in institutions and politics: the case of social health insurance in France and Japan' *First International Conference on Public Policy (ICPP)*, June 2013, Grenoble, France.
[52] G Carrin, I Mathauer, K Xu, and D Evans (2008) 'Universal coverage of health services: tailoring its implementation'. *Bulletin of the World Health Organization*, vol. 86, no. 11, pp. 857–863
[53] Jacob Hacker (1998) 'The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy', *Studies in American Political Development*, vol. 12, no. 1, pp. 57-130. See also: J Quadagno (2004) 'Why the United States has no national health insurance: Stakeholder mobilization against the welfare state, 1945-1996' *Journal of Health and Social Behavior,* Vol 45 (Extra Issue), pp. 25– 44.
[54] For example, Miguel Ángel González Block (1997) 'Comparative research and analysis methods for shared learning from health system reforms.' *Health Policy*, vol. 42, no. 3, pp. 187-209 or Julio Frenk (1995) 'Comprehensive policy analysis for health system reform.' *Health Policy*, vol. 32, nos 1-3, pp. 257-277 on Mexico
[55] Tim Ensor (1999) 'Developing health insurance in transitional Asia' *Social Science & Medicine*, vol. 48, no. 7, pp. 871-879.

Given this current literature, a governance-based, or institutional approach to explaining variation in enrolment must help explain not only why social health insurance schemes succeed in enrolling citizens, but also why schemes fail to enrol citizens. A framework that incorporates consideration of when the rules governing local cadre behaviour lead to successful implementation as well as when the rules fail to lead to successful implementation allows us to better conceptualise when the Chinese system appears to work, and when it appears not to work.

By first creating this stylised framework in the abstract, and then applying it to the specific empirical example of social health insurance enrolment, the thesis is able to analyse 'governance' in a relatively systematic manner. Current system-wide models often assume a single government function or objective — the 'central government' affecting the 'local government' — whereas studies of selective implementation concentrate more on specific policy failures in specific localities. I argue that neither of these approaches adequately captures the reality of a governance model in which many individual actors can on occasion be provided with incentives by the centre to all follow central orders but who also appear at other times to ignore central orders.

To attempt to better represent China's governance model, the thesis begins with a stylised abstract model of Chinese governance. Using an abstract model and then testing it with a number of structured case studies allows for an analysis of Chinese health insurance policy to add some new evidence to studies of Chinese governance more broadly. This is

because all of China's social health insurance schemes are completely state-run.[56] All of the health insurance schemes under evaluation require the state to implement the policy; establish the relevant bodies to run the scheme; provide funding for the administration of the scheme; ensure citizens are enrolled; and evaluate the success of all these activities.

The thesis develops an analytical framework to show how in some cases institutional change caused by central decree gave certain local actors across the country a standard set of incentives to implement SHI scheme. High levels of enrolment in social health insurance schemes in China will be shown to be the byproduct of the political arrangements that shape who implements a policy, and how the implementers are held accountable. By studying these political arrangements and the institutions of rank, document issuance, and delegation of powers from the centre (through the choice of *who* was held responsible for enrolment), the thesis will show how political organisation affects policy implementation. The next chapter will outline the methodology that will be used to do this.

Outline of the thesis

The chapter that follows, Chapter 2, will outline the methodology used in the thesis, will explain the analytical framework developed to explain the success and failure of different attempts to implement health insurance, and will discuss how this framework will be applied consistently across multiple case studies. Chapter 3, which follows the methodology, shows how a generalised model of governance can be created, and outlines what conclusions one would expect to see in an empirical analysis of a given policy area

[56] There are examples of the state contracting out its duties to private companies (see chapters 6 and 7), but even then, the state still assumes the obligation of creating the scheme, and acting as the principal for the private sector agent.

given the general structure of the Chinese state.[57] Following that, there are four structured case studies of different attempts to introduce rural social health insurance. Chapter 4 discusses the Maoist period in China, with its unusual peaks and troughs of insurance coverage. Chapter 5 examines the collapse of social health insurance following the Maoist period, and in particular examines the current debate between the theories of Duckett and the theories of Klotzbücher as to why the collapse occurred. Chapter 6 examines the many pilots and attempts to reinstitute social health insurance in the post-Maoist period, and shows why these attempts were unsuccessful. Chapter 7 discusses the successful implementation of the NCMS program, and shows what changed in this attempt at implementation that made the NCMS succeed where other, very similar, schemes had failed. Chapter 7 also brings discussion up to the present day. The final chapter examines briefly whether the analytical framework developed to examine social health insurance may also add valid explanations to other policy puzzles within the Chinese system, before recapping the findings of the thesis and highlighting some possible future replication and extension work.

[57] Note that these were originally methodological appendices, but they have been moved into the main body of the text to guide the reader.

Chapter 2: Methodology

Established institutions are frequently taken for granted. But how institutions are shaped, and their final structure and effects are issues at the core of why some good policies fail. Governance institutions do not need to be provided by a state, but the ability of the state to provide them can increase the state's effectiveness and legitimacy as a ruler to its people. And, as such, institutional arrangements and reform are at the heart of policymaking and implementation, because any given policy will be implemented and executed through institutions. So institutions have a number of purposes in studies of governance. They can define and enforce property rights; can help capture the benefits of trade and encourage specialisation; and they can help people act collectively to solve problems that it would not be rational to solve individually.

The relationship between governance and institutions is more complicated in an authoritarian or one-party state. Such states face significant information problems. For a state to increase its legitimacy either it must improve all governance institutions, or it must be sure that it is improving the governance institutions that the people wish to be improved. And authoritarian states have fewer mechanisms to learn what people wish to be improved. The state has a similar problem with decentralising governance institutions — it can delegate powers down to lower-level authorities, but it needs to be sure that the powers can be reclaimed, and it needs to ensure that the central government receives the benefits of any gains to its legitimacy from delegating powers.

The modern discipline of institutional analysis looks at how bodies solve problems of governance through resolving coordination and information problems. The Chinese state, a bureaucracy of Brobdignagian size, has developed its own methods at solving coordination problems, including the use of rank and hierarchy, the control of information, and the use of documentation. But, in order to work, the system must be understood by all actors within it and this requires an extensive set of rules and documentation.[58] The methodology used here is based on the idea that we can use the rules of the state itself to analyse where the state follows its own rules, and if so, whether the likely outcomes are reached, and if not, why not.[59]

This chapter outlines the methodology used to try to understand how the state sees and records its own processes and demands,[60] and then compares these idealised institutions with empirical records to illustrate the successes and failures of the state's actions. The chapter shows how the thesis will use techniques drawn from institutional analysis to examine the state's own rules and institutions. Using descriptive and analytical techniques to simplify what is an enormously complex system allows the creation of a number of testable hypotheses about when the Chinese state works or does not work. The goal is to show when the Chinese state is likely to affect behaviour nationwide, and when it is likely to fail to affect behaviour nationwide.

[58] Or, to use a more political economic turn of phrase, all parties must have total information.
[59] Those interested in the impact of Sovietology on Sinology would note that this approach is in many ways similar to Nathan Leites (1951) *The Operational Code of the Politburo*, McGraw Hill: New York, although the aim here to is look at the impact of the code on the practice of all individual decision makers rather than just the paramount leader.
[60] See James Scott (1998) *Seeing Like A State*, Yale Press: New Haven.

Analysing the Chinese state

The thesis examines government interventions and how different arrangements within government affect implementation. [61] The tools of political science, economics, development studies, sociology, and anthropology are traditionally brought to bear on the analysis of how states provide, or do not provide, public goods[62] such as health systems and health financing (including insurance). A recent *Textbook of International Health* for example argues that "the structure of health services reproduces the political economy of that country";[63] this is also the approach adopted by an influential recent book on Chinese health politics.[64] In political economy, this is commonly referred to as "government failure" (when a government system is not able to serve the purpose for which it is intended).[65] There are many problems with market failures in the health care sector,[66] with

[61] As Coase argued in his original work on government failure, 'Contemplation of an optimal system may provide techniques of analysis that would otherwise have been missed and, in certain special cases, it may go far to providing a solution. But in general its influence has been pernicious. It has directed economists' attention away from the main question, which is how alternative arrangements will actually work in practice. It has led economists to derive conclusions for economic policy from a study of an abstract of a market situation. It is no accident that in the literature...we find a category "market failure" but no category "government failure." Until we realize that we are choosing between social arrangements which are all more or less failures, we are not likely to make much headway.' Ronald Coase(1964) 'The Regulated Industries: Discussion,' *American Economic Review*, vol. 54, no. 2, p. 195.

[62] As Paul Pierson, one of the first people to use institutional analysis to look at health insurance puts it, a 'fundamental feature of politics is its preoccupation with the provision of public goods'. Paul Pierson (1995) 'Fragmented Welfare States: Federal Institutions and the Development of Social Policy.' *Governance*, vol. 8, no. 4, pp. 449-478.

[63] They proposed a political economy approach to studying a country's health system, arguing that the 'structure of the health services reproduces the political economy of that country'. Birn, Pillay and Holtz (2009) *Textbook of International Health,* Routledge: Basingstoke, p.143.

[64] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p. 143

[65] This can be either the failure to bring about a specific outcome, or a systemic problem which prevents an efficient government solution to a problem. Julian Le Grand (1999) 'Competition, cooperation, or control? Tales from the British National Health Service.', *Health Affairs*, vol. 18, no. 3, pp. 27-39.

[66] 'For example, there can be information asymmetry between the consumer and the producer. The classic example here is medical care. Doctors usually know more than their patients about the latters' state of health and are therefore in a position to exploit that knowledge by, for example, telling patients that they need more health care than they actually do. In this case, if, as in most markets in medical care, doctors' incomes depend on the amount of services they provide, medical care will be oversupplied relative to the efficient level. This situation will be compounded if patients are insured, for neither they nor their doctors will have any cost

a sizeable literature[67] devoted to showing that structural problems within health care markets can lead to market failures, particularly in regards to under-insurance against risks of major, or 'catastrophic'[68] health care expenditure. And there is a large body of policy-related literature that notes that state intervention is a possible remedy for these market failures.[69] The critical role of the Chinese state in instituting social health insurance schemes makes government failure an appropriate lens to examine attempts to.

Questions of when the state succeeds or fails are at the heart of many studies of Chinese politics and policy. While China is a unitary state, it is also a 'heap of loosely connected parts',[70] with many different layers of hierarchy and an array of different interests and agendas attempting to shape any given decision. Classically, the Chinese state is seen as being shaped by the bargaining between these many actors,[71] creating a system of

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incentive to restrict treatment. This is the problem of moral hazard.' Julian Legrand (1991) 'Quasi-markets and social policy', *The Economic Journal,* vol. 101, no. 408, pp. 1256-1267.

[67] Kenneth Arrow (1963). Uncertainty and the welfare economics of medical care. *American Economic Review*, vol. 53, no. 5, pp. 941–973; S. Bennett, B. McPake, and A.Mills (Eds.), (1997). *Private health providers in developing countries: Serving the public interest*. Zed Books: London and New Jersey. Amy Finkelstein (2007) 'The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare' *Quarterly Journal of Economics*, vol. 122, no. 1, pp. 1-37.

[68] The World Health Organisation (WHO) defines universal coverage as being the access of all people to comprehensive health services at affordable cost and without financial hardship through protection against *catastrophic* health expenditures. WHO (2010) *World Health Report 2010 (Health systems financing and the path to universal coverage)*. WHO: Geneva. Italics added by the author.

[69] Bloom et al (2008), *op. cit.*

[70] Joel Migdal (2001) *State in Society,* Cambridge University Press: Cambridge p. 22; see also Rachel Stern (2014) *Environmental Litigation in China,* Cambridge University Press: Cambridge, p. 4.

[71] There is a wide array of books on this topic. More recent examples include Andrew Mertha (2008) *China's Water Warriors: Citizen Action and Policy Change*, Cornell University Press: Ithaca and Andrew Mertha (2005) *The Politics of Piracy: Intellectual Property in Contemporary China*, Cornell University Press: Ithaca; Margaret Pearson (1997) *China's New Business Elite: The Political Consequences of Economic Reform*., University of California Press: Berkeley and Margaret Pearson (2007) 'Governing the Chinese Economy: Regulatory and Administrative Reform in the Service of the State, *Public Administration Review*, Vol. 67, Issue 4, July-Aug. 2007, pp. 1-34 or Scott Kennedy (2005) *The Business of Lobbying in China,* Harvard University Press: Cambridge MA and Scott Kennedy (2011) *Beyond the Middle Kingdom: Comparative Perspectives on China's Capitalist Transformation,* Stanford University Press: Stanford.

'fragmented authoritarianism'.[72] This fragmented system, and the relationships within the system lead to what O'Brien and Li dub 'selective policy implementation'.

There is an array of studies that discuss selective implementation. These studies note, *inter alia*, that fiscal inequalities;[73] increasing costs of bureaucracy and bureaucratic activity;[74] a constant pressure to meet economic development growth targets;[75] a lack of central commitment to a policy;[76] a policy containing multiple, conflicting goals;[77] the hindrance of legacy policies; reduced local reactions to the 'politics of crisis';[78] and local official rent seeking[79] all contribute to policies' not being implemented. In all of these cases, the central government is unable to force local governments to implement policies.[80]

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[72] Kenneth Lieberthal and Michel Oksenberg (1988) *Policy Making in China: Leaders, Structures, and Processes*, Princeton University Press: Princeton.

[73] See contributions in Vivienne Shue and Christine Wong (2007) *Paying for Progress in China: Public Finance, Human Welfare and Changing Patterns of Inequality*. Taylor & Francis: Oxford; Mingxing Liu, Juan Wang, Ran Tao, and Rachel Murphy (2009) 'The Political Economy of Earmarked Transfers in a State-Designated Poor County in Western China: Central Policies and Local Responses', *The China Quarterly*, vol. 200 p. 973.

[74] Graeme Smith (2010) 'The Hollow State: Rural Governance in China', *The China Quarterly,* vol. 203 pp. 601-618.

[75] Michelle Mood (2005) 'Opportunists, Predators and Rogues: The Role of Local State Relations in Shaping Chinese Rural Development'. *Journal of Agrarian Change*, vol. 5 (2) pp. 217-250.

[76] Cao Pu (2010) '1978-2002：关于农村合作医疗存废的争论与实证性研究的兴起' ('1978-2002: The rise of debate and evidentiary study on the retention or removal of rural cooperative health'), *Zhonggong Yunnan sheng weidangxiao xuebao (The Journal of the Central Party School, Henan)*, vol. 4, available online: http://www.cssn.cn/shx/shx_shflybz/201310/t20131026_584601.shtml.

[77] Maria Edin (2003) "State Capacity and Local Agent Control in China: CCP Cadre Management From a Township Perspective," *The China Quarterly,* vol. 173, pp. 35–52.

[78] 'In the Chinese case, the "state of exception" reated by crises articulated by the center have met with the selective implementation of emergency measures, evasion and obfuscation from lower- ranking officials and members of the public alike, even as those at the center justify their efforts as addressing the health and wellbeing of the population.' Patricia M. Thornton (2009) 'Crisis and Governance: SARS and the Resilience of the Chinese Body Politic' *The China Journal*, No. 61, Jan 2009: 23-48, p.31.

[79] Minxin Pei (2006) China's Trapped Transition: The Limits of Developmental Autocracy, Harvard University Press: Cambridge, MA.

[80] 'Central intervention may help clean up misconduct here and there, but in a country as vast as China personal intercession is not a solution to widespread, systematic misimplementation. Although some provincial governors, for example, have sought to make reducing burdens a binding target, they have often failed to persuade officials at lower levels (or even their own deputy governors) to take them seriously.' Kevin O'Brien and Lianjing Li (1999) *Comparative Politics,* vol. 31, issue 2, p. 168.

Yet there are also rare examples of the central government successfully forcing local governments to implement policy — indeed, this thesis will examine two of these examples. In this way, we have a problem with the current construct of 'selective implementation', which is that accepting that policy implementation is 'selective' creates a theoretical problem of explaining why in a communist state some policies are implemented as decreed and other policies are not.[81] Yet in current bodies of literature, there are few explanations as to when or why the rules governing local cadre behaviour lead to successful implementation or unsuccessful implementation. The mechanisms through which the centre can successfully force the local Chinese system to implement policies remain under theorised.[82]

The thesis is a study of the political economy of health care that uses institutional analysis to examine the question of selective implementation of central desires to create social health insurance schemes in rural areas. As recent World Health Organisation studies note, institutional analysis is useful for analysis of state behaviour in health systems as institutional analysis techniques can develop simple theoretical propositions that can be tested against the empirical data available.[83]

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[81] O'Brien and Li argued that cadres do not implement more popular policies because the Chinese state has stronger inducements to implement some (unpopular) policies, rather than implementing other (more popular) policies. Kevin O'Brien and Lianjing Li (1999) *Comparative Politics,* vol. 31, issue 2, pp 167-186.
[82] We have some models of endogenous change at the central level (Stephen Bell and Hui Feng (2014), *The Rise of the People's Bank of China: The Politics of Institutional Change*, Harvard University Press: Cambridge, MA) as well as models of endogenous change at the village level (Lily Tsai finds that implementation shifts due to the effects of village-level constructs such as lineage and ethnicity) but not across the whole system.
[83] As per current World Health Organisation documentation on institutional design and health care, institutions are defined as 'formal rules, namely legal and regulatory provisions relating to health financing; organisational practice refers to the way organisational actors implement and comply with these rules.' Guy Carrin (2000) 'Social health insurance in developing countries: A continuing challenge' in World Health Organization (2000) Health systems: improving performance, *The World Health Report 2000*, Geneva: WHO.

So what does "institutional analysis" mean here? This institutional analysis will explore how institutions structure political behaviour and interests.[84] The state itself maintains a structure, shape, rank and hierarchy that alters and influences bargaining and consensus-building at both central and local levels.[85] Institutions will be taken as being the 'rules of the game' that explain the conduct and behaviour of organisations, the 'players of the game'. Changes in institutions can change the incentives for organisations, and for actors within organisations. Similarly to North, the thesis takes institutions to be very broad, but separate from the organisations involved.[86] Organisations can be construed as material entities that typically have personnel, offices, equipment, financial resources and often legal personhood.[87]

The crucial actors are state organisations. These state organisations all must compete with each other for limited resources. These resources are allocated by the state itself according to rules, or "institutions", and state organisations must play according to those

[84] There are a plethora of manuscripts on this topic; an early overview of significance to this line of argument was Campbell, J. L. (1998) 'Institutional analysis and the role of ideas in political economy', *Theory and Society*, vol. 27, pp. 377–409.

[85] This point is also made by David Lampton (1992: 34) in Kenneth Lieberthal and David Lampton (eds) (1992) *Bureaucracy, Politics, and Decision Making in Post-Mao China*, University of California Press: Berkeley — 'bargaining is just one form of authority relationship; authority relationships depend on where the parties are located in the hierarchies'. A similar argument is made in modern sociological treatments of institutional analysis of China — '(f)irst, bureaucratic power is derived from the hierarchies of the organization, as embodied in the formal authority, and rules and procedures in organizations.' Xueguang Zhou, Yun Ai, Hong Lian (2012), 'The Limit of Bureaucratic Power in Organizations: The Case of the Chinese Bureaucracy', in David Courpasson, Damon Golsorkhi, Jeffrey J. Sallaz (ed.) *Rethinking Power in Organizations, Institutions, and Markets (Research in the Sociology of Organizations, Volume 34)* Emerald Group Publishing Limited: Dublin, p. 83. For a specific relation of this line of argument to the Chinese health care system, see Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.7.

[86] Douglas North (1990) *Institutions, Institutional Change and Economic Performance,* Cambridge University Press: Cambridge.

[87] *Ibid.* See also Oran R. Young (1989) *International Cooperation: Building Regimes for Natural Resources and the Environment*. Ithaca: Cornell University Press, pp. 36-69. Thanks to Julia Talbot-Jones for this point, and for pointing me in the right direction.

institutions (be they formal or informal). Strong or weak organisations within the state can be determined by their ability to insulate themselves from external pressure; their ability to have any mandate enforced; and by their ability to achieve their goals.[88] But this determination of "strength" is a byproduct of the organisation's reaction to the rules of the game they are playing.[89]

As many scholars have noted, an organisation's reaction to the rules of the game is often based on how the organisation's leadership tries to solve the problem of transaction costs, and how organisations use institutions to minimise transaction costs. Two major transaction costs of any interaction within the Chinese system are the provision of information to all relevant parties and the costs of defining authority on any given decision. Both of these transaction costs are coordination problems. The thesis looks at how the measures used by the state may or may not address this problem of transaction costs, and how these costs affect the transmision of orders (and power) from the centre down to the localities. As other studies have shown, the size and complexity of China's political organisation makes it difficult for the centre to force local governments to execute policy in the way that the centre might wish.[90]

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[88] A broader argument of this can be found in Danica Aligica and Peter Boettke (2009) *Rethinking Institutional Analysis and Development: The Bloomington School*, Routledge: London and New York.
[89] See Zhou et al (2012), *op cit.* or for a different take on communist power, Peter Boettke (1993) *Why Perestroika Failed: The Politics and Economics of Socialist Transformation,* Routledge: London.
[90] As Tsui and Wang state, 'Local cadres are thus confronted with the problem of allocating their efforts and fiscal resources with a view to maximizing the benefits of the local bureaucracy without at the same time endangering their career prospects. The strength of target-based vertical control is that local cadres have a strong incentive to exert efforts on those tasks that are easily measurable and to which upper-level governments attach heavy weight, but often at the expense of other important tasks that are less measurable or with less weight attached.' In this way, Tsui and Wang's analysis is largely one of *effectiveness*: it looks at whether strong target-based vertical control is enough to align the incentives of local government officials to implement central policies in accordance with local conditions and preferences. Kai-yuen Tsui and Youqiang Wang (2004) 'Between Separate Stoves and a Single Menu: Fiscal Decentralization in China' *The China Quarterly*, vol. 177, pp. 71-90.

In many ways, the problems of transaction costs and information asymmetries faced by the Chinese state are principal-agent problems. As with all large organisations, the Chinese state confronts a number of principal-agent problems.[91] The thesis will look mainly at how principals solve problems of divergent preferences with agents through providing incentives. The initial assumption is that the Chinese state[92] — including the government and the Party — wishes to control the behaviour of different actors internally by using institutions (namely methods of coordination and control) across a number of different hierarchical levels of government (vertically) and across different actors at the same hierarchical level of government (horizontally).[93] But principals in the Chinese system possess relatively crude tools to provide incentives and to influence behaviour. For example, the centre cannot fully dictate local effort levels, or monitor local enforcement capabilities, because such efforts are not easily observable or measurable.[94] To solve these problems, principals can take measures to to force agents to comply with orders of

[91] As Minzner (2009) pithily puts it, Chinese governance problems can be seen at heart as being one very, very, very big principal-agent problem. Carl Minzner (2009) 'Riots and Cover-Ups: Counterproductive Control of Local Agents in China' *University of Pennsylvania Journal of International Law*, pp. 53–125.
[92] Traditionally dictatorships can be seen as unitary actors. But dictatorships differ from each other as much as they differ from democracies — they draw on different groups to staff government offices and on different segments of society for support. They have different decision making processes, intra elite factionalism and competition, different ways of choosing leaders and handling succession, different ways of responding to societal interests and opposition. Because these differences have not been analysed systematically, some have argued that dictatorships remain under-theorised. See Barbara Geddes (2003) *Paradigms and Sandcastles*, p. 8; although many rational choice theorists believe that this was first outlined in Gordon Tullock (1987) *Autocracy*, Kluwers Academic Publishers: Amsterdam.
[93] Classically referred to in Chinese as controlling across *tiao* and across *kuai* respectively.
[94] On multidimensionality and its impact on measurement, see for example Bengt Holmstrom and Paul Milgrom (1987) 'Aggregation and Linearity in the Provision of Intertemporal Incentives', *Econometrica* vol. 55, no. 2, pp. 303–328; Holmström, Bengt, and Paul Milgrom, (1991) 'Multitask Principal-Agent Analyses: Incentive Contracts, Asset Ownership, and Job Design,' *Journal of Law, Economics, and Organization*, vol. 7, pp. 24–52; Bengt Holstrom (1999) 'Managerial Incentive Problems: A Dynamic Perspective,' *Review of Economic Studies*, vol. 66 no. 1, pp. 169–182.

implementation (be this through improving the flow of information or through the convergence of preferences).[95]

Given this principal-agent approach, we need to disaggregate the Chinese state into different actors, (or in other words, into principals and agents) rather than presuming that the state has a single interest.[96] In China, the state fulfils a number of roles in social health insurance enrolment — it not only provides services, but also designs policies, provides funding and enforces mandated policy measures — and thus there is no single 'state interest', but rather many state actors with multiple interests. There is no single state utility function.[97] The thesis assumes that these different actors within the Chinese state are rational actors who maximise their goals,[98] but that the goals of these rational actors will differ in line with the incentives each faces within the Chinese governance system.[99] We need to disaggregate the state to see which goals can exist simultaneously, and which goals conflict, within the state itself. [100]

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[95] See Yasheng Huang (2002) 'Managing Chinese Bureaucrats: An Institutional Economics Perspective', *Political Studies*, vol. 50 (1), pp. 61–79.

[96] Many others have followed similar lines of analysis in their work on China. See for example Susan Shirk (1993) *Political Logic of Economic Reform,* University of California Press: Berkeley for a particularly well-developed example.

[97] Although some presume that there is, and that this forms a unified 'development' incentive: Fang Ning (房宁), head of the Political Science School of the Chinese Academy of Social Sciences, wrote that the institutional secret of China's rise, was 'that one-time authorization [of political power] lowers the cost of decision-making.' D Bandurski (2010) 'How should we read China's "discourse of greatness"?' *China Media Project,* available online: http://cmp.hku.hk/2010/02/23/4565/

[98] This is not assuming a maximisation of income, rather it assumes that 'rationality means only that individuals attempt to achieve whatever goals they have by the best means at their disposal' Jeffry Frieden (1991) *Debt, Development, and Democracy: Modern Political Economy and Latin America, 1965-1985* Princeton University Press: Princeton, p. 18.

[99] T Besley and M Ghatak (2007) 'Reforming public service delivery', *Journal of African Economies*, vol. 1, supplement 1, pp. 127–156.

[100] In taking this approach, the thesis links incentives and service delivery — see Besley and Ghatak, *ibid.* And, similar to Besley and Ghatak, this institutional analysis includes state organisational structure: 'evidence on government failure has been mounting. On top of this, there is rampant absenteeism and poor quality service on the part of teachers and health workers. If we want services to match the best interest of the beneficiaries, we have to analyse the incentives that govern the behaviour of politicians and service providers.

There is also an element to this analysis which relates to the more classic literature on the study of politics. That is because, by analysing the state and the behaviour of different actors within the state as opposed to the role of society in changing the behaviour of actors within the state, there appears a tension in who or what represents popular will, and a tension in who or what represents "the state".

Within the thesis, the analytical framework concentrates on the rules of the Chinese Communist Party as they pertain to the rules of the "state"; this is because, as China's political structure is based on a Leninist political system,[101] almost all members[102] of the bodies charged with implementing policy decrees are first and foremost members of the Communist Party.[103] A Leninist system is Communist Party-led; the Party is the highest body,[104] the initiator of reform[105] and the leader of change within the system.

Consider the example of health care provision. Do doctors have good incentives to focus on the most socially worthwhile treatments? Are preventative measures in health care given sufficient priority? If no, then what is the best organisational structure to deliver health care that achieves this priority?', *ibid,* pp 130-131.

[101] Yu Xingzhong offers a far more nuanced and full description of the following two paragraphs in his works; see, for example, Yu Xingzhong (2002) "Citizenship, Ideology and the PRC Constitution", in Merle Goldman and Elizabeth Perry (eds.), *Changing Meanings of Citizenship in Modern China*, Harvard University Press: Cambridge, MA. There is a vigorous debate as to what this constitutionalism is — see for example Peking University's Pan Wei, who advocates a 'China Model' with the CCP at the top for another take (潘维 (2011) '怎样判断中国政治模式的成败', 人民论坛政论双周刊, (Pan Wei (2011) 'How to we judge the successes and failures of the Chinese governance model?') available online: http://www.21ccom.net/articles/zgyj/xzmj/article_2011022430514.html) — but this debate itself is premised on the idea that the Chinese Constitution remains the highest document within China.

[102] Note that there can be the odd exception — Chen Zhu, for example, was a minister without being officially a Party member; but the health *xitong* was still governed by Party rules throughout his term of leadership (2002-2007).

[103] This can be seen in the Preamble to the Chinese Constitution, the highest document in the Chinese system: 'Under the leadership of the Communist Party of China and the guidance of Marxism-Leninism and Mao Zedong Thought, the Chinese people of all nationalities will continue to adhere to the people's democratic dictatorship'.

[104] As per the preamble to the Chinese Constitution discussed above; the Constitution is premised on the leadership of the Communist Party

[105] A good outline of the idea of the Party as being the 'vanguard' of the revolution is most clearly outlined in Stuart Schram (1990) *The Thought of Mao Tse-Tung*. Cambridge: Cambridge University Press, p. 173-174

The Party achieves its role leading the state through its highest body's rank being higher than the highest legislative body's rank;[106] through ensuring that the Party outranks all sectors of the state, including government departments;[107] through the Party controlling the use of force through the People's Liberation Army, a Party army rather than a state army;[108] and through the Party controlling the consultative mechanisms of the state.[109]

So, unlike traditional governmental relations where legitimacy comes from the relationship between the state (rulers) and society (the subjects), in China the government is subservient to its overall ruler (the Party).[110] In other words, some actors or decisions can derive greater legitimacy from their relationship with the Party. Clearly other interests and society have (and will continue to have) their influence upon the government and policy outcomes. But, this simplification allows us firstly to concentrate simply on interactions within the state rather than interactions between the state and society, taking the methodological shortcut of taking the Party on its word that it represents 'the will of the people', and thus concentrating on the state (as in the Party and the government), rather than the state in society.[111] The state is structured according to rules and understanding

[106] The National People's Congress, or NPC, is the highest legislative body — see Figure 1 below for further detail

[107] See, among many, A Doak Barnett (1985) *The Making of Foreign Policy in China: Structure and Process*, Brookings Institute Press: Washington DC, p. 34.

[108] Dennis Blasko (2012) The Chinese Army Today: Tradition and Transformation for the 21st Century, Routledge: New York, p.11-12.

[109] Through controlling the People's Consultative Conference; see Figure 1 below for further detail.

[110] See Max Weber: 'even if the system of rule is so assured that legitimacy plays no part in the relationship between rulers and subjects, the mode of legimation retains its significance as the basis for the relation of authority between rulers and administrative staff, and for the structure of rule' Max Weber (1978) *Economy and Society*, Guenther Roth and Claus Wittich (eds.), 2 vols. University of California Press: Berkeley and London, vol. I, p. 169.

[111] I do this not to diminish this debate, or deny that the Communist Party position seems illogical; one is reminded of Robert Dahl's quote: 'Even the most repressive dictatorships usually pay some lip service to the

these rules can provide considerable analytical insight into the Chinese health care system.[112]

This approach leads to a different conceptualisation of what is referred to here as "accountability". In the Chinese context, accountability is much more likely to be "Party accountability" than "public accountability". Public accountability is a relationship wherein the governed (for the purposes here, the citizens of China) can call those governing them to account publicly for how they exercise public authority and then judge that account. But the Party, in China, represents the public.[113] And final decisions on disciplining the state, or finding policy solutions to state problems, must occur within the state system, rather than through external bodies such as courts or elections, even should there be reference to reason.[114]

A shift from "public accountability" to "Party accountability" changes how the state needs to be analysed. Political models are, classically, concerned with the form of *accountability* that a government faces in responding to the wishes of its citizens.[115] An

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legitimate right of the people to participate in the government.' Robert Dahl (1972) *Polyarchy: Participation and Opposition*, Yale University Press: New Haven. Rather, it is to say that if we want to see the Chinese system as it sees itself, then we must take its statements at face value.

[112] For example, all counties will have a Bureau of Health, and this Bureau will always have two reports — a horizontal report to the leadership of the county and a vertical report to the Provincial Department of Health. These reports are generally fixed, and will be the same across all of China.

[113] Or, as the Chinese Constitution puts it, the Party is the 'vanguard' of the people, and as such it acts in the best interests of the people.

[114] See Richard Mulgan(2000), 'Accountability': An Ever-Expanding Concept?' *Public Administration*, Vol. 78, p. 557.

[115] Similar to the concept of *public* accountability. Public accountability has a long history that distinguishes it from accountability within private organisations or social relationships. Whilst there is arguably increasing cross-over as private sector management approaches are imported into the public sector, as the role of private organisations in governance is explored, and as political representatives are held to account over their personal behaviour, the starting point is still to assume that public accountability is distinct; see Mulgan,R. (2003), 'Holding Power to Account: Accountability in Modern Democracies' Palgrave MacMillan,

actor is expected to account for decisions s/he makes or actions s/he performs in furtherance of goals of "governing".[116] While there are theoretically many bodies that can fulfil this role of governing, it is most commonly provided by a state. Should the state be able to provide governing institutions, or "good governance", it will gain greater legitimacy with its citizens.

In the current literature, this calling actors to account for failing to provide good governance is often seen as occurring through an interaction between "the people" and "the state". *Public* accountability is often treated as *democratic* accountability.[117] This is because in modern times "the people" are generally assumed — even if metaphorically — to be the relevant "other" to whom 'persons with public responsibilities should be answerable'.[118] So accountability relationships have often been conceptualised in terms of delegated authority,[119] with elected representatives being delegated authority by a sovereign citizenry and other public officials by that representative or a sovereign legislature,[120] and

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Basingstoke, UK. By the twentieth century, this was understood to apply primarily to governments, as well as to elected representatives. E.g. E Normanton (1966) *The Accountability and Audit of Governments,* University of Manchester Press: Manchester.

[116] For the purposes of analysis, governance here is taken as being the establishment, definition, maintenance and/or enforcement of institutions defining and/or enforcing property rights; institutions that lower transaction costs and/or augment the benefits of exchange; and institutions that help people act collectively to solve problems that it would not be rational to solve individually.

[117] See Sheldon Wolin (2004) *Politics and Vision: Continuity and Innovation in Western Political Thought*, Princeton University Press: Princeton, p. 10. Another approach is to distinguish between public and democratic accountability, with the latter referring just to electoral mechanisms and the former to mechanisms that render public officials *directly* accountable to the people between elections; e.g., Jens Steffek (2010) 'Public Accountability and the Public Sphere of International Governance' *Ethics and International Affairs,* vol. 24, issue 1, p.53.

[118] Michael W. Dowdle (2006) *Public Accountability, Designs, Dilemmas and Experiences*, Cambridge University Press: Cambridge, UK, p. 3.

[119] A metaphor that has been significantly displaced by principal-agent conceptions as government has been more frequently conceptualised in contractual terms. A compelling critiques can be found in Steffek (2010), *op cit.,* pp. 51-52.

[120] On this history see Melvin Dubnik (2002) 'Seeking Salvation for Accountability', Presidential Address, Annual Meeting of the American Political Science Association, August 29- September 1. On the fundamental link between accountability and representation in institutional contexts, see C O'Kelly (2011) 'Accountability

with competitive elections the ultimate bulwark for ensuring the accountability of public decision-makers. [121] China's system of governance challenges elements of this idea of public accountability. By having both a Party and a state system, and by essentially ensuring that the legal system is responsible to the Party more than to a body of law,[122] then public accountability involves a different mechanism. [123]

The reason for this is the all-consuming nature of the rule of the Chinese Communist Party ("the Party"), and the way that this rule changes how the state functions. I treat the Party as holding an ultimate monopoly on power, and assume that in any given situation, Party incentives will trump other incentives.[124] So this "Party accountability" in China is the accountability that actors have to more senior actors, and will occur through the Party-state system, as per the Party and State Constitutions.

A similar rationale applies for state enforcement. In most studies of democratic polities, institutions come from bodies vested with power to establish them (that is, legislative

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and a Theory of Representation' in M Dubnick and H Frederickson (eds.) *Accountable Governance: Promises and Problems*, M.E. Sharpe: New York, p. 255-268

[121] To some extent, however, accountability has come to be discussed in the same ways that "control" was in earlier eras; see collection in see F-X Kaufmann, G Majone, and V Ostrom (eds) (1986) *Guidance, control, and evaluation in the public sector: the Bielefeld interdisciplinary project*, volumes 1-3, De Gruyter studies in organization: Berlin. Mulgan points out this is to equate it with the entire field of 'institutional design'; see for example Jerry Mashaw (2006) 'Accountability and Institutional Design: Some Thoughts on the Grammar of Governance' in Michael W. Dowdle (ed.), *Public Accountability, Designs, Dilemmas and Experiences*, Cambridge University Press: Cambridge, pp. 115-156.

[122] Although this in itself is a broad topic — see Stanley Lubman (1999) *Bird in a Cage: Legal Reform in China after Mao,* Stanford University Press: Stanford.

[123] Recent studies have linked low enforcement, or the "unrule of law," to the limited reach of the state. For example, Soifer argues that government failure to enforce tax, conscription, and other laws in Peru was rooted in the state's limited infrastructural power in the countryside. Hillel Soifer (2015) *State Building in Latin America*, Cambridge University Press: Cambridge.

[124] I make this assumption because the Party controls all the institutions that incentives are derived from. As Chapter 3 will show clearly, promotion mechanisms, salaries and many major organisational incentives (including *inter alia* budgets and staffing) are controlled by Party bodies, not government bodies.

bodies, parliaments or courts). Obviously, in China, these bodies do not share most of the power — the Party does.[125] A shift in responsibility for the enforcement of an institution from one organisation to another can induce a change in power that can change the rules themselves. But major shifts in responsibility are decided by the Party.[126] And state practice, moreover, is measured and decided by the Party.

As a result, the variable of greatest interest to the thesis is the level of enrolment in social health insurance *as it is reported to the Party*. This is not to say that there are not problems with using this variable. An absence of reliable data is a major obstacle to studying social health insurance in China. The scale of the country makes it difficult to extrapolate from single studies. Data, where it is available, is often unreliable. The level of homogeneity in the official nationwide and provincial data may indicate false reporting of data, and in particular may reflect local officials reporting statistics to the level above that are not actually true.[127] And there are some additional obstacles to gathering qualitative evidence. Party rules and regulations are considered sensitive issues, and can be considered state secrets. Rules can differ between local jurisdictions. Officials in interviews can

[125] Under this theory, which focuses on transition away from autocracy, new institutional arrangements are most likely to endure where rule writers either (a) gain the acceptance of powerful actors and groups who remain outside the rule-writing process or (b) decisively defeat major opponents, thereby destroying their capacity to overturn the rules in the future. Where neither occurs, powerful actors who lose out under the new institutional arrangements are likely to work to overturn them as soon as they are in a position to do so. See Adam Przeworski (1991) *Democracy and the market: Political and economic reforms in Eastern Europe and Latin America*, Cambrige University Press: Cambridge, pp. 81–88.

[126] Murray Scott Tanner (1999) *The Politics of Lawmaking in Post-Mao China: Institutions, Processes and Democratic Prospects*, Oxford: Oxford University Press on the Party discipline and supervision bodies for example.

[127] See Carsten Holz (2004) "China's Statistical System in Transition: Challenges, Data Problems, and Institutional Innovations." *Review of Income and Wealth,* vol. 50, no. 3, pp. 381–409 or Matthew Crabbe (2014) *Mythbusting Chinese numbers*, Palgrave McMillan: London. Mitigation techniques are discussed in Gary King, Robert Keohane and Sidney Verba(1994). *Designing social inquiry: Scientific inference in qualitative research*. Princeton University Press: Princeton, NJ.

prevaricate, or outright lie. Verification of information at the scale necessary to make claims for national programs is not possible.

But the thesis takes the stance that any false reporting (to the Party/state), should it occur, still provides useful insights — as it is the data used by the state in making its policy and funding decisions. Indeed, by using a typology of explanations that all apply at the national level and a number of different time periods, the false reporting of one program but not another program can itself be a variable that the thesis analyses. In this sense, whether or not the data are "right" does not prevent them from telling us something about the activities of the state and the incentives provided to its agents. Reporting high levels of enrolment is not cost-free in any of the schemes examined. The reporting of a certain level of enrolment brings with it a certain bundle of commitments that must be met, and each of these commitments is of enough weight that false reporting increases the burden on local officials rather than diminishing it.[128]

We can make this claim because we presume that, as rational actors,[129] the individuals that hold positions within the state system have constant preferences in respect of maintaining their careers (either through the seeking of promotion, or the wish for a 'quiet life').[130] Their goal is to 'maximise the chances of staying in power'. [131] So, the presumption

[128] See for example the assumptions in Sarah Eaton and Genia Kostka (2014) 'Authoritarian Environmentalism Undermined? Local Leaders' Time Horizons and Environmental Policy Implementation in China', *The China Quarterly*, Vol. 218, pp 359–380.
[129] Barbara Geddes (1994) *The Politicians Dilemma,* University of California: Berkeley.
[130] Put differently, it presumes that individuals serve in office seek to maximise their personal utility. As such, I've relaxed these assumptions to fulfil neo-classical assumptions of the utility maximising individual with constant and given preferences, with the assumption that this individual is acting under constant and coherent rules or constraints in each interaction situation (ie, in each implementation).

is that self-interested Party members, many of whom are members of local government, have the primary objective of maximising the likelihood of their staying in their position, which relies heavily on their wish to receive good performance evaluations or even be promoted.

The argument thus concentrates on these career incentives, rather than looking at the personal pecuniary incentives of local officials.[132] By concentrating on career incentives, we assume that actors are attempting to act in the best interests of the state as defined by the state's own evaluations (and ultimately, as it controls the institutions, by the Party's own evaluations). These individuals may face other incentives (such as avarice or personal gain), but it is presumed that these opportunities only exist while individuals stay in the good books of the system. In other words, politicians' incentives are derived from the Chinese governance system.[133]

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[131] Hence, the assumption of the thesis is that the state uses the utility-maximising goal of local officials to control the behaviour of local officials; this control occurs through the use of institutions, or the 'rules of the game' that provide incentives for local officials to act as the state wishes. This is consistent with formal modelling the interaction between rational actors and constraints — see George Tsebelis (1990) *Nested games: Rational choice in comparative politics*, University of California Press: Berkeley, p. 40: 'rational choice approach focuses its attention on the constraints imposed on rational actors — the institutions of society… individual action is assumed to be optimal adaptation to an individual environment and interaction between individuals an optimal response to each other. Therefore the prevailing institutions… determine the behaviour of the actors, which in turn produce political or social outcomes'.

[132]Yuen Yuen Ang (2010) *State, market, and bureau-contracting in reform China*, Stanford University, Stanford, California, p. 13 'From a rational choice point of view, individuals who serve in office seek to maximize their utilities, either by amassing personal wealth or by climbing the career ladder. Bureaucracies and money have been the subjects of this study. My focus on fiscal incentives is deliberate. The essence of bureau-contracting is the union of bureaucrat and entrepreneur.'

[133] Scholars from other areas of the rational choice tradition, on the other hand, generally expect institutions to change in response to exogenous changes in power and preference distributions — see Jack Knight (1992) *Institutions and Social Conflict,* Cambridge University Press: Cambridge; see also the critique of this, e.g., Donald Green and Ian Shapiro (1996) *Pathologies of Rational Choice Theory: A Critique of Applications in Political Science*, Yale University Press: New Haven.

Given this approach, any institutional analysis needs to cover the incentives for central and local actors; it also needs to cover the interactions between levels of government; and it needs to cover the roles of the Party and of the government. The Chinese governance system extends from the central level down to the lowest, most local level of government;[134] the institutional model used in the thesis thus does the same.[135]

This analytical framework is then applied to the specific area of rural social health insurance implementation. By using this framework, the health financing system — and its interactions with the levels of enrolment in SHI schemes — is analysed with reference to the broader goals of the Chinese health system[136] (or, at least, the broader goals outlined by China's leaders).[137] For example, health insurance is considered a fundamental part of health financing, and has three major functions: collecting revenue, fund pooling, and purchasing health services.[138] Health financing is considered "functioning" when it

[134] What is local government remains a vexatious issue within studies of Chinese government. All levels below the provincial level have good claims to be 'local' governments. I outline the distinctions between the levels throughout my analyses in this chapter.
[135] Normally, historical institutionalist approaches to social health insurance concentrates on one level (rulers and the ruled). As explained at greater length below, I relax those assumptions, but note the effects of decentralisation on the local state in doing so. This is not dissimilar to Antonia Maioni's approach to analysing federalism and health care reform in Canada and the United States by showing how institutions such as party systems affect the policy-making process. See Antonia Maioni (1998) *The Emergence of Health Insurance in the United States and Canada,* Princeton University Press: Princeton.
[136] Xuedan You and Yasuki Kobayashi (2009) 'The new cooperative medical scheme in China.' *Health Policy*, vol. 91, no. 1, pp. 1-9.
[137] This concept has already been used by others with reference to health insurance. See for example S. Bennett (2004) 'The role of community-based health insurance within the health care financing system: a framework for analysis'. *Health Policy and Planning*, vol. 19, pp. 147–58.
[138] G Carrin, M Waelkens, and B Criel (2005) 'Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems'. *Tropical Medicine and International Health* , vol. 10, pp. 799–811.

ensures that 'sufficient financial resources are made available so that people can access effective health care.'[139]

As noted previously in this chapter, within the Chinese system state intervention and management has been required in order to create this 'functioning system'. This fits with broader bodies of literature on fundamental tasks that a state must achieve in order to function as a state: collect tax, create a functioning administrative system, and enforce rules and laws.[140] Previous studies have shown that a lack of state capacity in China makes the performance of these tasks difficult,[141] and the size, scale, decentralised system and regional heterogeneity of China further complicate the problem.[142] This is also the case with the establishment of state-funded, state-managed, and state-initiated health insurance programs. Thus, when there are high levels of health insurance up-take, the assumption is that the state provided some form of incentive or support for the scheme to overcome the problems of market failure. As China is such a decentralised polity, these incentives or support must be provided nationwide to many different actors in order to shape each of their choices to implement or not implement a mandate from above.

[139] As per the framework of the World Health Organisation: World Health Organization (2000) 'Health systems: improving performance', in *The World Health Report 2000*. WHO: Geneva.
[140] Margaret Levi (1991) *Of Rule and Revenue*, Cambridge University Press: Cambridge; Merrilyn Grindle (1996) *Challenging the State: Crisis and Innovation in Latin America and Africa,* Cambridge University Press: Cambridge.
[141] See Zheng Yongnian's concept of decentralisation as 'retreat from state tasks', and thus a failure to perform state duties (although he sees this as a normatively beneficial concept; the point here is not whether the capacity is 'better' or 'worse' but rather how difficult it is to perform certain functions as opposed to others). Zheng Yongnian (1994) *The Making of a Federal System: Quasi Corporatism and the Rise of Local Power in China*, Ph.D dissertation, Princeton University: Princeton and Zheng Yongnian (2008) *De Facto Federalism in China: Reforms and Dynamics of Central-Local Relations,* World Scientific: New Jersey.
[142] Daniel Béland and Ka Man Yu (2004), 'A Long Financial March: Pension Reform in China,' *Journal of Social Policy*, vol. 33, no.2, pp. 267–288.

The analytical framework

Looking at social health insurance enrolment as a byproduct of individual choices made by local government officials nationwide, under the direction of the central government and ultimately the Party, allows us to examine social health insurance as an implementation problem rather than just a policy design problem. More importantly, institutional analysis allows the development of a coherent framework that is applicable across the whole country, and that is applicable across multiple time periods. The Chinese governance system is national and is based on a Leninist structure (see Chapter 2); this allows us to assume that the political organisation system is regularised nationwide. This regularity means that each individual choice is usually made under similar incentives, as many incentives that are provided by China's political organisation are similar nationwide. So policy-making and policy implementation in rural China can be studied — in much the same way as it is in non-communist countries — by treating cadres as rational actors and looking at the incentives these actors face.[143] This is because, as this thesis will show, China's political structures, and the institutions governing the behaviour of actors in these structures, create incentives that are systematic and constant. These systematic and constant incentives allow us to try and explain why many actors all act the same way — because they face similar incentives to act that way. Thus, we can develop models examining policy implementation based on the responses of local government actors to attempts by the Chinese state to control their behaviour by forcing them to implement

[143] As distinct from historical institutionalist models of health insurance, such as Jacob Hacker's. See Katherine Thelen (1999), Historical Institutionalism in Comparative Politics, *Annual Review of Political Science,* no. 2, pp. 369–404 for an overview. Thelen argues that rational choice models use institutions as coordination mechanisms rather than treating institutions as emerging from concrete temporal processes.

schemes from above. This allows us to take a national approach, while still analysing the behaviour of local officials.[144]

As the implementation is systematic, we need to find a way to model the system, including methods of:

- distinguishing between Party and state structures across all political levels, and accurately describing their rank and hierarchy
- identifying the incentives used by higher ranks to control and coordinate the behaviour of lower ranks
- identifying rules, norms and strategies for actors
- analysing how Party rank and other governance tools are used for coordination and control, and the incentives for actors to act a certain way that are produced through these methods of coordination and control.

The techniques used to analyse China's system of governance come from institutional analysis and modern techniques of political science. There is some extension of current methods: set diagrams are used first to establish which power are held by which body; to establish what the authority and power of a given decree; and finally to establish which incentives are delegated to which actor for a given command to implement. These set diagrams shows that holding the local Party secretary responsible for the implementation

[144] This itself affects the analysis however — in modern political economy treatments of these problems changing authority means that it is 'shifted away from unsupervised central bureaucrats that seek to maximize bribe incomes, toward elected officials of local governments whose objective is to maximize the chances of staying in power.' Pranab Bardhan and Dilip Mookherjee (2006) 'Decentralisation and Accountability in Infrastructure Delivery in Developing Countries', *The Economic Journal* Vol. 116, Issue 508, pp. 101–127.

is a *necessary* condition for ensuring high enrolment in a social health insurance scheme. The thesis then creates a taxonomy of rank and authority of orders to see whether holding the local Party secretary is a *sufficient* condition for ensuring high enrolment in a social health insurance scheme.

While the use of diagrams may appear unusual, it follows the call of Henry Brady's Presidential Address to the American Political Science Association in 2011. Brady argued that 'spatial diagrams of politics could and should be iconic for political science in much the same way as supply-and-demand curves are in economics'. Brady argues that 'spatial diagrams raise questions and provide insights … They provide us with powerful images that aid memory and facilitate analysis'.[145]

The thesis creates a form of spatial diagram that allows for comparison of governance settings across different time periods. Put simply, it 'maps' the Chinese governance system. These maps contain rules (institutions), organisations and enforcement bodies. Hence, rather than looking at the 'grammar' of this system through text, as is customary in institutional analysis,[146] these institutions and the political organisations and actors working under these institutions are examined through diagrams. This creates a 'pattern language'[147] of institutions — a visual representation of the organisation, rules and flows of

[145] Henry Brady (2011) 'The art of political science: Spatial diagrams as iconic and revelatory', *Perspectives on Politics,* vol. 9, pp 311-331.
[146] Sue E. S. Crawford; Elinor Ostrom (1995) 'A Grammar of Institutions', *The American Political Science Review*, Vol. 89, No. 3. (Sep., 1995), pp. 582-600.
[147] Pattern language means that each part needs to be considered next to other parts — the structure of a pattern language is created by the fact that individual patterns are not isolated (e.g. Christopher Alexander, Murray Silverstein, and Sara Ishikawa (1977) *A Pattern Language,* Oxford University Press: Oxford, p.311 and it is the network of connections between the different patterns that creates the language (*ibid*: 313). These patterns create a system of order (e.g, Christopher Alexander (2000) *The Nature of Order,* vols 1-3,

information through the system.[148] Structural maps lay out the invariant government or Party entities and institutions or rules that must be gone through in order to solve the problem. Maps also allow for quick comparison of what would happen should either the organisational positions changed, or should the institutional rules be changed or relaxed.[149] Common, or likely, responses by actors within the system can emerge from this form of analysis.[150]

In taking a system-wide, institutional approach, the argument focuses on actors within the system who have to choose to implement the policy or not — government officials and Party cadres, rather than doctors or citizens. The preferences of these actors involve 'the choice between conflicting or competing ends—different needs of different people'.[151] For these actors to implement a social health insurance scheme means that they will make decisions about which goals 'will have to be sacrificed if we want to achieve certain others'.[152] Using enrolment as the dependent variable allows analysis of the actions of the

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Oxford University Pres: Oxford). This is similar to modern focii on 'networks'; but as the phrase 'network analysis' is used to analyse links between individuals more than the institutional structure that links individuals, this thesis uses 'pattern language' instead. Note that the concept would also be highly familiar to anyone who is trained in object-oriented programming (and indeed, that is how the author first came across the idea), but the links to programming sites have been omitted from the text to ease the reader's boredom levels. Further information can be found at James Coplien and Douglas Schmidt (Editors) (1995) *Pattern Languages of Program Design,* Addison-Wesley: Reading, Massachusetts. While this may seem far removed from the world of Chinese politics, Alexander himself notes that the inspiration for much of *A Pattern Language* came from his love of Turkish and Persian carpets. See *A Foreshadowing of 21st Century Art: The Color and Geometry of Very Early Turkish Carpets* (1993) Oxford University Press: New York.

[148] Christopher Alexander (1964) *Notes on the Synthesis of Form,* Harvard University Press: Cambridge.

[149] Christopher Alexander, Murray Silverstein, and Sara Ishikawa (1977) *A Pattern Language,* Oxford University Press: Oxford, page xiv

[150] 'The idea of a diagram, or pattern, is very simple. It is an abstract pattern of physical relationships which resolves a small system of interacting and conflicting forces, and is independent of all other forces, and of all other possible diagrams. The idea that it is possible to create such abstract relationships one at a time, and to create designs which are whole by fusing these relationships-this amazingly simple idea is, for me, the most important discovery of the book.' Alexander (1964), *op cit.*, p. ii; see also pp. 33-40 and 121-125.

[151] F.A. Hayek (1944) *The Road to Serfdom,* reprinted edition (2007), University of Chicago Press: Chicago, p. 106.

[152] William Easterly (2012) *The Tyranny of Experts*, Basic Books: New York, p. 88.

state itself. According to Chinese law and Party documentation, both Maoist and non-Maoist schemes were strictly implemented under 'voluntary' (*ziyuan de* 自愿的) conditions. But, despite this official position, the program was hardly voluntary at all. As the thesis will show clearly, there were considerable amounts of official coercion to force enrolment. Furthermore, even fully voluntary schemes require considerable amounts of state effort to implement, manage and run the scheme.

Importantly, the fact that all social health insurance schemes were to be 'voluntary' indicates that any response in the levels of enrolment at the national level (as opposed to at the local level) is likely to be systematic. There is an enormous amount of heterogeneity in the Chinese system in terms of geographical diversity, fiscal capacity, ethnicity, trust, local kinship groups, and many other matters. This is particularly a problem comparing local government reaction to national priorities at lower levels such as the village,[153] or even the township.[154] It is, therefore, highly unlikely that homogeneous responses to voluntary programs could occur nationwide. This divide between homogeneous response and heterogeneous local conditions means that I confine my typology of possible explanations to explanations that apply at the system-level (that is, that apply for all of China rather than for specific parts of China).

Using system-level explanations for selective policy implementation rules out the use of randomised controlled experiments — if it is nation-wide, it would be too hard to tell

[153] Lily Tsai (2007) 'Solidary Groups, Informal Accountability, and Local Public Goods Provision in Rural China,' *American Political Science Review*, vol. 101, no. 2, pp. 355–372.
[154] Ben Hillman (2014) Patronage and Power: Local State Networks and Party-State Resilience in Rural China, Stanford University Press: Palo Alto.

which of the variables were altered due to local conditions and which ones due to the incentives at the national level. The need to consider counterfactuals, the many different waves of political reform in recent Chinese history, and the shortage of organisations able to collect data within China (or let the data out of China)[155] also rule out the use of panel and survey data. While some useful panel data exists on the Chinese health system,[156] it only began in 2000, and there has been no systematic tracking of household enrolment in health insurance throughout that time period. Although these data have been extensively used by researchers to examine the form,[157] treatment type[158] and even the determinants of coverage[159] for social health insurance, the lack of data across different attempts at implementing health insurance schemes mean that it is difficult to use this panel data to construct any sort of counterfactual case.

Given the shortcomings of other approaches, there are some major advantages in taking a system-level approach in analysing the Chinese health care system. The Chinese political system is highly suitable to structural analysis. The fundamentally Leninist nature

[155] Once a study is classified as either an 'internal' or a 'classified' investigation (*diaocha*), the release of the data is restricted under Chinese state secrecy laws.
[156] The China Health and Nutrition study run out of the University of North Carolina, now up to its fifth wave. Used previously by Adam Wagstaff and Magnus Lindelow (2008). Can Insurance Increase Financial Risk?: The Curious Case of Health Insurance in China. *Journal of Health Economics, 27(4),* 990-1005 and, Xian Huang (2014). 'Expansion of Chinese Social Health Insurance: Who Gets What, When and How?' *Journal of Contemporary China*, vol. 23, no. 89, pp. 1-29 for their studies.
[157] Xuedan You and Yasuki Kobayashi (2009) 'The new cooperative medical scheme in China.' *Health Policy*, vol. 91, no. 1, pp. 1-9.
[158] KS Babiarz, G Miller, H Yi, et al. (2012) China's new cooperative medical scheme improved finances of township health centers but not the number of patients served. *Health Affairs*, vol. 31, pp. 1065-74.
[159] Liu Junqiang (2012) 'Dynamics of social health insurance development: examining the determinants of Chinese basic health insurance coverage with panel data', *Social Science and Medicine* vol. 73, no. 4, pp. 550-8.

of China's political system[160] means that changes in political structure must be adopted across the whole country both horizontally (that is in relation to other actors at the same level) and vertically (that is in relation to other actors at the political levels above or below). This allows us to look at system-level explanations. There is a considerable body of research on political organisation within China. These structural comparisons can then be used for the analysis of China's health care system. This has been already acknowledged informally in parts of the Chinese health care literature.[161]

The nationwide nature of this Leninist system means that the system replicates itself across the whole country in systematic ways. So the Shanghai and the Gansu provincial governments will have almost identical political structures, offices, titles and vertical reports. This creates ubiquitous political incentives in an environment where, analytically, there are many other disparities (such as quality of facilities, ease of access, ability to pay). I argue that the Chinese political structure is so structured in some ways that — while acknowledging that the deliberations made by this structure are opaque — it allows the researcher an opportunity to undertake valid structural comparisons.

[160] A Leninist political system is characterised by dominance of Party institutions and a replication of central political structures throughout lower-level political structures. See, for example, Susan Shirk (1994) *How China Opened the Door*, Brookings Institute: Washington DC, pp 15-18.

[161] For example, influential Chinese health care scholar William Hsiao argued that 'in many towns, there are separate clinics for family planning and MCH. Each clinic fights for better equipment and personnel while neither is fully utilized', and that 'organisational and incentive structures placed at the provincial level can greatly influence behaviour of county hospitals, and the relationship between the county government and the country hospital: 'a hospital director only needs to account for the number of hospital days and outpatient visits provided. His revenues should meet expenses, although the government will make up deficits as a last resort.' William Hsiao (1995) 'The Chinese health care system: lessons for other nations', *Social Sciences and Medicine,* vol. 41, no. 8, p. 1049 and p. 1051.

The use of such an overtly structural approach can make it hard to accurately analyse the motivation of actors. To attempt to obviate some of these issues, the thesis follows an explicit rational actor approach. It assumes that people are self-interested; they seek solutions to problems that will maximise their own benefit. This does not mean that they only care about themselves. One can benefit from all sorts of interactions. But it presumes that people are motivated by the search for some form of benefit. And as a result, the behaviour of the state system should be analysed through trying to understand the behaviour of the individuals who comprise the system itself. Along with others, I note that the motivation of actors in the health system can be affected by the type and level of the organisation for which they work.[162] However, the motivation derived from actors believing solely that their actions are 'in the good of society' is not examined. In other words, pro-social motivation is not itself taken as a reason for cadre behaviour.[163] Rather, it is assumed that people's behaviour changes in response to changes in benefits or changes in costs. While people may not be perfect calculators of these costs and benefits, changes in them can lead to changes in behaviour.

So the thesis assumes that the actual choices made by actors whether to implement or not implement a central decree are based on what incentives the actors are provided to follow orders. A common explanation for why China's public good provision in the post-Mao period was often poor and did not reflect the vast economic accomplishments of the Chinese state was that the system contained mixed or flawed incentives for agents to

[162] KL Leonard, MC Masatu, A Vialou (2007) 'Getting Doctors to Do Their Best: The Roles of Ability and Motivation in Health Care Quality' *Journal of Human Resources*, Summer 2007, vol. XLII no. 3, pp. 682-700.
[163] Contrary to the work of Bruno Frey and many others — see Bruno Frey (2001) *Inspiring Economics: Human Motivation in Political Economy*. Edward Elgar Publishing: Cheltenham, UK.

implement orders from above.[164] And, as Maria Edin noted, 'the system cannot cope with more than a few state goals simultaneously, especially when those goals conflict'.[165] But the NCMS, and the CMS before it, appeared to overcome this complexity, and the centre *did* manage to force local leaders to implement the policy. Why did these decrees work, and others fail?

In this way the argument in the thesis, in line with the admonitions of many social scientists, 'begins with questions about experience for which answers are wanted'.[166] To develop the answers, it uses multiple observations of a policy implementation where the policy settings change little and only one variable in the governance settings change. George and McKeown called this methodology 'structured focused comparisons'.[167] The thesis examines the same possible causes and effects for each case; measures the same possible causal factor (the decision to hold the Party secretary accountable or not) in the same way for each case; and then strives to make observations across each case comparable in order that generalisations can be drawn from them.[168] Specifically, the thesis compares all attempts made by the central state to institute rural social health insurance schemes. Each attempt to introduce a national policy is compared using extensive Chinese primary

[164] Tony Saich (2008) *Providing public goods in transitional China,* Palgrave MacMillan: London.
[165] Maria Edin (2003) 'State Capacity and Local Agent Control in China: CCP Cadre Management from a Township Perspective', *The China Quarterly*, vol. 173, pp. 35–52.
[166] Harry Eckstein (1975) 'Case study and theory in political science', in Fred Greenstein and Nelso Polsby (Eds.), *Handbook of political science*, pp. 79-138. Addison-Wesley: Reading, MA, US, p. 91. See also Bernard Grofman (2001) *Political science as puzzle solving*, University of Michigan Press: Ann Arbor.
[167] Alexander L. George and Timothy J. McKeown (1985) 'Case studies and theories of organizational decision making', in R. Coulam and R. Smith (Eds.), *Advances in information processing in organizations.* JAI: Greenwich, CT, US, vol. 2, pp. 21-58.
[168] Note the influence of Barbara Geddes (2003). *Paradigms and sandcastles: Theory building and research design in comparative politics*. University of Michigan Press: Ann Arbor, p.137: 'examines the same possible causes and same effects for each observation; uses the same categories for assigning values to variables — that is, measures the same potential causal factors in the same way for each observation; and, in whatever other ways are appropriate in specific studies, strives to make analyses of observations comparable so that generalisations can be drawn from them.'

source documentation, and a number of different primary and secondary data sources.[169] The following section discusses the data sources used by the thesis.

The use of multiple data sources to overcome methodological problems

The thesis uses a wide range of data sources. First, it uses academic research on China's governance structures. The work of academics who spend considerable time 'embedded' in the Chinese state (such as Graeme Smith) or who have Party positions that allows them to access and publish state materials (such as Zhao Shukai or Cao Pu) has been particularly useful.

Secondly, I collect data on China's social health insurance experiments and their impact on enrolment. This data includes multiple official data sets from the Ministry of Health and the Ministry of Health's *Health Services Survey*; data sets collected of the number of villages offering social health insurance schemes;[170] officially sanctioned and Party-published data on social health insurance schemes, especially from a recent Central Party School project on social health insurance; and finally, various official data provided by the state to academics, policy researchers and multilateral organisations. There has been a wide array of studies on China's health system, many of which also contain useful secondary source data. While I have limited the data used in the thesis to that which can be

[169] Albeit using data only provided from official sources or published by official or quasi-official publications (such as the Chinese Academy of Social Sciences or the Central Party School) to ensure comparability between data. The interest is in looking at what the state itself acknowledges the data to be. Problems of verification of this data are discussed further in the main body of the text above.
[170] Wang Shaoguang (2009) 'Adapting by Learning: The Evolution of China's Rural Health Care Financing', *Modern China,* vol. 35 no. 4, pp. 370-404

verified through multiple records, I attempt to provide links to other data in the footnotes and bibliography.

I make extensive use of Party and state documentation relating to governance. Many official documents are provided online as part of the process of governance. In order to "triangulate" this documentation, any documentation received was compared to other documents already obtained via fieldwork or prior research. Apart from official documentation, these other bodies of information included Party-sanctioned secondary literature, including Party histories, Party collections of major events, the personal memoirs of leaders, and official biographies. This collection of documents provides a rich, if somewhat mutable, array of primary documents on what the Chinese Party-state tells itself and the general public.

The diagrams used in the thesis are based on interpretations of both internal and external Party documents, regulations, [171] official media articles, [172] other Party

[171] New regulations were usually taken from the Legal Daily *Fazhibao* (available online: http://www.legaldaily.com.cn).

[172] Preference in these matters was given to official media (such as *Xinhua* or *People's Daily*). As the People's Daily is charged with maintaining notifications of Central Committee and National People's Congress activities ('The central websites group comprising CPC News, NPC News, China Government News, CPPCC News, Trade Union News as well as Women's Federation News has become a crucial way to release important news of China, interpret government policies and laws, and facilitate exchanges between the government and the general public'), this was the most used primary source facility. The next level of information was reprints of official media in quasi-state media (such as *Sohu).* Occasionally, materials such as explainers (*jieshao)* or longer reports were available through other media — see for example: 北京青年报 (2014) '哪些政府部门副部长"官高半级', (Beijing Youth Daily (2014) 'Which government department deputy heads are 'half a rank' higher?) 13 February, available online: http://epaper.ynet.com/html/2014-02/13/content_40639.htm?div=-1 or (for an explainer): Sina (2013) 如何品出公报的意思？ ('How are government communiques put out?', 31st October, available online: http://news.sina.com.cn/c/t/20131031/1714144.shtml.

information[173] and primary source archival material.[174] The initial aggregation of the bodies in the Chinese system was compiled through both primary[175] and secondary material.[176] A list of all the bodies was compiled. That list was matched with lists of the individuals in the system,[177] and the bodies were matched with the official lists of committees (including their membership), [178] and primary and secondary source information regarding leading small groups (including their membership).[179] This showed who was a member of which body, and which committee at the central level. Internal Party

[173] For example, new meetings are listed at the 'Internal Party Building Research' portal maintained by the Organisation Department: http://www.zgdjyj.com

[174] These primary source documents consist mainly of official pronouncements and policy specifications (accessed through fieldwork; through a number of trips to Beijing; through a period of time at the Chinese Academy of Social Sciences; and through the official holdings of the Bodleian Library Chinese Collection, the Australian National University's Menzies Library China Collection, and the National Library of Australia's China collection). These primary source documents include also holdings from the Central Party School in Beijing, available through the Australian National University's relationship with the Party School. Many of these holdings overlapped, although some significant ones — such as the 1400 internal Party documents republished by the Service Centre for Chinese Publications and held by the NLA in Canberra — were only available in one place.

[175] Usually official reports, and website information. See, for example, the Shanxi standing committee is described here online: http://news.163.com/14/1010/08/A86CSTNF00014SEH.html, or Xinhua (2012) *List of members of 18th CPC Central Committee Secretariat*, available online: http://news.xinhuanet.com/english/special/18cpcnc/2012-11/15/c_131976457.htm.

[176] Significant secondary literature includes: Susan Lawrence (2013) *Understanding China's Political System*. US Congressional Publishing Service: Washington DC; A Doak Barnett (1967) *Cadres, Bureaucracy, and Political Power in Communist China*. Columbia University Press: New York; Franz Schurmann (1966) *Ideology and Organization in Communist China*. University of California Press: Berkeley; Harry Harding (1984) *Organizing China.* Stanford University Press: Palo Alto; Kenneth Lieberthal (2004) *Governing China : From Revolution to Reform*. Second edition, W. W. Norton: New York; London; Joseph (2012) *Politics of* China. Oxford University Press: Oxford.

[177] Compiled using *China Vitae* (available online: www.chinavitae.com) and official Chinese documentation (see for example: Xinhua (2012) *List of members of 18th CPC Central Committee Secretariat*, available online: http://news.xinhuanet.com/english/special/18cpcnc/2012-11/15/c_131976457.htm).

[178] For the rules binding individuals who are members of committees, I used the websites of the individual committees where possible; the Politics and Law Committee, for example, not only lists its members activities, but also maintains separate sites at the provincial level — see http://www.chinapeace.gov.cn/node_28648.htm. The membership of different bodies draws heavily on the work of Alice Miller in the *China Leadership Monitor,* especially Alice Miller (2013), 'The Work System of the Xi Jinping Leadership', *China Leadership Monitor,* vol. 41, available online: http://www.hoover.org/research/work-system-xi-jinping-leadership

[179] Wu Xiaolin (2009) '小组政治' 研究:内涵、功能与研究展望', ('Small group governance: documents, function, and research prospects') *Qiushi*, issue 3, available online: http://www.usc.cuhk.edu.hk/PaperCollection/Details.aspx?id=7149; see also the indispensible Alice Miller: Alice Miller (2013) 'More Already on the Central Committee's Leading Small Groups' China Leadership Monitor, issue 44, pp 1-26.

rules and regulations posted on official central Party websites were then used to analyse the rules governing behaviour of individuals in these central bodies and committees.[180] A similar process of review of primary[181] and secondary source[182] literature occurred for official bodies at each political level to ensure that anomalies[183] in the rank[184] and the replication of political bodies (such as bodies that exist in the centre, but not at the county level) were accounted for, that a list of bodies for each political level existed, and that the

[180] Much of this is listed in the relevant footnotes for each judgment. More broadly, occasionally, individual regulations are available for different bodies that allow us to see the rules that individuals must follow as members of the organisation. The most useful of these by far is the Party regulations regarding the powers available to Party members (中国共产党党员权利保障条例, ('Regulations of Communist Party power and document rank') available online: http://zygjjg.12388.gov.cn/html/law/3.html). Other committees also issue useful documentation — see the CPPCC rules for protecting online information for example: 全国人大常委会关于维护互联网安全的决定 (National CPPCC decision regarding the protection of online information) (2000) http://zygjjg.12388.gov.cn/html/law/11.html

[181] The most useful resource at this level was the official websites for the different committees at provincial and municipal levels. There were also some counties that made committee organisation charts available. For a good collection of the different provincial and municipal Party discipline links, see Flora Sapio (2015) 'Resources on Party Discipline', *Forgotten Archipelagos,* available online: http://florasapio.blogspot.hk/p/internet-resources-on-party-discipline.html

[182] Examples are contained in the footnotes throughout the thesis, but broadly speaking the work of Zhao Shukai at the township level: Shukai Zhao (2013) *Township Governance and Institutionalization in China.* Singapore: World Scientific Publishing Company Incorporated; of Maria Edin (2003) "State Capacity and Local Agent Control in China: CCP Cadre Management From a Township Perspective," *The China Quarterly,* vol. 173, pp. 35–52; Ben Hillman, (2010) "Factions and Spoils: Examining Political Behavior Within the Local State in China" *The China Journal,* no. 64, pp. 1–20., Graeme Smith (2010) "The Hollow State: Rural Governance in China," *The China Quarterly,* no. 203, pp. 601–18. See also Susan Whiting (2006) *Power and Wealth in Rural China*, Cambridge University Press Cambridge at the county level; and Lily Tsai (2007) "Solidary Groups, Informal Accountability, and Local Public Goods Provision in Rural China," *American Political Science Review*, vol. 101 (2), pp. 355-372 at the village level were, among other sources, used.

[183] Such as the role of banks; the position of the National Development and Reform Commission (which does not always extend to the county level); and the replication of the State Asset Supervision and Administration downwards (appears to only be for cities ranked *shengbuji or fushengbuji* and above).

[184] This was usually resolved through secondary literature that focused on specific *xitong,* for example*:* Jean-Pierre Cabestan (2009) 'China's Foreign- and Security-policy Decision-making Processes under Hu Jintao', Journal of Current Chinese Affairs, vol.38 (3), March 2009, pp.63-97; Kenneth Lieberthal (2011) *Managing the China Challenge: How to Achieve Corporate Success in the People's Republic*. Washington DC: Brookings Institution Press; Stephen Bell and Hui Feng (2013) *The Rise of the People's Bank of China: The Politics of Institutional Development in China's Monetary and Financial Systems.* Cambridge, Massachusetts: Harvard University Press.

relationships between the bodies at each level concurred with other primary[185] and secondary literature.[186]

In line with the recent work of scholars such as Michael Schoenhaals,[187] the thesis also uses a considerable number of primary source Party materials gathered from so-called 'garbology' (垃圾学 *lajixue*). Garbology is the purchase or scavenging of original field material from second-hand flea markets or garbage yards (including on the internet). These materials — mainly instruction manuals,[188] but also local and central government records of events and decisions (*dashiji* 大事记)[189] — proved invaluable for understanding the instructions that were given by the centre to local hospitals, doctors, and health administrators during the Maoist period,[190] and for the period 1978-1990.[191]

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[185] Apart from the author's own field work, journal articles often used fieldwork to focus on specific parts of the system, and these were frequently used to resolve debates as to where different bodies should be placed, and the rank held by different bodies. Specific examples are in the footnote text throughout the thesis, but general resources of great use included: Kjeld Erik Brødsgaard, "Institutional reform and the *bianzhi* system in China," *The China Quarterly,* No. 170 (June 2002), p.364 (on the local government); Graeme Smith, Measurement, promotions and patterns of behavior in Chinese local government, *Journal of Peasant Studies,* vol. 40 (6), pp. 1027-1050 (on local government); Zhou Xueguang (2004)*中国县级行政结构及其运行： 对W县的社会学考察*, 贵州人民出版社 (*China's county-level administration and structure: A study of W county*, Guizhou People's Press).

[186] A number of broad surveys of local politics based on fieldwork were then used to resolve problems in the local government models regarding how these different political levels relate to each other. These include: Susan Whiting (2000) *Power and Wealth in Rural China: The Political Economy of Institutional Change.* Cambridge University Press: Cambridge; Yang Zhong (2004) *Local Government and Politics in China: Challenges from Below*, M. E. Sharpe: Armonk; Jean Oi (1999) *Rural China Takes Off: Institutional Foundations of Economic Reform*. University of California Press: Berkeley.

[187] See the methodologial comments in Michael Schoenhaals (2013) *Spying for the People: Mao's Secret Agents 1949-1967*, Cambridge University Press: Cambridge; while much of it is based on archival material, he also used a number of *lajixue* methods to access materials to allow his study.

[188] For example 北京医学院革命委员会 (1969) *农村卫生工作队医疗手册,* (Beijing Research Hospital Revolutionary Committee (1969), *Manual for rural health work teams*) 北京医学院革命委员会: Beijing.

[189] 卫生部红色造反团 (1968) 农村卫生工作两条路线斗争大事记 1949-1966, (Ministry of Health Red Rebel Group (1968) A record of the two-line struggle in rural health 1949-1966) 天津市卫生系统劳动卫生斗批改联络站: Tianjin.

[190] 转发中央卫生部 (1963)"关于农村联合医疗机构和开业医生暂行管理办法", 鄖县人民政府 (Ministry of Health (1963) 'On temporary administrative methods of ensuring rural health care structure and production', Yun County Press), Ministry of Health (1978) 农村合作医疗管理方法 试行草案征求意见稿, (Draft opinions and viewpoints on methods of rural health management), Beijing.

Finally, individual questions were resolved through periods of fieldwork, or through interviews. This includes five trips to China to conduct interviews (mainly in Beijing, but also in Henan; see Chapter 7). The interviews conducted in periods of fieldwork were especially helpful, if only to confirm nascent thinking. Any of the judgments influenced by fieldwork are noted in the footnotes of the relevant text sections.[192] The thesis uses some secondary literature (in both English and Chinese), national statistics,[193] and subnational statistics. But primarily, the thesis is based on the interpretation of vast amounts of Chinese primary source documentation. These primary source documents consist mainly of official pronouncements and policy specifications. Very few of these primary source documents have been used in prior analyses of Chinese health care reform or Chinese SHI implementation.[194]

There are limitations to all of these types of evidence. However, when taken together, they form a compelling picture.[195] Moreover, a central argument in this thesis is that the Chinese system relies on documents, and that we should study these documents in order to gain insights about the Chinese system. The goal of the thesis is to show that the synthesis

[191] E.g., 中国农村医学编辑部编 (1982)*中国农村医学增刊:基层医务人员初晋中复习考试参考题解*, 人民卫生出版社: Beijing (Editorial Board of China Rural Health (1982) Supplement and Notes for Rural Medical Professional Progress Examinations, People's Publishing House: Beijing).
[192] For example, a copy of the 2007 Shenzhen leading cadre targets (指标 *zhibiao)*
[193] This is necessary for ensuring some form of data integrity given that subnational statistics were rarely kept for swathes of the Maoist and early post-Maoist period.
[194] Accessed through fieldwork; through a number of trips to Beijing; through a period of time at the Chinese Academy of Social Sciences; and through the official holdings of the Bodleian Library Chinese Collection, the Australian National University's Menzies Library China Collection, and the National Library of Australia's China collection. These primary source documents include also holdings from the Central Party School in Beijing, available through the Australian National University's relationship with the Party School.
[195] Phrase taken from David Skarbek (2014) *Governing the Underworld*, Cambridge University Press: Cambridge, p. 12

of these different materials provides an accurate and "thick" description[196] of how a part of the Chinese system actually works.

Conclusion

This chapter has shown briefly how the thesis will look at the rules of the state itself, the problems of undertaking such an examination, the methodology used to overcome these problems and the information sources used in the thesis. It has argued that any explanation for high enrolment in social health insurance needs to be system-wide, as the program would need to be implemented nationally. It has also argued that while the preferences of top leaders may have a major influence on policy, it is also necessary to disaggregate the state in order to isolate different actors within the system and how they relate to each other — and to analyse the motives and behaviour of actors at all levels in the Chinese state. The thesis will use techniques drawn from institutional analysis to find rules that are common to each political level, and incentives that are common to different actors and implementation attempts. These institutions will be analysed in order to seek empirical generalisations that hold system-wide. An institutional analysis allows the thesis to also account for the superior power of the Party above the state in various arenas of governance. The next chapter, Chapter 3, constructs a simple, stylised framework of how the Chinese governance system works in the abstract.

[196] Clifford Geertz (1973) 'Thick description: Toward an interpretive theory of culture', in *Interpretation of Cultures: Selected Essays,* Basic Books: New York, pp. 1-30.

Chapter 3: A framework for understanding Chinese governance institutions

This chapter outlines a simple framework outlining the conditions under which the centre is more or less likely to be able to force implementation nationwide. The framework aims to describe how the centre is able to influence each local government nationwide in order to compel them to follow their command. It begins at the central level, before moving to the subnational level, and then the local level. Top down implementation happens in a structured way. Orders are passed down from level to level. Each level must coordinate the different interests and agencies involved in a given order. And each level must also issue its own orders downwards to the next level. At each level, the framework shows the rank of different actors, shows how different policy interests are coordinated, and shows how orders are passed to the level below. In doing so, it shows how preferences at the centre are formed and passed down to the lower levels. It also shows how there are likely responses to central preferences due to the manner in which the Chinese governance system is organised and how the Chinese system tries to obviate principal-agent and information problems.

Creating a standard framework also shows how local processes of adapting orders from above to local conditions and subsequently passing them down to yet lower levels affect implementation. There are different types of orders, and each type of order has a different level of authority. The rank of the body that issues the order affects the authority of the order. This system of authority is outlined in an array of official documents. Distortions

within this top-down system of authority have a systemic effect on implementation. These distortions come from both the way the central system issues orders, and from the way in which the local system follows these orders. These distortions are systemic, and can be analysed through determining the authority of the body who issued the order, and the authority of the order itself (based on its classification). Using tools of institutional and flow-chart analysis, a framework analysing rank, document issuance, and authority to act is developed in order to map the implementation of different policies.

In other words, this framework uses Party documentation to build a taxonomy of authority and rank that can then be used to interpret how powerful an order from the centre appears to local governments. This analytical framework allows us to outline a first principles argument regarding how the centre would be able to introduce nationwide enrolment in social health insurance. The rest of the thesis uses this framework in analysing implementation to analyse the many different attempts by the centre to force local governments to institute a national rural social health insurance program, and to enrol local citizens in it.

How central governance structures function

To help understand these rules, I first discuss the central governance system before shifting attention to lower political levels. The central governance system issues the decrees that the whole system is to follow. It also determines the structure for the rest of the system. This is because the many different organisations in the party state are then

replicated at lower political levels — from provincial level to municipal level to county level.[197]

Understanding where each actor or document sits is essential to understanding their authority within the Chinese system. There are two important analytical tasks. One is to ascertain where different bodies sit in relation to each other. Regarding questions of rank and authority at the central level, the order of bodies is taken first from constitutional documents,[198] then the charters of the highest coordination bodies,[199] then through official Party and state organisation charts,[200] then through Party regulations,[201] then through laws,[202] and through the order in which bodies are mentioned in speeches or decrees. Secondary source literature was also used when formal documentation was unavailable.

[197] Note that this includes the respective lower bodies also considered to be of that 'rank' — ie 'provinces' means all bodies of provincial rank, which includes provinces, autonomous regions, directly managed municipalities and special administrative regions (I exclude Taiwan from this analysis, not as a political statement, but because their social policy is administered by a different body). Similarly, municipality includes a number of subareas, each that can be called municipality (地区,自治州, 地级市, 盟，and so on).
[198] The highest of these is the national constitution, available online: http://www.12388.gov.cn/html/law/1.html; followed by the CCP Constitution http://zygjjg.12388.gov.cn/html/law/2.html.
[199] Charter of the Chinese People's Political Consultative Conference; State Council official organisation chart (available online: http://english.gov.cn/state_council/2014/09/03/content_281474985533579.htm) and official department descriptions (available online: http://www.china.org.cn/english/kuaixun/64784.htm)
[200] As well as individual departments putting their organisation charts online, some Party departments put their regulations online: 中国共产党纪律处分条例 (Party discipline regulations) http://zygjjg.12388.gov.cn for CCDI for example has both regulations and organisation charts; the *Communist Party News* maintains a comprehensive list of Organisation Dept activities http://cpc.people.com.cn/GB/64114/75347/; and of Propaganda Department activities http://cpc.people.com.cn/GB/64114/75332/. New projects and schemes also often have websites (see for example the 12380 program of the Organisation Department: http://www.12380.gov.cn). All of these websites also allow membership of their respective organisations to be checked against those maintained in the model (with the acknowledgment that these are often drawn from Alice Miller's work and databases — see below).
[201] I used the Central Committee (2012) 'Party Regulations on enacting Party laws and regulations' *Zhongfa no. 5* for the basic starting model. For the conflict between different procedures, laws and regulations, Flora Sapio's ongoing work was invaluable (see http://florasapio.blogspot.hk/).
[202] The 2005 Civil Servant Law of the People's Republic of China and subsequent Party implementation plans divide the posts of civil servants into the category of leading posts and non-leading posts. As Glenn Tiffert noted, the draft implementation plan of this law ('中华人民共和国公务员法实施方案') (2006) paradoxically makes all Party members subject to the 2005 state law. This is not taken as an authoritative decree, but it does mean that the 2005 Civil Servant Law can provide useful documentation and pointers as to internal Party rank.

The second analytical task is to develop a taxonomy of the rank and authority of different decrees. This is achieved using official Party documentation at the central level,[203] (with the aid also of invaluable secondary source guides to Party terms)[204] and then adapting Party regulations at the local level.[205]

As discussed in the methodology chapter, rank is attached to the individual and individuals then assigned to bodies in the Party-state. Party rank is more important than the rank of one's agency, ministry, or government department. Hence, an individuals' rank within the Party assigns one's rank within the broader system.[206] The roles of individuals change according to the position that the Party places them in within the bureaucracy; and they are rotated regularly.[207] Individuals generally derive their rank — and their clout — *ex officio*.[208] Hence, one's rank within the system as an individual is not only the measure of one's position in the system, but also a strong predictor of the power one's organisation[209] or interest area holds within the system.[210]

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[203] The 2012 Central Committee Directive on dealing with work documentation (which itself updated the 1995 interim regulations on dealing with work documentation) outlines the order of documents and the process for dealing with them.

[204] Tim Heath (2014) China's New 'Governing Party' Paradigm: Political Renewal and the Pursuit of National Rejuvenation, Ashgate: New York. Michael Schoenhals (1992) Doing Things with Words in Chinese Politics: Five Studies. University of California Press: Berkeley.

[205] Gao (2007) *op cit.* notes the 1995 Notice on Strengthening and Improving the Evaluation of Work Accomplishment of the Leadership Corps of Party Committees and Governments at the County (Municipal) Level remains the primary document outlining how the centre assessing the actual work achievements of the local leadership corps; I have taken the methodological assumption of presuming that the 2012 Central Committee directive that updates (and outranks) the 1995 Notice is similarly binding at local levels.

[206] This can be seen from official speeches and protocol order, which lists individuals in order as per their Party rank.

[207] Many individuals hold multiple positions, in a phenomenon referred to as 'double hatting' *dai liang ge maozi*.

[208] There are occasionally exceptions where individuals are granted promotions, but are not elevated to higher Party bodies. Chen Deming, for example, was an alternate member of the 17th Central Committee, but was then made Minister for Trade — yet did not gain full membership of the Central Committee for a number of years later, in spite of his ministerial rank.

[209] While individual actors — such as ministers, or commission heads — can also be members of coordination bodies, and their primary interest is to represent the interest of the body they head, they are

The order of precedence and authority within the Chinese system facilitates the coordination of different interests of individuals and agencies. Formal coordination bodies — usually committees — control and coordinate multiple interests, and act as the arbiters among different interests.[211] While members of coordinating bodies may have multiple tasks, and interests, these bodies are designed to be arbiters of different interests,[212] and the final decisions of these coordinating bodies are binding. It is the decrees from these coordination bodies that govern China. [213]

Figure 3 below describes how these bodies interact, and the approximate directions of the flow of information between them. The diagrams used in this thesis are based on interpretations of both internal and external Party documents, regulations,[214] official media articles,[215] other Party information[216] and primary source archival material.[217]

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then bound by any decision that comes from a coordination body that they sit on. For example, while the head of the National Development and Reform Commission (NDRC) currently sits on the Standing Committee of the Chinese People's Consultative Conference (CPPCC), his power is derived from his prosecution of the interests of the NDRC, rather than his role in the CPPCC — but he is bound by any CPPCC pronouncement or decree, should the CPPCC issue one relevant to his station.

[210] This is not to say that individual power is not also of interest, but organisational theory commonly has it that public sector organisations, or 'bureaucracies', generally feature decision makers that are concerned more with their position in the system than with salary. James Q. Wilson (1991) 'Bureaucracy: What Government Agencies Do And Why They Do It', Basic Books: New York, p. 76.

[211] Similar to Huang Yasheng's model of single task versus multiple task bureaucrats — Yasheng Huang (2002) 'Managing Chinese Bureaucrats: An Institutional Economics Perspective', *Political Studies*, vol. 50, no. 1, pp. 61-79.

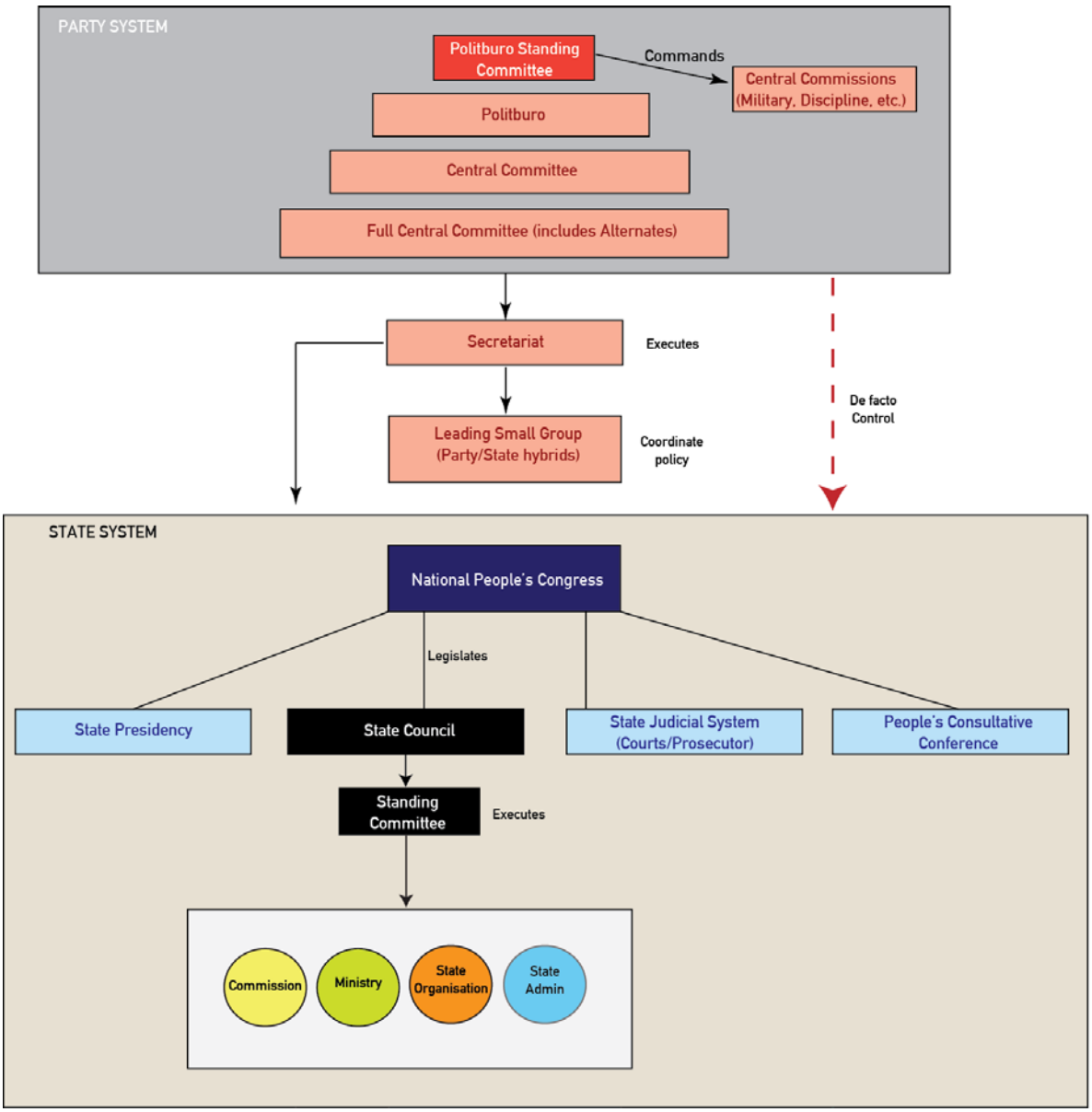
[212] This is a distinction originally made by Huang Yasheng, *ibid.,* p. 68

[213] The deliberations of these coordinating bodies are not released to outsiders, although the topics of the deliberations are sometimes released. See for example Sina (2013) 如何品出公报的意思？('How are government communiques released?), 31st October, available online: http://news.sina.com.cn/c/t/20131031/1714144.shtml

[214] New regulations were usually taken from the Legal Daily *Fazhibao* (available online: http://www.legaldaily.com.cn).

[215] Preference in these matters was given to official media (such as *Xinhua* or *People's Daily*). As the People's Daily is charged with maintaining notifications of Central Committee and National People's Congress activities ('The central websites group comprising CPC News, NPC News, China Government News, CPPCC News, Trade Union News as well as Women's Federation News has become a crucial way to release

Figure 3: China's central governance structure and coordination bodies



Source: Author's analysis

important news of China, interpret government policies and laws, and facilitate exchanges between the government and the general public'), this was the most used primary source facility. The next level of information was reprints of official media in quasi-state media (such as *Sohu).*

[216] For example, new meetings are listed at the 'Internal Party Building Research' portal maintained by the Organisation Department: http://www.zgdjyj.com

[217] These primary source documents consist mainly of official pronouncements and policy specifications (accessed through fieldwork; through a number of trips to Beijing; through a period of time at the Chinese Academy of Social Sciences; and through the official holdings of the Bodleian Library Chinese Collection, the Australian National University's Menzies Library China Collection, and the National Library of Australia's China collection). These primary source documents include also holdings from the Central Party School in Beijing, available through the Australian National University's relationship with the Party School. Many of these holdings overlapped, although some significant ones — such as the 1400 internal Party documents republished by the Service Centre for Chinese Publications and held by the National Library of Australia in Canberra — were only available in one place.

Figure 3 above shows a number of things. Firstly, it shows the preeminence of the Party in central organisation. In addition, it shows that there are three major coordination bodies of interest to analysts of China's Party state. The leading Party body, leading coordination body, and the peak body within China, is the Party Central Committee.[218] The Central Committee's 205 members are assigned by the Party to the most important positions in the Chinese state. The second of these major coordination bodies is the peak body of the system of government — the National People's Congress (NPC). The NPC is a parliament-like body that officially oversees the State Council (an executive body similar to the UK Cabinet), but the NPC is subordinate to the Party Central Committee. The peak government administrative body is the State Council —China's cabinet — headed by a State Premier, who plays a role similar to that of a Prime Minister, and who, with a number of Vice-Premiers and State Councillors, controls a government system.[219] The State Council controls a wide array of central bodies of lower rank, including commissions; ministries; administration bodies; and central organisations (such as hospitals). But each of these major coordination bodies meets rarely, usually annually. Instead decision making powers are delegated to other committees who meet far more regularly.[220] These very highest[221] coordination bodies communicate their judgments through a Party Secretariat.[222]

[218] The Party Central Committee formally controls the Central Military Commission; but the Central Military Commission also meets more regularly than the Party Central Committee.
[219] None of whom serve on the Politburo, but each holds the rank of *zhengguoji*. OECD (2005) *Governance in China*. OECD Publishers: Paris.
[220] For example, the full Central Committee only meets once a year. So its decisions are delegated to the Politburo Standing Committee (PBSC), which is reported to meet every 7-10 days. The PBSC itself is a small group of individuals who are delegated powers by the Politburo, of which they are all members and which is reported to meet around fortnightly. As with the Central Committee, the NPC meets annually, and delegates its decision-making largely to its Standing Committee, which meets every two months. The full State Council meets biannually, and delegates its decision making in the interim to its Standing Committee. Jean-Pierre

The leaders of the highest ranked coordination bodies in China are ranked as *zhengguoji* 正国级 or the highest state rank, that of being "full state". *Zhengguoji*[223] leaders are the heads of the major executive bodies (the Politburo, State Council Standing Committee, the Party Secretariat); the heads of the military; and the heads of the highest legislative and consultative bodies in China.[224]

These highest bodies (and individuals ranked as *zhengguoji)* can also form their own coordination mechanisms to investigate any interest they feel is not covered by the current system, or to force implementation of any issue they feel is not adequately addressed by the current system.[225] These 'leading small groups' (中央领导小组 *zhongyang lingdao xiaozu*)[226] can be established to look into any issue — there were leading small groups ("LSGs") for the 2008 Olympic Games for example — and they function both as coordination mechanisms for different state and Party interests, and as bodies to implement central

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Cabestan (2009) 'China's Foreign- and Security-policy Decision-making Processes under Hu Jintao', *Journal of Current Chinese Affairs*, vol.38, no. 3, March 2009, pp. 63-97

[221] The head of the Secretariat (currently Liu Yunshan) has what appears to be an *ex officio* position on the PBSC. The secretariat contains the secretary of the State Council standing committee, as well as the heads of the Party bodies responsible for enforcing and translating Central Committee orders (discussed in the next section). See Xinhua (2012) *List of members of 18th CPC Central Committee Secretariat*, available online: http://news.xinhuanet.com/english/special/18cpcnc/2012-11/15/c_131976457.htm.

[222] Also through the State Council General Office, but this is junior to the CCP Secretariat, as the head of the General Office is an ordinary member of the Secretariat Standing Committee.

[223] To ensure that the reader can see the difference between state and Party bodies, and in the absence of a useable translation that makes this distinction clear, the thesis will refer to this highest level simply as *zhengguoji*.

[224] *Zhengguoji* bodies are: Central Committee General Secretary, Politburo Standing Committee members, Politburo members, Secretariat of the Central Committee, Chairman and Vice Chairman of the Central Military Commission, and the following state leaders: President and Vice President of China, Chairman and Vice Chairman of the Standing Committee of the National People's Congress, Premier, Vice Premiers, State Council members, Chairman and Vice Chairman of the National Committee of the Chinese People's Political Consultative Conference.

[225] Technically, any body can have a 'small group', but only *zhengguoji* bodies can introduce small groups known as 'leading small groups' — Org Dept official, Beijing, interview 2009.

[226] Note that there can also be ordinary 'small groups' *xiaozu* as well; the difference is due to the body that set the group up, and the membership of the group.

directives.[227] The LSGs rank is usually dependent on the rank of the body that established the LSG, and the rank of the most senior member upon the LSG.[228] Again, rank is determined at the individual level, the highest ranking member of the LSG is held accountable for the group's activities. The more powerful the head of the LSG, the more powerful the LSG is seen to be, and the more able it is to prosecute its agenda within the Chinese system.[229]

In addition, the system has a Party-led system of enforcement within the central ranks. As well as the traditional forms of enforcement (such as a court and a prosecutor), there are also a number of internal Party bodies that are able to attempt to force implementation to occur (by investigating or prosecuting individuals within Party bodies). Specialist Party bodies include a Party investigation body (the Central Commission for Discipline and Inspection or "CCDI", which despite its name functions as an organisation rather than committee), a Party personnel system (the Organisation Department), and a Party communication system (commonly known as a propaganda system, *xuanchuan* 宣传). As the rank of the individual comes from their rank within the Party, enforcement of rule-breaking similarly occurs within the Party. The Party has special investigation powers, and the head of the Party's investigation unit is a member of the Politburo Standing

[227] The CCP Constitution notes that the main responsibility for LSGs are to ensure 'line, principles and policies are implemented, to discuss and decide on matters of major importance, to manage cadres, to rally the non-party cadres and the masses in fulfilling the tasks assigned by the party and the state, and to guide the work of the party organization of the unit and those directly under it.'

[228] Wu Xiaolin (2009) '小组政治' 研究:内涵、功能与研究展望', ('Small group governance: documents, function, and research prospects') *Qiushi*, issue 3, available online: http://www.usc.cuhk.edu.hk/PaperCollection/Details.aspx?id=7149.

[229] Alice Miller (2013) 'More Already on the Central Committee's Leading Small Groups' *China Leadership Monitor*, issue 44; Central Committee's LSGs (of which there are usually thought to be 8), or Party Secretary Xi Jinping's recently-established LSGs (as of writing, there were 11) are very important.

Committee. Should someone be removed from power, then they lose all of their positions, to be replaced by another Party member as chosen by the Party.

The importance placed on enforcement can be seen by the very high rank of individuals responsible for discipline. The leader of the rules enforcement organisation and the leader of the communication organisation are members of the Poliburo Standing Committee, while the leader of the Party personnel system is a member of the Politburo. While this system makes it difficult to enforce any rule held against a Politburo Standing Committee member, all other individuals within the Chinese system are outranked by the leaders of these Party enforcement organisations, and the organisations themselves thus have the ability to enforce all decrees made by the Party. The enforcement organisations themselves are formally ranked as one level below *zhengguoji*, a rank higher than Ministerial. These bodies, ranked as deputy-state or *fuguoji* 副国级 are all responsible for Party matters, Party discipline, and the legal system.[230] These *fuguoji* bodies are then subject to Party supervision through both individual leaders being held accountable in coordination body meetings of bodies of higher rank (*zhengguoji* bodies, see Figure 4 below) and, in more recent years, through a push for more 'inner-Party democracy', or more elite bodies reporting to larger bodies[231] and using stricter regulations and guidelines.

However, the vast majority of bodies within the central system sit below these ranks of *zhengguoji* or *fuguoji.* These bodies include most of those that we traditionally associate

[230] *Fuguoji* bodies are: Communist Commission of Discipline and Inspection, Supreme People's Court, Supreme Procuratorate (public prosecutor's office), Party departments (Organisation, Propaganda)
[231] Heath (2014), *op cit.* p. 193, see also党建专家谈党内监督条例：让制度制约权力

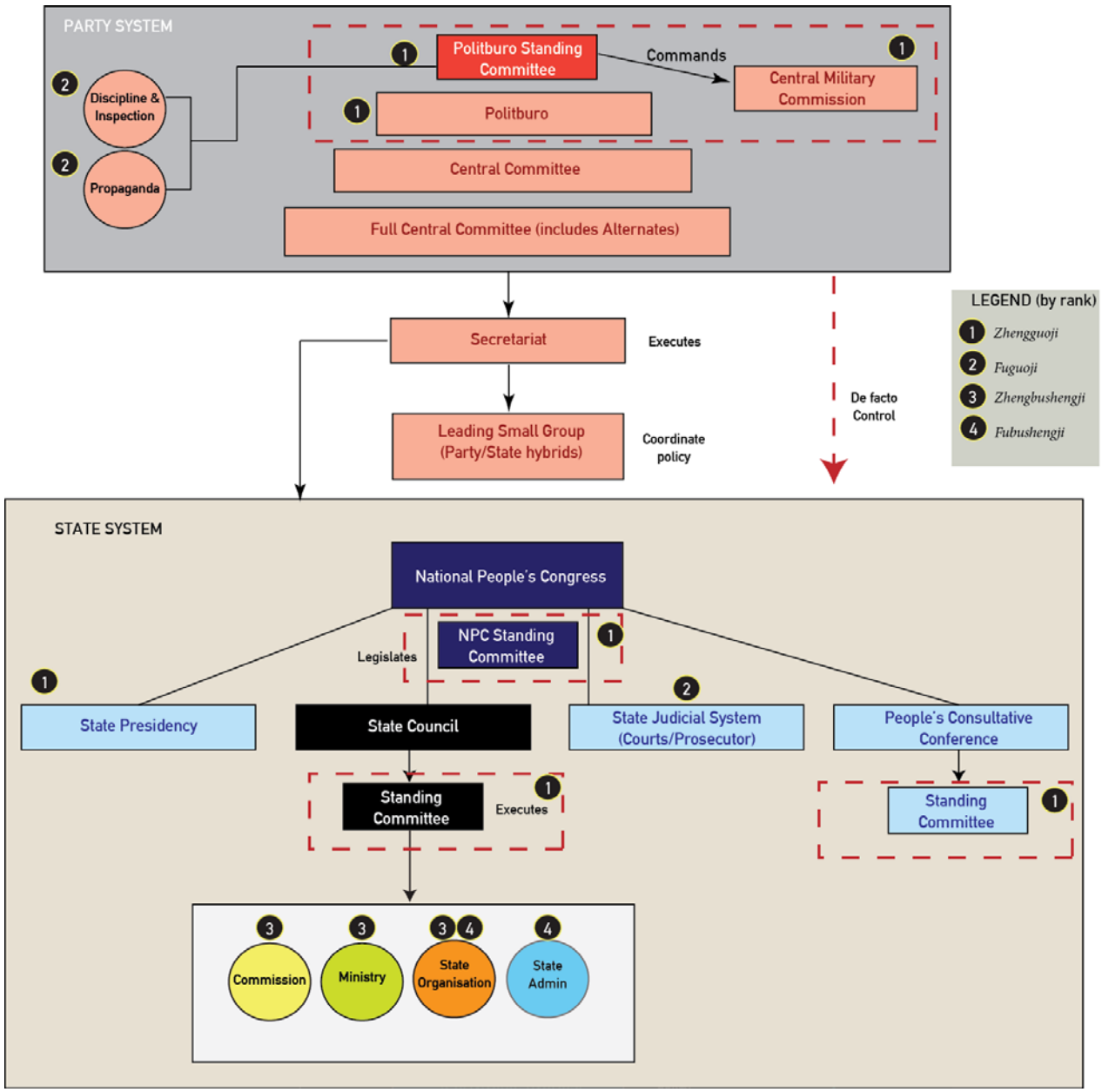
with the arms of the state, such as ministries, regulators and administrative bodies.[232] They are ranked as either ministerial/provincial rank *zhengbushengji,*[233] or, for the rank below, quasi-ministerial or quasi-provincial rank *fubushengji.*[234] Note that as these actors can be enormously varied (including *inter alia* banks, State Owned Enterprises (SOEs), and public service providers such as hospitals and universities), their rank can vary; thus they are represented as both a 3 and a 4 in the diagram. Figure 4 below shows where all bodies sit in the system, and their different ranks.

[232] Much of this table, and the initial idea for the ranking system at ministerial level, is compiled from the work of Susan Lawrence (2013) *Understanding China's Political System*. US Congressional Publishing Service: Washington DC.

[233] Commissions, ministries, regulatory commissions, provinces/autonomous regions/Ministerial-level cities, some central State Owned Enterprises (SOEs), mass organisations (Communist Youth League, All China Confederated Trade Unions), Xinhua News Agengy, and academies (Chinese Academy of Social Sciences, Chinese Academy of Science and Chinese Academy of Engineering).

[234] State Bureaux, offices and administrations (State Statistical Bureau, Food and Drug Administration body), 15 cities (Changchun, Chengdu, Dalian, Hangzhou, Harbin, Guangzhou, Jinan, Nanjing, Ningbo, Qingdao, Shenyang, Shenzhen, Wuhan, Xiamen, and Xian), China's 5 largest banks; some SOEs (including the State Tobacco company); 32 universities (including Tsinghua and Beida).

Figure 4: China's central governance structure and coordination bodies, all central ranks



Source: Author's analysis[235]

[235] See above for details of their derivation.

How solving information problems affects power and authority

The Chinese system is different from many classical conceptions of the "state". From the perspective of optimising the ability to control subordinates in a political structure, however, the system of political organisation has some advantages for the senior leaders of the Chinese party-state. Sociologists[236] and economists[237] both note that, in general, principals in vertical hierarchies find it difficult to extract information from the intermediate levels of a hierarchy; that agents are often able to falsify information given to principals; and that coalitions can easily develop among agents. The structure of the Chinese party-state can be seen as a response to this vertical hierarchy problem. Using Party discipline and measurement bodies (agents), senior leaders (the principals) keep tight watch on all organisations below and prevent them from coordinating or forming cliques or fiefdoms among each other that may disturb or threaten the hierarchy, or that may reduce the ability of senior ranks to enforce their will.[238]

This structure is underpinned by a detailed system of rank. A strict formal rule of rank helps resolve organisational conflicts between the many different bodies and actors that

[236] Melville Dalton (1959) *Men who manage: fusions of feeling and theory in administration*. John Wiley and Sons: New York.
[237] Jean Tirole (1986) 'Hierarchies and bureaucracies: On the role of collusion in organizations', *Journal of Law, Economics, & Organization,* Vol. 2, No. 2 (Autumn, 1986), pp. 181-214.
[238] This traditional battle against 独立王国 *duli wangguo* 'independent fiefdoms' can be traced from Mao's critique of Rao and Gao (see Teiwes (1993) *Politics and purges in China : rectification and the decline of party norms, 1950-1965*. M.E. Sharpe Press: Armonk, NY, pp 161-170) to the modern critique of Bo Xilai ('他们想在那里建立独立王国，要挟中央，与中央对抗' ('they wanted to build an independent kingdom, to coerce the centre, and to resist the centre') BBC (2012) 重庆市长：薄王事件影响招商引资 ('Chongqing Mayor: Bo wanting to be king has influenced our ability to attract trade and investment') available online: http://www.bbc.co.uk/zhongwen/simp/chinese_news/2012/07/120712_chongqing_huangqifan.html.

comprise the Chinese party-state.[239] But it also means that decrees that are issued by different bodies and organisations have different levels of rank and order.[240] Organisations are not able to issue decrees or orders binding upon other organisations at the same level; they are only able to coordinate an opinion and then submit it to higher body for approval.[241] Occasionally, individuals of higher party rank can run an agency that is nominally at the same level; in that case, the individual of higher party rank has some greater level authority to speak within Party forums as rank follows individuals rather than following agencies.[242]

The need to prosecute one's interest against a number of other actors also prosecuting alternative interests makes different ministries and organisations of the same rank enormously (horizontally) competitive with each other. For example, the wide array of commissions, ministries, and state administrative and regulatory bodies under the State Council are generally considered 'a fractious, highly competitive group of institutions with sometimes overlapping jurisdiction'.[243]

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[239] Ignoring informal and personal clout or charisma; e.g., T Gold, D Guthrie and T Wank (eds) (2002) *Social Connections in China: Institutions, Culture, and the Changing Nature of Guanxi,* Cambridge University Press: Cambridge on social connections in China.

[240] See Central Committee and State Council (2013)党政机关公文处理工作条例 ('Regulations of use of documents within Party and State organs'). This tradition was also the underpinning of the 1995 temporary regulations on the use of documents within the Party.

[241] *Ibid,* clause 16.4: 涉及多个部门职权范围内的事务，部门之间未协商一致的，不得向下行文；擅自行文的，上级机关应当责令其纠正或者撤销. ('For matters involving the scope of authority of multiple departments, the departments must negotiate together and must not communicate written orders to lower level departments; unauthorised communications to lower levels will result in higher-ranking bodies cancelling or revoking the orders').

[242] Thus individuals can become ministers in the government, but still not be Central Committee members (even though normally they would be, *ex officio*) until the next Central Committee meeting is able to upgrade them. This occurred with Minister of Trade Chen Deming in the 17th Party Congress for example — he remained an alternate member of the Central Committee, whereas all his ministerial peers were full members.

[243] Lawrence (2012), *op cit,* p. 30.

In many ways, this fractiousness further aids China's highest leaders in any quest to control subordinates. As agencies of equivalent rank cannot issue binding orders to each other,[244] nor compel state coordination of an issue, any issue or dispute must go to a higher body. This makes the highest coordination bodies the most powerful within the central system, as they remain the final arbiter of disputes. So while commissions, ministries, state administrative and regulatory bodies, and the many other actors in the Chinese party-state can have overlapping jurisdictions, any arbitration or final decision must come from the highest coordination bodies. When the highest coordination bodies make their decision, then and only then can it be transmitted throughout the whole Chinese party-state.[245]

So the decrees of the *zhengguoji* bodies (the highest-ranking bodies — see Figure 4 above) are vital and create a documentary system.[246] Once a decision leaves the *zhengguoji* bodies, it can be taken as the central leadership's revealed choice. This choice must be communicated to the entire system — and it must be communicated in a way that allows the system to recognise the importance of this choice compared to others. Given that the deliberations of coordination bodies are not made public, the documentary evidence passed down to other actors are seminal to these actors' deciding whether and how to implement a policy. There needs to be the transfer of tacit information into formal,

[244] Kenneth Lieberthal (2011) Managing the China Challenge: How to Achieve Corporate Success in the People's Republic. Washington DC: Brookings Institution Press, p. 50. See also Lawrence, p.15.
[245] See Central Committee and State Council (2013)党政机关公文处理工作条例 ('Regulations of use of documents within Party and State organs'), , clause 16.4: 涉及多个部门职权范围内的事务，部门之间未协商一致的，不得向下行文；擅自行文的，上级机关应当责令其纠正或者撤销. ('For matters involving the scope of authority of multiple departments, the departments must negotiate together and must not communicate written orders to lower level departments; unauthorised communications to lower levels will result in higher-ranking bodies cancelling or revoking the orders').
[246] The author would like to thank Geremie Barmé for pointing this out, and for a number of illuminating discussions on this theme.

standardised information that can be applied homogeneously across the system.[247] This transfer of information into a concrete form also can act as a signalling device to the rest of the system as to how all its parts should respond to the command. The rank of the issuing body, and the authority of the document communicating the central decision are critical signalling devices.

But the next problem faced by the central bodies — as with any ruling body/ies — is ensuring that its decrees are followed.[248] For any given order, each actor decides whether to cooperate with orders from above or to defect and pursue its own interests or the interests of the organisation it is leading. The structure of the Chinese party-state aims to ensure obedience from each of these actors by reducing the incentives to "defect" (ie to not follow orders). As discussed above, following the issuing of orders, the system has a number of enforcement mechanisms to ensure that implementation occurs. the system holds the reins of all punishment mechanisms by making the major central enforcement bodies Party enforcement bodies, and by holding individuals personally accountable through Party mechanisms. There are enormous incentives to cooperate with any order from above; defecting can effectively be turning their back on a life of considerably greater comfort should they be forced to exit the Party.[249] The party-state also aims to reduce monitoring

[247] As noted by many, including Weber and Arrow, bureaucracies are organizations mainly run by rules. For a Chinese take on this, and on the importance of documents for this transfer of knowledge see Schoenhals *op cit.,* especially pp. 8-21

[248] See for example James Q. Wilson (1991), *op cit.,* p.309.

[249] Those with the rank of full ministers are assigned a car costing up to $71,000, with a full-time driver; provided state funds for the purchase of residences up to 2,400 square feet in size; and given access to exclusive health care, including single-person VIP hospital rooms and the convenience of having all medical bills automatically settled by the Ministry of Health. All those privileges continue for life, with health privileges being the most prized. Retired full minister-rank officials are also assigned a full-time secretary, again for life. See Qian Haoping, 中国有多少部级单位？ ("How Many "Ministerial-Level" Units Does China Have?"), *Nanfang Zhoumo* (Southern Weekend), February 16, 2012.

and verification problems by having almost all the leaders in the same place (Beijing), by bringing all important regional leaders to Beijing for decision making processes (see next section), and by ensuring that major decrees are the product of the *zhengguoji* coordination bodies.[250]

While these implementation mechanisms do not obviate the difficulties of coordinating multiple interests,[251] they do reduce the possibility that any individual actor is coordinating alternative interests, or forming factions, outside of formal coordination bodies. Hence, should any of the top coordination bodies come up with a coordinated position, and issue a specific notice to that effect, there are few incentives not to cooperate at the centre. Or, put differently, there are sufficient discipline and coordination mechanisms to make defection very difficult. Actors at the centre who can be easily measured are unlikely to defect or defy a direct order with some form of measurement attached to it.

But in most situations, there are less likely to be direct orders; rather, the Party indicates its policy preferences through changes in ideology, and the system is to respond through introducing policies that it feels best represents the centre's wish. This is shown in Figure 5 below. The shifts in ideological guidance (see the left hand side of Figure 5) trigger a cascade of responses by different actors within the system (indicated also on the left hand side).

[250] With the exception of provincial leaders, which are covered in the next section

[251] On coordination problems in Chinese politics, see Minxin Pei (2006) *China's Trapped Transition: The Limits of Developmental Autocracy*. Cambridge: Harvard University Press.

So, should the Party decide there ought to be a change in ideology or in how the Party sees the world,[252] it will document this new ideological guidance, or shift in the current ideological guidance. There must then be corresponding shifts within state practice (that is, within the system) in response to this change in ideology. The box in the left hand side of Figure 5 shows the different ranks of ideological pronouncements that the centre can make. These ranks are based on Party documentation. The order of the documents and ideological statements for Figure 5 is taken from the order listed in official documents, and from the 2013 *Central Committee Notification on the Use of Official Documents*.[253]

Responses to changes in ideology are themselves transmitted through another series documents, with a system of rank and authority that then carries throughout the whole Chinese governance system. So, as the right hand side of Figure 5 below (labelled "Document Issuance") shows, should the Party itself wish to take a new policy direction, or want subordinates to fulfil specific tasks, or wish to specify what it wants its response to ideological shifts to be, then it can do so through the use of particular types of documents, through the use of specific phrases[254] or through classifying documents as being more important. The issuance of documents is affected by Party rank — specific meetings, specific decisions and specific types of documents can only be released by bodies of a certain Party rank. Hence, agencies of too low a rank to issue decrees governing behaviour

[252] See Heath 2014, *op cit.* for a more comprehensive description of this phenomenon.
[253] Central Committee and State Council (2013)党政机关公文处理工作条例 ('Regulations of use of documents within Party and State organs').
[254] Such as the declaration of things to be 'important tasks' —重要任务要任务 as compared with the declaration of things to be 'strategic tasks' 战略任务

must take their problem to the *zhengguoji* governing bodies[255] in order to have an authoritative decision made and communicated throughout the system. This is shown in Figure 5; all bodies of the party-state are dependent on the Central Committee's issuance of ideology or documentation before they can then issue their own documentation.[256] And all bodies must follow documentary orders from bodies of a higher rank.

This gives tremendous power to the parts of the system with the authority to change ideology, or with the ability to issue binding decrees (see "Document Issuance" on the right hand side of Figure 5). Actors with the same rank cannot issue binding orders to each other, regardless of the policy issue, and so should the ideological foundations of any debate where there are multiple interests or the problem cannot be solved must go up to a higher coordination body for resolution.[257] Higher coordination bodies are then able to signal their preferences through the issuance of documents.

The role of signalling higher-level preferences through the issuance of documents makes the specificity of the order from above yet more important. Specific orders from above with clear targets, accountability systems and defined measurements put lower level parts of the system under tremendous pressure to fulfil these central decrees. Yet unclear,

[255] This can occur through the use of official notification documents *tongzhi* or through official reports *baogao*.

[256] See Central Committee and State Council (2013)党政机关公文处理工作条例 ('Regulations of use of documents within Party and State organs'), , clause 16.4: 涉及多个部门职权范围内的事务，部门之间未协商一致的，不得向下行文；擅自行文的，上级机关应当责令其纠正或者撤销. ('For matters involving the scope of authority of multiple departments, the departments must negotiate together and must not communicate written orders to lower level departments; unauthorised communications to lower levels will result in higher-ranking bodies cancelling or revoking the orders'). In other words, if anyone else has an interest in an issue, it must go to a higher-ranking body.

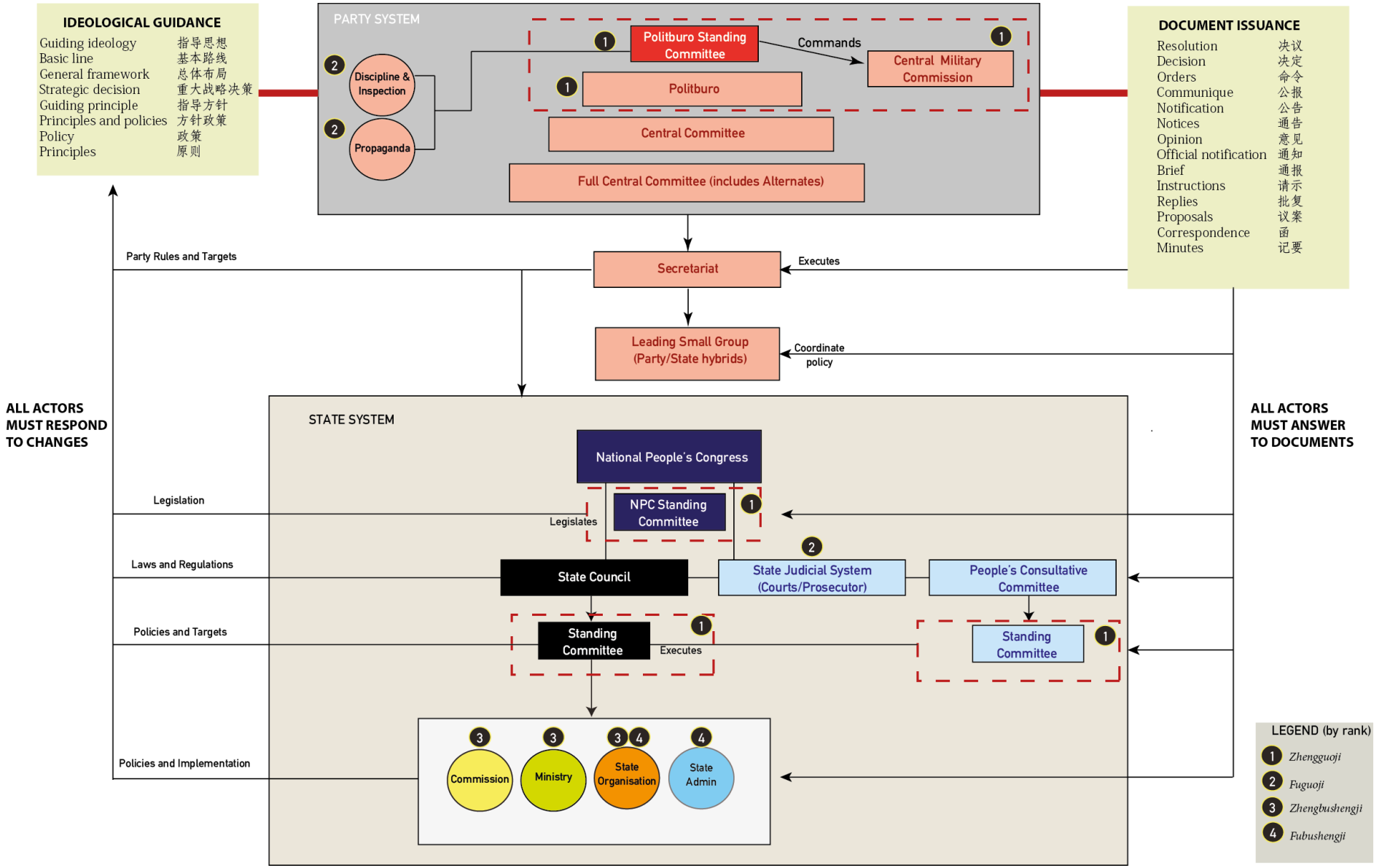
[257] Thanks to Linda Jakobson for pointing this out — see L Jakobson and D Knox (2010) *New Foreign Policy Actors in China,* SIPRI Policy Paper No. 26, SIPRI: Helskinki, for further information.

but important orders from above can often stimulate policy competition as different agencies or parts of the party-state compete to see how to best express their interests in the terms of the latest decree from above. Broad policy directives may set or alter the broad ideological direction of the state, as well as update lines of thinking, change types of policies, or outline and alter broad strategic goals. These shifts force subordinate bodies to specify how they will change the current policies within their area of interest in order to best respond to the new thinking, and new decrees. So policy is often developed by subordinate agencies in the 'spirit' of a major central ideological program or change,[258] as subordinates can choose to meet this 'demand' for certain policies through reading the approved documents and preparing responses for higher level leaders in the hope that it might be picked up.[259] Figure 5 below illustrates how this works.

[258] *jingshen*. Heath (2014), *op cit.,* p.196 expands on this idea

[259] Informally, a note (报告 *baogao)* asking for guidance; formally, through an official notification 通知 *tongzhi* asking for clarification.

Figure 5: Document order in China's central governance structure
Source: Author's own research and schema



How the institutional rules of the central system affect behaviour

The formal structure alters the behaviour of actors within the Chinese central system. For example, while the system is able to prevent factions from developing by forcing the most important issues to be discussed in coordination bodies rather than delegating decision making authority down to the relevant agencies, this also presents the problem of forcing lower-ranked actors to always go up to coordination bodies of higher rank in order to prosecute policy interests. This competition will occur under the rules outlined above, and illustrated in Figure 5.

This consensus-based central governance system makes it difficult for actors to collude or coordinate positions outside formal coordination bodies. Senior leaders are not encouraged to meet individually with other leaders and form coalitions on policy positions. Rather, coordination is structured to occur in the meetings of the highest coordination bodies described above. Powers can then be formally delegated to lower-ranked bodies. For example, should a policy position be agreed upon by the Central Committee's delegates (the Politburo and/or Politburo Standing Committee), the Secretariat can communicate the decision to any other group or decision maker.[260] Similarly, once a decision is made by the highest coordination body, then the decision on how best to communicate it can be made. The communication of decisions occurs through a combination of rank and document issuance. This system is designed to ensure that the major Party bodies, the highest ranking bodies, make the policy decisions.

[260] Interview, Organisation Department cadre, 2009. The Politburo Standing Committee, Politburo and Central Military Commission all meet far more regularly and distribute their orders far more regularly (through the Secretariat) than the Party Central Committee.

State organisations implement and execute policy. Despite being, in principle, subordinate to Party organisations, state organisations can heavily influence policy through leading the implementation of any ambiguous policy 'goals' coming from above. State organisations have considerable scope to implement policy, although less to frame and set policy.[261] State organisations' role in drafting rules, regulations, laws and implementation directions can also give them enormous influence over the final shape of policy. But the higher rank of the *zhengguoji* bodies' allows them to reduce slippage of authority for any order or policy direction they wish. Should they wish, they can designate actions as being 'settled';[262] they can force meetings to focus on implementation;[263] they can release decrees with specific targets and responsible parties; and they can issue official notification that a policy or opinion is now official guidance, and must be followed as directed.[264] In these ways, the authority of an order provided from above shapes the ability of subordinate bodies to interpret the order.

In this way, central orders can take the form of an authoritative statement with specific metrics of performance attached[265] — akin to a complete contract when all parties specify contingencies and property rights, rather than a less formal, incomplete contract.[266] The interests of senior leaders can be translated into targets by the Secretariat and Organisation

[261] This tension is the origin of the classic idea of China having a 'fragmented' authoritarian system: see Lieberthal and Oksenberg (1991) *op cit.*
[262] Usually through a 'decision', *jueding,* which makes clear that there is to be 'no experimentation' — see Heath (2014), *op cit.* p. 188.
[263] The Central Work Conference, for example, or a National Work Forum.
[264] This can be done through an official notification 通知 *tongzhi;* or through a change in guiding principles *zhidao fangzhen* 指导方针.
[265] Most commonly this is done through a policy *zhengce* or notification *tongzhi.*
[266] A complete contract is that in which all parties agree and specify their respective property rights and duties for any possible future state or eventuality that may occur. See Oliver Williamson (1996) *The Mechanisms of Governance*. Oxford University Press: Oxford.

Department.[267] Within the centre in particular, coordination bodies can decree orders to be implemented completely and totally as demanded.[268] While such specific pronouncements and targets are rare (although, as we shall see in Chapter 7, they do occur), senior coordination bodies also have the power to call meetings, create work forums, or give speeches associated with specific workshops in order to outline how subordinate bodies should implement policy decisions.

But, within the coordination bodies themselves, each member is of a similar rank, and decisions must be unanimous. building consensus for any policy initiative is considered essential.[269] Any interests held by an individual *zhengguoji* rank leader must be coordinated with the interests of other members of the coordination body.[270] Without total consensus within a coordination body,[271] a final decision cannot be made and issued. Given this structure, it appears reasonable to view decrees at this level as the collective revealed preference of the central leadership. The issuing of a formal decree from these governing bodies allows us to treat these decrees as their revealed preference.

Given this, while this system of political organisation can lead to considerable inefficiency for the Chinese party-state itself, it has a theoretical advantage for the scholar. The advantage is that we can take the central coordinating body's position as the revealed

[267] Interview, central Organisation Department senior cadre, 2009.
[268] Through *mingling* for the most senior two leaders; through resolutions (*jueyi* or *jueding*) for the Central Committee.
[269] See William Joseph (2012) *Politics of* China. Oxford University Press: Oxford, for example
[270] Normally, the Standing Committees of the State Council, Central Committee, National People's Congress.
[271] The *yipiao foujue* rule. See for example Wu Xiaolin (2009) '小组政治' 研究:内涵、功能与研究展望', ('Small group governance: documents, function, and research prospects') *Qiushi*, issue 3, available online: http://www.usc.cuhk.edu.hk/PaperCollection/Details.aspx?id=7149.

preference of the centre. In most political studies of policy in China we look at the different policy preferences of senior leaders, be they the head of the Party, the minister for health etc. Examining the interactions between different actors centrally, and disaggregating their individual preferences, is undoubtedly of considerable use to political and policy studies. But this has a problem in that the deliberations themselves are kept secret. There are a number of studies examining this area, and most importantly of all, we actually can't know what was said behind closed doors, or know who really made the vital speech or whispered in the right ear at the right time. Furthermore, what is released to the public is almost always released in memoirs or official document collections, and there are some serious issues with our ability to believe exactly what is written in these documents.

Taking the central bodies' preferences as set when they release the documents and then analysing the rank and type of the document issued allows a form of reliable measure for the power and clout of any implementation order. For each order, a scholar can note which body/ies of the central system issued the document, the rank of that body/ies, and the rank of the document itself. These classifications are all on the public record and are released by the Party itself; moreover, they are the way that the state itself judges the gravity of the central position. For the local actors, the more senior the rank of the issuing body, and the higher the classification of the document issued, the more powerful the incentive to follow the order of implementation.

For ministries, while their interests (and thus the interests of their minister) can change, the rank of their minister (and thus the *de facto* rank of their ministry) does not

shift, no matter how many interests are added to their ministry.[272] Thus, there competition between ministries at the central level to compete with others of the same rank for the favour of the *zhengguoji* bodies. This is because, while ministries can issue their own rules, they are always superseded by any orders or comments issued by the *zhengguoji* bodies. So a change in ideology or the issuance of documents from above by a senior ranking body will trigger competition for ministries — as they will be forced to respond to a change of direction in the *zhengguoji* bodies, or to implement specific policies passed down by *zhengguoji* decree.

Some common strategies used by ministries in response to this institutional environment are to compete with all other bodies at the same level or rank as one's body's rank in order to capture or draw the attention of the senior leader or full coordination body to one's policy interest. Higher bodies can then alter the directive — or issue another directive that outranks the previous directive — that prosecutes this interest.[273] Another strategy is to build consensus among other bodies before submitting proposals to higher bodies — for example, through finding a more senior organisation, or leader, with similar interests.[274] Or else the ministry can join with a number of other organisations of similar rank to form a coalition around an interest, and then take this "bloc" to a more senior

[272] For example, the five so-called 'super-ministries', formed out of a 2008 administrative reform, although many argue that the Ministry of Industry and Information Technology was the only true winner from this reform. Another example can be seen in the creation of the Ministry of the Environment out of the former State Environmental Planning Agency, with the new ministry going up a rank). Thanks to Graeme Smith for pointing this out.
[273] Lawrence (2012), *op cit.* p.30
[274] But the members of coordination bodies are not meant to represent any interest groups, nor any specific interest. However, this could also be taken to extremes: Li Peng famously declared at an early press conference in 1988 that his hobbies were being a communist party cadre, and in his spare time he solely read Marxist-Leninist thought. Geremie Barmé, launch of *Red Rising, Red Eclipse*, Australian National University, November 2012.

organisation, or leader, with similar interests.[275] The development of new policy interests by central leaders can allow lower-ranked bodies to be seen as more credible on a particular issue, and thus gain powers that are not represented in the formal structure.[276] Finally, should an interest gain a place on a Leading Small Groups (LSG), they can prosecute their interests within the LSG and possible elevate the issue or shape the implementation of a policy. But in all these cases, the basic structure of decision making remains forced by the party-state's organisation: the lower levels must compete and coordinate among themselves and then submit to a higher level in order for the binding decision to be made.

This response to the structure allows us to draw some initial conclusions about the likelihood of a given policy being implemented. Decrees by the highest bodies are the most authoritative. The more specific the implementation targets within the decree, the more likely for them to be adopted as pronounced. This structure has considerable consequence for the strategies used by players within the Chinese central system.

But this situation changes are you go down the hierachy of the party-state. Lower levels are more difficult to monitor. And should they be given a specific order, it is easier for

[275] For example, the joining of State Planning Commission, Ministry of Agriculture, Ministry of Civil Affairs interests in countering the 1997 launch of social health insurance; see Cao Pu (2013), *op cit.* p. 191.
[276] In banking, for example, Bell and Hui argue that while the National Development and Reform Committee (NDRC) outranks all ministries, regulators, and banks, the People's Bank of China (PBoC) managed to be put in charge of many of the administrative functions of the Chinese monetary environment by arguing that it was the only group able to understand how these functions would affect the economy. Stephen Bell and Hui Feng (2013) *The Rise of the People's Bank of China: The Politics of Institutional Development in China's Monetary and Financial Systems,* Harvard University Press: Cambridge, MA. To give a quick example, today, the head of the PBoC is considered enormously powerful worldwide — Zhou Xiaochuan, its current head, has been steadily ranked in the top 15 in the Forbes magazine 'most powerful people in the world' list for a number of years. But Zhou is barely in the top 100 most powerful people in the Chinese Communist Party.

lower levels to try and manipulate the order by "cooking the books" or meeting the target numerically. Following sections will discuss how these manipulations affect China's governance structure at lower levels of government.

China's subnational governance system

Subnational governments down to the county level have a different political organisation from that at the centre. The central governance system in Beijing issues the decrees that the whole system is to follow, and its focus remains on optimising control from above, and ensuring that its orders are followed.[277] The system of control and coordination changes the incentives for local governments to implement policies; the incentives give almost total power to the local Party secretary and his/her standing committee.

The critical feature of the Chinese governance structure below the central level is the simultaneous existence of both horizontal and vertical control mechanisms for almost all actors in this level. The provincial system contains almost all of the same actors as in the central system[278] — as China has a Leninist political system, each of the major bodies represented on central bodies above must have a provincial counterpart. [279] So the central

[277] See for example Hu Jintao's outgoing speech at the 18th Party Congress on strengthening Party reform (available online: http://news.xinhuanet.com/english/special/18cpcnc/2012-11/17/c_131981259_2.htm); a similar line has consistently been followed by Xi Jinping.
[278] Excluding the Presidency.
[279] Some central bodies do not need a formal provincial counterpart. The People's Consultative Conference, for example, has a provincial counterpart, but no ability to provide binding decisions or recommendations at a subnational level, and the provincial committees do not have to formally report to the central bodies. Under Article 19, Section 2 of the Charter of the Chinese People's Political Consultative Conference, the relationship between the National Committee and the regional committees is a relationship of guidance (no

Ministry of Health will usually have a provincial Ministry of Health, a prefectural Ministry of Health, and a county Ministry of Health.[280] And almost all actors at the local level have a system of dual reporting — one report is horizontal (across to the Standing Committee and Party Secretary of the local polity) and one vertical (up to the corresponding body in the level above — that is municipal to provincial) (see Figure 4).

The crucial actors making this system work are the two most senior leaders at each political level. Unlike all of the other actors at that political level (who report both across and up), the two most senior leaders only report vertically, to the level above. Consider the circumstance of provincial leaders.[281] A Provincial Party Secretary and Governor are also members of the Central Committee; they therefore answer solely to *zhengguoji* or *fuguoji* leaders[282] in Beijing (as their vertical report under the system of rank). Other parts of the central system (such as ministries, commissions, organisations) cannot pull rank on these provincial leaders.[283] They can only be controlled vertically from Beijing.[284] Similarly, a municipal Party Secretary and Governor would only be measured vertically by the provincial-level Party Standing Committee ("PSC").

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direct leadership). So are the relationships between upper-level regional committees and lower-level committees. Operating budgets on each level are independently administered by the financial administrations for the region, making the National committee and all regional committees separate individual entities. Similarly, the State Presidency only exists centrally.

[280] Some provinces skip the prefectural, though the point remains the same.

[281] The province is the political level below the central.

[282] Provincial leaders are assessed and promoted by the central Party bodies (*fuguoji)*. The Central Party can also send Central Committee Discipline and Inspection Commission (CCDI) teams into provinces to investigate corruption allegations against provincial agents — as long as this is signed off by the head of the CCDI, a Standing Committee member (who outranks all provincial leaders). The Central Party can also send the General Auditor's Office into provinces to conduct audits. Susan Lawrence, *op cit.*

[283] Indeed, provincial party secretaries for particularly important areas are *ex officio* members of the Politburo — this is the case for Beijing, Guangdong, Chongqing, Tianjin, Shanghai.

[284] And even then it can be complex — note the Bo Xilai case and the need to have it signed off by the PBSC; Jamil Anderlini (2012) *The Bo Xilai Scandal: Power, Death, and Politics in China.* Penguin Books: London.

This unidirectional report for the top two leaders of any political unit has advantages in terms of monitoring and enforcing the behaviour of local cadres. The major provincial leaders (Party Secretary and Governor) are members of the Central Committee in Beijing, allowing the centre to keep a close eye on them, and making them subject to — and a part of — the authority of the central government. This vertical control and enforcement means that individual provincial leaders are likely to be highly focused on the concerns of the highest coordination bodies only. The centre tightly monitors these provincial leaders — then sets goals for them and delegates almost all powers down to the leaders,[285] but holds them personally responsible for failures that occur within their province.[286] This system of accountability means that the two most senior provincial leaders are unlikely to defect from central vertical instructions. There are very few incentives to deviate from orders from above, should such orders be received. The centre's leverage is increased because provincial leaders compete with each other (horizontally) for promotion.

In return, Beijing delegates down to these two leaders — and their standing committees — almost total control over the levers of government in their province. The Party Secretary and Governor outrank all other actors, and control all of the important incentives within the province. They become the principals for the whole province, and all other actors within the governance system are effectively their agents. While the other actors have other reports (ie the provincial health ministry reports across to the standing committee (PSC) and up to the central health ministry), the horizontal report into the standing committee

[285] At each of these levels, these leaders are given the power to issue orders in whatever way they wish — for example, they have the power to issue laws or regulations.
[286] Carl Minzner (2009) 'Riots and Cover-Ups: Counterproductive Control of Local Agents in China' *University of Pennsylvania Journal of International Law*, pp. 53-125.

(PSC) sets promotions, punishments, and enforcement institutions. This makes the horizontal report much more significant for actors than the vertical report.

The provincial leaders control provincial Party standing committees (PSCs). The standing committee contains the leaders who are the heads of the provincial equivalents of the major central coordination bodies,[287] headed by the two provincial leaders.[288] The provincial Party Standing Committee (PSC) is marked on Figure 6 below with an "A". The two provincial leaders can be held personally responsible for the behaviour of the standing committee. Through the standing committee, the provincial leaders can control the means of evaluation, promotion and discipline.[289] All other agencies (ministries, organisations, SOEs, etc.) must have a Party committee that controls 'political decisions',[290] oversees ideology and has the final say on personnel decisions.[291] The Party committees of these many other parts of the provincial party-state must all report to the equivalent body vertically, or to the PSC horizontally. These bodies are marked on Figure 6 with a "B".

At each level down to the county this system replicates itself. So for the county Party secretary, they report to the level above (the prefecture or province) in the same manner that the provincial Party secretary reports to central leadership in Beijing. And the system

[287] The equivalent of the State Council Vice-Premiers at provincial level, each with specific roles; and the provincial heads of the Party Organisation Department, the Party Propaganda Department, and Party Discipline and Inspection Committee.
[288] Contains members from CPPCC and NPC (usually these roles are taken by people who are already on the Standing Committee). See, for example, the Shanxi standing committee described here: 山西官场补缺完成13名常委班子成员排序, available online: http://news.163.com/14/1010/08/A86CSTNF00014SEH.html
[289] This is because the heads of the provincial Party Organisation Department and the provincial Discipline and Inspection Committee are *ex officio* members of the provincial standing committee. This means that these Party bodies are ranked above all of the other actors in the system at the same political level.
[290] Usually thought to be any decision that the Party thinks is important
[291] In most cases, the Minister or Chairman serves concurrently as the head of his organisation's Communist Party committee.

of the standing committee controlling the rules for all of the actors at that political level also remains the same. Figure 6 below illustrates, and shows how the structure constrains actors at each level of the party-state down the county.

From the perspective of the Party at the centre, this system is likely to have evolved in response to a considerable principal-agent problem, and particularly, to prevent the development of factions opposing their control.[292] As Tirole notes, formation of coalitions unambiguously decrease the efficiency of the vertical structure.[293] Central bodies hold far less information and have far less ability to enforce any demands at local levels (see below for more on this). The local system is, in many ways, a logical response to these problems of management. [294] The two top leaders at any political level are tightly controlled vertically to prevent the undermining of central control while still giving the local government discretion. Hence, there are very few coalitions between local government heads, because the system is designed to prevent them. An individual government head competes with other local government heads of the same rank, measured by the PSC the level above. This competition means that there are few incentives for local government heads to collude with one another horizontally; as local heads are monitored, assessed and promoted from

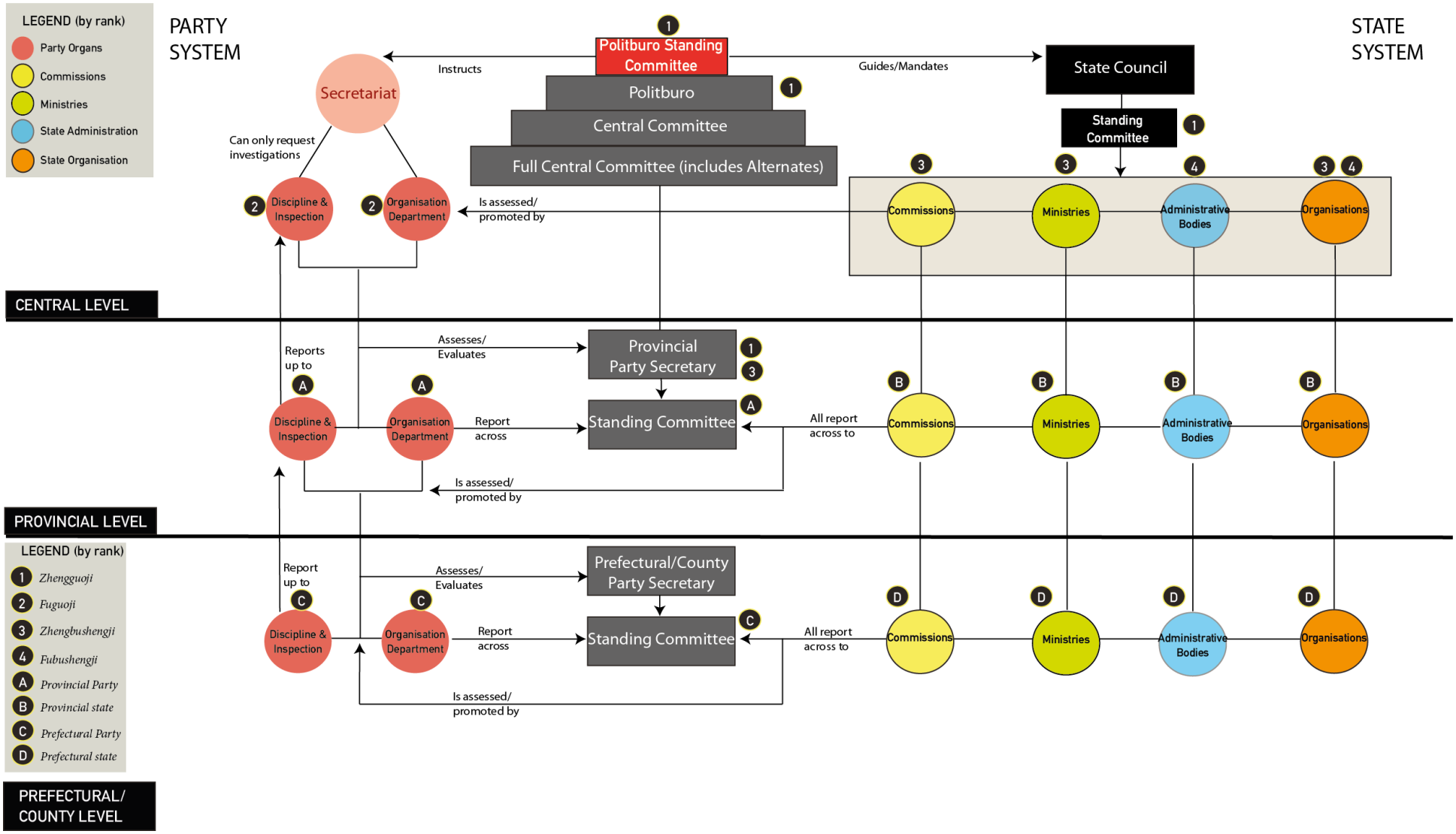
[292] Mao (1945) 'Decisions on Several Questions of Party History', speech to 7th Party Congress, April 24, available online: www.marx2mao.com/PDFs/MaoSW3App.pdf; see also: "From the Journal of Ambassador Pavel Yudin: Memorandum of Conversation with Liu Shaoqi and Zhou Enlai," March 09, 1954, History and Public Policy Program Digital Archive, Archive of Foreign Policy of the Russian Federation (AVPRF) obtained by Paul Wingrove.
http://digitalarchive.wilsoncenter.org/document/111377

[293] Tirole (1995) *op cit.*

[294] Partly, this system is a legacy of previous systems. Fewsmith has argued that 'this [system] served the CCP well during the revolution: cadres at higher levels were unable to monitor subordinates who were far away. Instead they delegated authority and held the individual responsible for what happened beneath them. In return, the individual sought significant freedom to manage subordinates and affairs in the way that he/she saw fit.' Joseph Fewsmith (2013) *The Logic and Limits of Political Reform in China*. Cambridge: Cambridge University Press, p. 43.

above, collusion with a fellow local government head is a potential blockage to future promotion or reward. Provincial leaders themselves can focus their attentions on the leaders the level below them (municipal/county level) — and a similar dynamic of competition occurs at that level. In this way, vertical control of the leaders of the Party standing committees continues down *seriatim* from centre to province to prefecture to county.

Figure 6: Governance structure and coordination bodies by rank
Source: Author's own research and schema



How subnational governance institutions can influence behaviour

This structure of authority and responsibility shapes the behaviour of officials and Party members throughout the system. It also means that local leaders and standing committees are far more responsive to concerns vertically up the line.[295] Vertical assessments are highly effective in controlling or 'pressurising' local leaders,[296] who in turn have authority — and the rule-making power — to 'pressurise' the rest of the local system, because all of the local system at that political level has to report in to the PSC. This confers tremendous formal power on a select, heavily monitored elite, in the same way that the central system confers tremendous formal power on the *zhengguoji*-ranked leaders.

So a select few who get to set the targets are able to set incentives for the many who have to follow the targets.This system means that 'for a task to be vigorously and consistently pursued by local leaders it must be assessable by higher levels',[297] and that 'local officials are extremely sensitive to bureaucratic fiats and policy shifts'.[298] This is because should an agent the level below fail to meet a target — of which, should we include

[295] Zhou Xueguang (2010) 'The Institutional Logic of Collusion among Local Governments in China. Modern China, vol. 36, no. 1, pp. 47-78: 'The measures of 'achievement' are the primary interest of the top Party leaders in any political unit — In the past, a policy would undergo a certain process of experimentation and evaluation in selected localities before it was formally adopted. But now our superiors are anxious to have "political achievement." … All that he is concerned about is the outcome, and not the process how you will get it done.'

[296] Zhao Shukai (2012) '地方政府公司化: 体制优势还是劣势?', 文化纵横, ('Local government corporatisation: is the strength of the system also its weakness?, *Cultural Review),* vol. 2.

[297] Gang Guo (2007) 'Retrospective Economic Accountability under Authoritarianism.' *Political Research Quarterly*, vol. 60, no. 3, pp. 378-390.

[298] Xueguang Zhou and Wei Zhao (2012) "Social Science Research on Chinese Organizations in the English Literature." in *A Scholarly Review of Chinese Studies in North America,* edited by Haihui Zhang, et al. Association for Asian Studies, Inc. Asia Past & Present: New Research from AAS, Number 11, pp. 1912-231 see especially p 1215; Xueguang Zhou, Hong Lian, Leonard Ortolano and Yinyu Ye (2013) 'A Behavioral Model of "Muddling Through' in the Chinese Bureaucracy.' *The China Journal* (July) 70: 120-147.

direct and indirect targets, there are thousands for the average local leader — then the agent can be held responsible under strict liability.[299]

Within this political structure, there are a number of general rules influencing the behaviour of individuals. There are a number of rules forcing local actors to rotate their position, placing a time limit on their tenure and forcing them to avoid serving in their home region. This makes many cadres able to be 'time-sensitive' to how long tasks will take, as should an individual be transferred before a task is completed, the task becomes a problem for their successor rather than themselves.[300] This system creates an incentive for short-term, measurable goals at the expense of long-term prospects,[301] as actors are able to use short-term "wins" to try and get themselves promoted (preferably before any long-term problems become clear).[302]

[299] As Minzner argues, this target-based, strict liability system is a by-product of the Chinese governance system itself. Targets and evaluations are fundamental to how the Chinese government addresses principal-agent problems. This makes setting numerical, verifiable targets for vertically-managed leaders, and then holding them personally accountable for any failures, very attractive. To quote Minzner:
Mine disasters can be covered up; investment figures can be altered. But doing so requires hiding bodies, forging bank records, and paying off the relevant people. It is certainly more difficult than simply lying about one's own performance in a qualitative report ("Yet another outstanding year again, boss") or altering statistics that are entirely within the control of local officials (number of work conferences held)… Evaluating these claims requires access to information under the control of local officials—information that can be difficult or impossible for central officials to obtain. Strict liability resolves these problems by limiting the need for central authorities to engage in complex fault- based analyses. Minzner (2009), *op cit.*
[300] The most comprehensive overview, including some empirical analysis, is Sarah Eaton and Genia Kostka (2014) 'Authoritarian Environmentalism Undermined? Local Leaders' Time Horizons and Environmental Policy Implementation in China', *The China Quarterly*, Vol. 218, pp 359-380.
[301] O'Brien and Li note that one Henan county leader ordered every village in his jurisdiction to set up a paper mill within a year. Some one hundred paper mills were built and the county leader received a promotion on the basis of his economic accomplishments, but when the mills went bankrupt, and their environmental consequences became clear, the county leader had already been rotated to another county, presumably having reaped the career benefits of his earlier "successes." Kevin J O'Brien and Lianjiang Li (1999) 'Selective Policy Implementation in Rural China.' *Comparative Politics*, pp. 167-187.
[302] Sarah Eaton and Genia Kostka (2014), *op cit.,* pp. 359-380.

This system also greatly concentrates the ability to get things done in a number of individuals.[303] The system gives local leaders — and their delegates, the Standing Committee — control over almost all of the rules that affect actors within the Chinese state. The most important of these institutions is the personnel management system. Standing committees have the ability to assign staff through their control of the Party's organisation bureau[304] and its subsequent control of the assignment system for all Party cadres (*jigou bianzhi*)[305] and other public servants.[306] Organisation departments compile job descriptions and evaluations of candidates for any position. The Standing Committee then has the right of the final say or review of any key appointments.[307] A number of field

[303] As Tirole notes, this power can also be used to generate favours. This use of authority to generate favours as an informal institution has been extensively covered in the literature.
[304] Kjeld Erik Brødsgaard, "Institutional reform and the *bianzhi* system in China," *The China Quarterly,* No. 170 (June 2002), p.364. See also Mertha (2005), *op cit.,* and Melanie Manion (1993) *Retirement of Revolutionaries in China: Public Policies, Social Norms, Private Interests.* Princeton University Press: Princeton.
[305] This control occurs through the head of the organisation bureau having an *ex officio* role on the standing committee, and through the party secretary being able to assess the performance of the head of the organisation bureau as a result. The organisation bureaux have, as Graeme Smith puts it, 'a major say in any appointment above the rank of tea lady'. Graeme Smith (2013) Measurement, promotions and patterns of behavior in Chinese local government, *Journal of Peasant Studies,* vol. 40, no. 6, pp. 1027-1050.
[306] As Smith's study of a local county notes 'the head of the (state) Personnel Bureau is always the deputy Party secretary of the Organization Bureau, a clear indication of his/her relative importance. Effectively, the Personnel Bureau serves as an extension of the Organization Bureau.' Graeme Smith (2007) *The political economy of agricultural extension in rural Anhui, China*, PhD Dissertation, Australian National University: Canberra, p. 72.
[307] Standing Committees are responsible for the final signoff on any major personnel decision — see Hillman commenting at the county level: 'The final decision over leading cadre appointments rests with the Party Standing Committee, which … has become more powerful since administrative reforms in 2004 required it to cast formal votes for senior appointments (previously, the Party Secretary signed off on appointments single handedly).' Ben Hillman (2005) *Politics and power in China : stratagems and spoils in a rural county,* PhD Dissertation, Australian National University: Canberra, p. 14.

studies argue that this gives the committee, and particularly the Party Secretary,[308] considerable power over subordinates.[309]

Control over appointments means control not only over new jobs, but also control over the job classification of all staff, and also control over how many staff are allowed in any given organisation.[310] Control over staffing also gives the Standing Committee control over the budget and revenue targets of any body.[311] This is because budgets are directed with reference to the numbers of personnel, rather than the numbers of personnel being determined by the budget.[312] Thus, whoever controls the ability to specify the number of personnel controls the revenue targets of different organisations. Control over appointments also determines a high level of control over public servants' working conditions.[313] All of these institutional powers provide standing committees with almost

[308] Too much power is vested in the "first-in-command" (*yi ba shou* 一把手). If I'm the county Party secretary, and I recommend someone for a post, will that carry the same weight as another county leader? I'm the Party secretary, so all candidates who've been recommended or who are seeking posts will come knocking. Whatever I say, the Party Organization Bureau will obey. Procedures are there in name only. Lines of authority that are there on paper don't exist. *These problems are systemic*. Graeme Smith (2007), *op cit.,* p. 83.

[309] Zhou Xueguang's study of 'W' county, for example, argued that local Party secretaries could 'set the direction' through saying who they wanted to be in a position to the Organisation Dept. — and, should the Organisation Dept. refuse, instead give them criteria for the position that so closely fit the person they wished to be in the position that only that person could be appointed. Zhou Xueguang (2004)*中国县级行政结构及其运行： 对W县的社会学考察*, 贵州人民出版社 (*China's county-level administration and structure: A study of W county*, Guizhou People's Press).

[310] The Standing Committee is able to outline the authorized number of personnel for any 'administrative organ, service organisation or a working unit (*danwei)*', and in doing so, 'determin(es) which functions the state should take care of and which should be handed over to society'. He Xingyan (1993), translated in Michael Dutton (1999) *Streetlife China*, Oxford University Press: Oxford, pp 42-61

[311] Article 17, Law on NPC Standing Committee and Local Government. 'Where … the budget needs to be partially adjusted during implementation, the State Council and the local governments at or above the county level shall submit a plan … Adjustment of budgetary funds between different headings shall strictly be controlled. Where the funds arranged in the budget for agriculture, education, science and technology, culture, public health, social security and the like need to be reduced, the State Council and the local governments at or above the county level shall submit the matter to the standing committees of the people's congresses at the corresponding levels for examination and approval.'

[312] See for example Kjeld Erik Brødsgaard, "Institutional reform and the *bianzhi* system in China," *The China Quarterly,* No. 170 (June 2002), pp. 361-362

[313] As Graeme Smith argues, if staff are classified as 'administrative officers' (*xingzheng ganbu*), rather than 'technical officers', they are far less likely to lose their jobs. Smith cites Li Changjin (2006) "Nongji tuiguang

total control over promotion and evaluation, and, in essence, with almost total control over the career prospects of everyone within that political level. In other words, the standing committees control the incentives at any given political level.

The ability to determine who works where and what they do gives local leaders the ability to prioritise tasks. When orders from above are directed to local leaders as particularly important or significant,[314] they can draw resources from anywhere within the local government system to fulfil these orders.[315] Staff can be reallocated from one area to another anywhere in the jurisdiction. The family planning offices for example, can almost always bring in personnel on short notice.[316] But this is a phenomenon that is not unique to the family planning offices.[317]

Aside from these broad powers, standing committees also control the regular evaluations of staff members (through holding the ability to sign off on any evaluation by the organisation or personnel bureaus). This evaluation system functions as an incentive

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zhi tong [The Difficulties of Agricultural Technology Extension]," Sannong Zhongguo [Rural China] Vol. 8, No. 2 (2006), p. 137. Smith also notes with regards to these *xingzheng ganbu* that 'these are workers who are considered somewhat similar to Western bureaucracy's 'policy officer'. See also: interview — Organisation Department, Beijing 2009; county-level government employee 2013.

[314] These priority targest are usually those classified as being *yipiao foujue*. Edin *op cit*, among others, gives a background of *yipiao foujue* and its impact on the *zhibiao*

[315] This ability of local governmental organisations to easily expand their staff for short periods may be a possible explanation for what Heilmann and Perry called Mao-style 'adaptive governance', whereby small trial projects are worked on intensely and there are constant small 'mobilisation' campaigns or rapid retasking in response to crisis. See S Heilmann and E Perry (eds.) (2011) *Mao's Invisible Hand: The Political Foundations of Adaptive Governance in China*, Harvard University Press: Cambridge MA.

[316] Other studies attribute this to both family planning's status as a *guoce* or national priority policy (see Greenhalgh (2008) *Just One Child: Science and Policy in Deng's China*, University of California Press: Berkeley) and to its ability to be easily monitored and checked up on (see Zhao Shukai (2012) *op cit)*.

[317] Yuen Yuen Ang notes that 'education bureaus "borrowed" teachers from public schools to work in the bureaus as administrators … [n]ot only would the education bureau not violate the administrative hiring quota, "the schools will have to pay for them [the borrowed personnel]"'. Yuen Yuen Ang (2010) *State, market, and bureau-contracting in reform China*, Stanford University, Stanford, California, p. 138.

and steering system to ensure actors behave the way the centre wishes; as a control and pressure system; and as a feedback mechanism for policy implementation.[318] Promotion either up the bureaucratic ladder, or across to a position in an area which offers them a 'comfortable life'[319] is based on one's evaluations. [320]

All these powers give local leaders an enormous amount of discretion to translate orders from above in a way that may suit their interests. Moreover, as local leaders report solely to (and are monitored by) the vertical level above, the interests of the local leaders are likely to be closely tied to the incentives passed down by the level above. Local leaders and the PSCs they command then translate these orders from above, with their varying levels of specificity, into targets for the area under their jurisdiction (that is, they take the order from the vertical level above and translate it into orders for all the actors at that level horizontally). This system means that there is scope at each political level to develop policies or interpret unspecified directives in their own way. This is because these local leaders are able to translate these orders in documents from above into targets for all the other actors at their political level. Similar to how ministries must 'compete' to meet ideological shifts mandated from above, local leaders too must show a response to orders from above. The magnitude of this response is dependent on the classification of the document, and the authority of the body that issued the document.

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[318] Gao (2007) *op cit.* notes the 1995 Notice on Strengthening and Improving the Evaluation of Work Accomplishment of the Leadership Corps of Party Committees and Governments at the County (Municipal) Level remains the primary document outlining how the centre assessing the actual work achievements of the local leadership corps.

[319] See Jean Tirole, Mathias Dewatripont, and Ian Jewitt (1999) 'The Economics of Career Concerns, Part II: Application to Missions and Accountability of Government Agencies' *Review of Economic Studies*, vol. 66, pp. 199-217.

[320] Susan Whiting (2000) *Power and Wealth in Rural China: The Political Economy of Institutional Change.* Cambridge: Cambridge University Press.

In this way, China's system is a far more documentary governance system that one may assume *ab initio*.[321] The documents themselves can then, without any further explicit intervention from above, alter or constrain the behaviour of local actors.[322] There can be significant variation in policy as it is passed vertically down each level of the political structure. Shifts in policy direction using central documentation set off a chain reaction through the different political levels. This is because different actors can use central decrees to attempt to prosecute their policy interests with their relevant standing committees. Lower-level actors are able to interpret any ambiguity in language of central (and provincial or lower level) orders and instructions as to how to implement them in increasing detail. For the centre, the only way in which to mitigate divergent outcomes is to tighten its ability to hold local leaders responsible — and they can achieve this by using personnel-system-based coordination mechanisms (ie targeting individuals) or through using more detailed documentary specification.

The structure of this leader-focused, document-driven system of accountability greatly constrains all other actors within the system. It changes how commissions, ministries, administrative bodies and organisations implement policy. They have very few powers. And as they need to accept both horizontal and vertical command, they receive multiple

[321] A judgment that is at odds, for example, with Graham Allison (1968) *Essence of Decision: Explaining the Cuban Missile Crisis*, p. 181. Allison believes that documents do not capture accurate accounts of bargaining. What is required, he argues, is access to the players before their memories fade too much. As a master of this style of analysis has declared: 'if I were forced to choose between the documents on one hand, and late, limited, partial interviews with some of the participants on the other hand, I would be forced to discard the documents.'

[322] See for example Zhao Shukai's concept of 'pressurisation', or Zhou Xueguang's idea of 'incapacity' based on structural logic (Zhou Xueguang (2012) 运动型治理机制：中国国家治理的制度逻辑再思考, *Open Times* 开放时代, issue 9).

orders. Central ministries, for example, do not control the rules that govern how their provincial subordinates act; rather, their subordinate ministries are controlled by the local standing committee. Should the local standing committee prioritise a measure, it is more able to enforce this prioritisation and ensure implementation. But these standing committees are focused on vertical concerns. This puts ministries in a difficult position. Ministries have their own vertical commands from the levels above. But these commands cannot change the incentives of personnel or revenue. So to force lower-level bureaux to implement a policy or reform requires a central ministry in Beijing to convince the highest coordination bodies to decree the directive must be implemented and hold local party-state leaders accountable (as the local leaders control the PSC and the institutions that command personnel and revenue). Otherwise, ministries must encourage the subordinate body at the lower level to force their local standing committee to implement the measure, a negotiation in which the local standing committee holds all the cards, controlling the money, physical assets, and the people necessary to implement a policy. Line agencies have to concentrate on convincing local standing committees that a policy idea is worthy and should be implemented.

Hence, almost all local actors face a raft of competing issues at any given time, and these issues can be directed at them from a variety of different political levels. At any given time they may face the need to fulfil very formal, specific orders given to them by the local standing committee in order to fulfil their priorities; need to meet directives ordered by their higher-level counterpart; need to meet targets set by other bodies and authorised by the local Standing Committee; and need to meet targets set by their parent body in Beijing.

This means that the specificity of the order from above is important. It also means that there are many, many targets and evaluations in the Chinese system.[323] Line ministries are more closely linked to their horizontal reporting lines than their vertical reporting lines, as the horizontal reporting controls personnel, promotion, and in many cases, budget. From this analysis, we would presume that any effective mobilisation of the local state must focus on the PSC, and on holding its members (and specifically, the Party Secretary) personally responsible with a measurable directive from above.

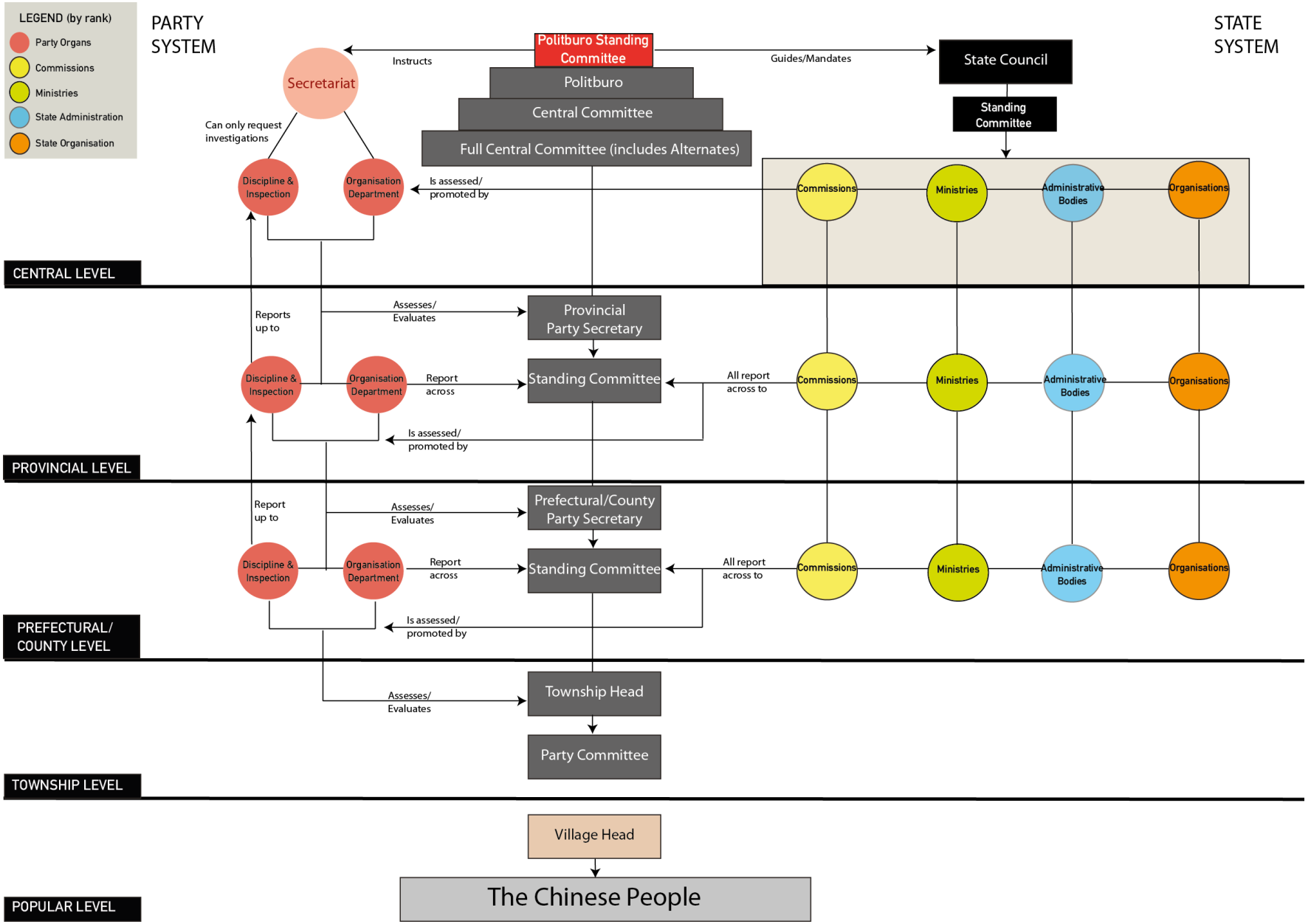
China's local governance system

The party-state system changes again for the sub-county local government level. The Party system of political organisation continues down into the township and village, but the government political organisation system only fully replicates itself down to the county level.[324] The county is thus the lowest body that the state system (actors such as commissions, ministries, regulatory bodies and others) can effectively reach. However, Party structures can be used to control township and village party secretaries. As with the central and local government party-state systems, this control of party secretaries is vertical, with the county party secretary controlling the township party secretary, and the township party secretary responsible for the village. This can lead to the imposition of a large number of tasks onto the township and village party secretaries. This system, as

[323] For example, Zhou Xueguang's study of 'W county' showed that in 2007, it developed a total of 1143 indicators to measure whether local officials had fulfilled their functional targets (Zhou Xueguang (2012), *ibid*). The author has a copy of the Shenzhen targets (指标 *zhibiao)*, which similarly number in the hundreds. Obtained and verified through fieldwork, available to examiners/interested parties on request.
[324] Powerful ministries, such as Finance, remain largely intact at the township level. Thanks to Graeme Smith for this point, and for many illuminating conversations on this theme.

described in Figure 7 below, also leaves township and village governance dependent on the relations of leaders with the county standing committee.

Figure 7: China's assessment function step-wise by level
Source: Author's own research and schema



The county holds the township Party secretary responsible through a system that is mainly contractual. For important tasks, township Party secretaries sign contractual agreements with the level above agreeing to undertake certain priority tasks and meet certain measurements. This undertaking is mediated by rules set by the county standing committee, who decide which measures are to be considered 'important' and which measures are not, and then pass these measures down to the township leaders.[325] As the county Party Secretary chooses what is 'important', it is likely that that they prioritise any measures for which they are held responsible,[326] and to prioritise measurements that are easy to evaluate, and that are able to be verified relatively simply.[327]

This contract-based system is then the basis for how the township party secretary governs.[328] Based on the commands passed down by the county party secretary, s/he signs corresponding contracts with other local organisations or bodies, holding them responsible for meeting the targets within their individual contract.[329] Township leaders are held personally accountable for implementation problems, and for other problems. This binds them closely to the wishes of the county party secretary and standing committee.

[325] Clause 24.2 of 2013 Central Party notification on the regulations of documents — the issuing body of the directive is able to register the importance of the document; this power also combines with that of clause 20, which specifies that local standing committee to county level need to receive warnings of important drafts, and clause 22, which specifies that the party secretary must sign off on the order. Central Committee and State Council (2013)党政机关公文处理工作条例 ('Regulations of use of documents within Party and State organs').
[326] This also applies to their delegates from the standing committee, due to absolute liability.
[327] Minzner (2012), *op. cit.*
[328] 政治责任制 *zhengzhi zeren zhi* or political responsibility system.
[329] Hansheng Wang and Yige Wang (2009)目标管理责任制:农村基层政权的实践逻辑, 社会学研究, ('Target managed political responsibility systems: the logic and practice of rural local government power', *Studies in Society)* vol. 2, pp 1-33.

The key to this is the relationship between the township standing committee and the county level organisation bureau, controlled by the county standing committee. The county standing committee decides on the candidates for each position in the township standing committee. The decisions are then forwarded to down to township leaders.[330] But the county Organisation Department is responsible for selecting the major players within the township,[331] and is responsible for enforcing personnel rules. In this way, the county monitors township heads, and retains the lure of promotion and the threat of demotion. [332]

This county-led control is very effective at ensuring township heads are responsive to county wishes. Large empirical studies of township governments find township heads 'highly responsive' to county standing committee diktat, largely because their promotion is dependent on the county standing committee's say-so.[333] But this county-led control also leaves township heads with limited information, and a limited ability to set any rules.[334] The formal power over personnel decisions and budget allocations still

[330] There is some scope for the township leaders to shape this process through the provision of information *ex ante*. Township leaders control information flow, position description information, and the ability to add people within village or township to the cadre reserve list (领导干部后部名单 *lingdao ganbu houbu mingdan)*. Promotions are meant to come from this list, although estimates make clear that the number of people on the list is far greater than the possible number of positions. John Burns estimated in the 1980s that there were already 8 million people on the list; see Sebastien Heilmann (2000) 'The Chinese *Nomenklatura* in Transition', *China Analysis*, vol. 1., p. 3.

[331] They select the party secretary, deputy party secretary, mayor, and the deputy mayor.

[332] Many seek transfer to county level government positions (same pay grade, less responsibility) as this allows them future promotion within the county system, as well as minimising their personal accountability.Yang Zhong (2004) *Local Government and Politics in China: Challenges from Below*, M. E. Sharpe: Armonk, p. 123, (note that he calls them calls them 父母官 *fumuguan)*.

[333] Zhao Shukai (2012), *op cit*.

[334] Although this problem was noted early on in the development of the modern system (see 张厚安 (ed) (1982)*中国农村基层政权建设*, 四川人民出版社, pp. 88-90 (Zhang Houan (1982) *Building China's rural grassroots political power,* Sichuan People's Press: Chengdu), regular complaints about it remain (e.g. Liu Yawei (2004) 渐进式民主:中国县乡的直接选举 ('Gradually advancing models of people's power: direct elections at county and township level in China') http://www.aisixiang.com/data/2975-6.html).

resides with the county. And township leaders have limited amounts of policy discretion.[335] Township leaders also have very little ability to know the full information or context of many of the decisions that they are meant to implement. Internal, important, memoranda are classified as being available to county-level officials or above.[336] The county-level heads are supposed to communicate the 'spirit' of the decree down to the lower levels in the county.[337] This communication of spirit commonly occurs through mass movements[338] and group study sessions of the relevant policy. The county heads in this way are able to interpret most policies in any manner they wish, as they will be conveying it downwards.

In this way, the horizontal and vertical systems begin to break down. The insistence on keeping information tight within the county makes it difficult for parties to contract effectively between themselves at different political levels, as all contracts must be horizontal (that is, with other county bodies) or vertical (that is, county standing committee to township standing committee). To give an example, the head of the health bureau can have a contract with the county party secretary. The county party secretary can have a contract with the township party secretary or head. The township party secretary can have a contract with the township health centre. But the head of the

[335] This appears to be widely discussed and even acknowledged at high levels of the Party. See senior official (and quasi-professional gadfly) Yu Jianrong's comments on township governance being widely reprinted in Party media. 于建嵘(2013)我国农村基层政权建设亟需解决的几个问题?, *行政管理改革*, vol. 10, pp 1-6, available online: http://theory.people.com.cn/n/2013/1025/c207270-23326212.html. The point has also been made by others, e.g. Fewsmith (2012), *op cit.*, p. 32; 肖继耘 (2010) '有限责任制度论', *北大法律信息网*, available online: http://www.aisixiang.com/data/34720.html.

[336] Central Committee and State Council (2013)党政机关公文处理工作条例 (Regulations of use of documents within Party and State organs)

[337] jingshen 精神.

[338] Usually, set meetings in which local leaders are forced to study the policy and brainstorm the way that the policy will be promoted to local people through media, the internet, etc.

county health bureau cannot sign an enforceable contract with the township health centre that alters its budget or staffing levels; it can only set its funding and treatment goals. Rather, the head of the county health bureau must convince the county party secretary to change the budget or staffing of the township health centre. And while the township party secretary is held responsible for budget shortages or unwanted behaviour within the township health centre, s/he has few standardised rules they are able to use to change this behaviour.

Similar problems arise in township/village relations. All villages have party committees.[339] As with the county-township party secretary relationship, township leaders are able to sign contracts with the village party secretary. Village party secretaries are allowed to create village economic organisations, and draw a salary — or 'compensation for their time' from these village economic organisations. This power is contracted down to them by the township head.[340]

But the township standing committee faces considerable principal-agent problems in dealing with village leaders. In the first place, village leaders are not state employees and lack many of the benefits given to state employees.[341] This can lessen the financial hold that townships have over village leaders. Village leaders are allowed to be drawn from that village, which can give them a local power base that the township head is

[339] All villages with 3 members of more have to have a party branch, and all party branches have a party sec, an organisation person, a disciplinary person, and a propaganda person

[340] The township head allows members of the village committee to receive 'compensation' for their time, drawn from fee revenue/village economic committee revenue, but that compensation is based on institutions controlled by the township head. Yang Zhong (2003), *op cit.*

[341] 不是吃皇粮的人 ('people who eat the emporer's grain') — see also Yang Zhong, *op cit.* p.170; thanks also to Graeme Smith for making this point to the author during conversations on the topic.

unable to mimic. As such, kinship groups and solidarity organisations have advantages in resisting pressure from township heads.[342] Township heads can provide village heads with some pecuniary advantages, but they cannot provide village party secretaries the promise of promotion as village party secretaries who wish to join the township still have to compete with entrants to the system who have taken the civil service exam.[343] Most of the incentives that can be provided to village party secretaries — such as the ability to change their residence permit — are in the control of the county standing committee, rather than the village.[344]

How China's governance system makes national implementation difficult

What does this analysis of local governance tell us? Firstly, it shows that it is essential to use vertical mechanisms of control to implement a policy. The control of institutions lies with the vertically controlled leaders. Any national reform needs to hold each level vertically responsible; this is done most effectively through targeting the top two leaders at each level. Holding these leaders responsible also requires specific, measurable targets to which the leaders can be held to account.

But, for the centre, using these coordination mechanisms and detailed documentary specification is not cost-free. The centre can pass programs down to lower levels without necessarily being able to force them to be implemented nationwide — that is,

[342] see Lily Tsai (2009), *op cit.*
[343] Those who pass the (highly competitive) civil service exam are given guaranteed employment.
[344] If you become a township official, then your residential hukou is changed from rural to urban — Yang Zhong (2003), *op cit.* 170

different provincial leaders can react to what s/he believes may be central concerns and initiate policies in different ways from other provincial leaders. And the same goes with the county leader who interprets provincial policy differently to the neighbouring county leader. There will therefore always be difficulties rolling policies out nationally, as *all* provincial or *all* county leaders are required to implement the schemes in order to ensure national implementation. Furthermore, even should provincial, prefectural and county compliance occur, county standing committees have the power to subcontract their responsibilities downwards to townships and villages through assigning townships and villages targets in their responsibility contracts. Township and village officials are then expected to fulfil targets within this nebulous 'spirit' of the decree. Forcing this to happen throughout the many, many, townships and villages in China is quite a feat.

Making national policy in China is in fact exceedingly difficult. Information flows are highly cumbersome, particularly for issues cutting across multiple interests. Every interest has to pass the problem up to a higher-ranked body for coordination; and knotty problems may need to go up vertically to be resolved. And higher level bodies then suffer from classic multidimensionality problems.[345] The more important a topic, the lower the levels of policy discretion higher level bodies are likely to wish to give to subordinate agencies[346] — thus the tight vertical control of the party secretaries of each

[345] The sheer number of contracts for the centre to chase up would overwhelm it. For more on the theory see Bengt Holmstrom and Paul Milgrom (1991) 'Multitask Principal-Agent Analyses: Incentive Contracts, Asset Ownership, and Job Design', *Journal of Law, Economics, & Organization*, Vol. 7, Special Issue: pp. 24-52; also see T Besley (2003) 'Incentives, Choice, and Accountability in the Provision of Public Services' *Oxford Review of Economic Policy*, vol. 19, no. 2 pp. 235-249.
[346] Randall L. Calvert, Mathew D. McCubbins and Barry R. Weingast (1989) 'A Theory of Political Control and Agency Discretion' *American Journal of Political Science*, Vol. 33, no. 3, pp. 588-611; see also Mathew D. McCubbins, Roger G. Noll and Barry R. Weingast (1987) 'Administrative Procedures as

area. But this tight vertical control forces the centre to choose in which issues it will personally intervene, and for which it will want to measure, enforce and hold local actors accountable. It goes without saying that the size of the Chinese system makes it difficult to do this for anything other than an issue considered of the highest importance.

From the perspective of China's highest leaders, it is much easier to deal with this problem by delegating these choices down to lower levels of government, and to hold vertically-managed leaders responsible for how they deal with a delegated problem. Local leaders can then create their own systems of staff assignation, salary designation, and performance evaluations to control behaviour.[347] But, unless the centre is able to create relatively complete contracts which specify exactly what they want all levels to do with easily measureable metrics, this delegation to local leaders makes *national* implementation very difficult.

This is particularly the case at the county level — each province would need to make sure that each county is given relatively complete instructions in order to make sure that goals are met, as the county then holds the institutional power needed to mobilise townships and villages. Township leaders have very little ability to comprehend the full information or context of many of the decisions that they are supposed to implement. Thus, township and villages need complete contracts from county-township-village.

Instruments of Political Control' *Journal of Law, Economics, & Organization*, Vol. 3, No. 2 (Autumn, 1987), pp. 243-277.

[347] Jean Oi (1999) *Rural China Takes Off: Institutional Foundations of Economic Reform*. University of California Press: Berkeley, pp.103–15.

This forces executable plans to be complete contracts, quantitative measures, and designated as priority targets for the Standing Committee. Effective *national* programs are rare because they have to hit all of these targets.

In consequence, we see far less successful implementation of central policy directives than one would expect from a top-down system *ex ante*. This difficulty of national implementation is endemic because of the features of China's political organisation — only when all individuals at a particular level nationwide are held responsible in a particular way is there likely to be common nationwide implementation of policy programs. This also helps explain why trials or provincial level reforms may be possible, but do not always provide strong indications of future national success (or even of future nationwide adoption).

Conclusion

The introduction set out the puzzle that the thesis is trying to address. The methodology chapter argued that this puzzle can only be solved with a comprehensive understanding of the interactions between central and local governments in China. China has a system of governance that uses documents and rank to coordinate different interests. This chapter has shown how this system works in the abstract, and has demonstrated the framework that will be used to analyse the interactions between different state actors in the empirical case studies. It argued that the top-down system of control delegates authority in such a way as to make nationwide implementation of any

policy very difficult for the centre. It also argued that incentives embedded within the Chinese governance system make some programs far more likely to be implemented nationwide than others, and that there are commonalities in successes and failures across different programs.

An important assumption is that the authority of the document used to create a program or scheme and the rank of the actor that issued the document shape the behaviour of actors within the Chinese political system, and affect the likelihood of actors implementing the scheme as mandated. But, despite an array of studies of China's political organisation,[348] the assertion that document type and rank can alter outcomes through a top-down process has yet to be formally derived. And, while there are a number of excellent institutional analyses of Chinese policy at the local level,[349] many of these studies are place- and time-specific, and cannot be generalised to national programs. The argument here extends the current literature in this field.

The nature of China's political organisation makes some policy outcomes more likely than others. At the central level, the authority of central policy decisions can be

[348] A Doak Barnett (1967) *Cadres, Bureaucracy, and Political Power in Communist China*. New York: Columbia University Press; Franz Schurmann (1966) *Ideology and Organization in Communist China*. Berkeley: University of California Press; Harry Harding (1984) *Organizing China.* Stanford: Stanford University Press; Kenneth Lieberthal (2004) *Governing China : From Revolution to Reform.* Second edition. New York; London: W. W. Norton.

[349] See, for example, the work of Zhao Shukai at the township level: Shukai Zhao (2013) *Township Governance and Institutionalization in China.* Singapore: World Scientific Publishing Company Incorporated; of Maria Edin (2003) "State Capacity and Local Agent Control in China: CCP Cadre Management From a Township Perspective," *The China Quarterly,* vol. 173, pp. 35–52; Ben Hillman, (2010) "Factions and Spoils: Examining Political Behavior Within the Local State in China" *The China Journal,* no. 64, pp. 1–20., Graeme Smith (2010) "The Hollow State: Rural Governance in China," *The China Quarterly,* no. 203, pp. 601–18; and Susan Whiting (2006) *Power and Wealth in Rural China*, Cambridge: Cambridge University Press at the county level; and Lily Tsai (2007) "Solidary Groups, Informal Accountability, and Local Public Goods Provision in Rural China," *American Political Science Review*, vol. 101 (2), pp. 355-372 at the village level.

seen as a by-product of the rank of the decision making body, and the method used to promulgate the decision.

But once central policy choices are made, there is a subsequent need to translate orders from above into targets and goals for each level to implement. The Chinese system of rank concentrates power at the local level in the Party standing committee at that same political level. This means that government departments have limited authority over their policy areas; the authority is instead held by the local Party leaders. This hinders the implementation of policy at local levels.

The only way around this problem is to force all local Party leaders to implement a policy through holding them personally accountable. But this requires a very high level of 'weight' within the Chinese system. This weight comes from the rank of the body issuing the document, and from the authority given to the document within the Chinese system. This weight then combines with the specificity of the document to guide how closely any order is followed. Less authoritative, or less specific, documents are able to be reinterpreted more easily by subordinate actors.

Hence, for an order to be accepted and commonly acted upon nationwide, we would expect it to be issued by one of the highest coordination bodies (*zhengguoji* rank), we would expect the order to target the county Party secretary or the county standing committee and hold them personally responsible, and we would expect the order to be specific and easily measurable. Such orders exist but rarely — yet they are possible. This,

I argue, helps explain the phenomenon of 'selective implementation'. Some programs are able to obviate the selective implementation problem by having been framed with specific, and measurable, criteria for implementation at the highest levels, and the system then holding the Standing Committee of the relevant political level (usually the county) personally responsible for any failure of implementation in the specific, measurable criteria.

This analytical framework uses the party-state's own systems of rank, document issuance, and authority to attempt to explain how 'selective implementation' may, in the abstract, occur. Later chapters apply this framework and the techniques developed in this chapter to the specific case of SHI implementation. This allows us to answer the question of how enrolment nationwide could vary so dramatically between different SHI programs — and how some programs can be so successful and others not.

Chapter 4: How the Party became principal

Governing (and analysing) an autocracy is a difficult balancing act. For the leader, it is difficult to know who will follow your commands. For other members of the system, it is difficult to know how to balance different commands. For analysts trying to understand government behaviour, it is difficult to see which policies were initiated or implemented in response to commands from above, and which policies were initiated or implemented in contravention of commands from above. Hence, an understanding how incentives change the behaviour of, and what choices are available to, those responsible for policy implementation is vital to understanding how policies succeed or fail. As recent studies of social health insurance and historical institutionalism show, an analysis also needs to highlight how incentives and choices are themselves constrained by previous policy attempts. A careful analysis of the conditions under which health insurance enrolment succeeded and failed can thus aid understanding of why local governments chose to implement health insurance goals in preference to other social goals.

This chapter discusses the implementation of health insurance policy during the Mao period. During Mao's rule of China, local governments had to choose between implementing many different social policy and health care goals. In looking at how local governments chose between different policy goals, we can analyse why some goals were more successful than others. We can also analyse how concepts of historical

institutionalism, and particularly the work of Jacob Hacker on health insurance, can be applied to the study of China. In modern theories of historical institutionalism, a successful or failed policy constrains and alters the choices of future policy makers.[350]Hence, an understanding of the nature of any success or failure allows us to make comments about how social health insurance schemes reflect how the state or society is more able to effectively implement policy.

But the periods of effective implementation of social health insurance within rural China appear different from what one would expect from existing theory. For example, the seminal work on the Maoist period, by David Lampton, argues that the medical bureaucracy was often able to reassert control over the health care system during Mao's rule. One might expect major social health insurance schemes, and concomitant increases in coverage, to occur in periods of relative stability, or to occur in periods when the health ministry was particularly strong.[351] And, as a corollary, one might expect health insurance schemes with broad levels of coverage to involve a considerable increase in public spending on health care.[352] Yet the opposite occurred. Social health

[350] In the field of health insurance, this is often associated with the work of Hacker (Jacob Hacker (1998) 'The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy', *Studies in American Political Development*, 1998 vol. 12, no. 1, pp. 57-130); for a more general overview of recent conceptualisations of the impacts of historical institutionalism on policy see Kathleen Thelen and James Mahoney (eds.) (2009) *Explaining Institutional Change: Ambiguity, Agency, and Power*, Cambridge University Press: Cambridge.

[351] 'This underlines the need for the government to fund a substantial share of health expenditure out of general revenues, particularly in poor localities. The paper notes that many successful prepayment schemes depend on close supervision by local political leaders.' Gerald Bloom and Tang Shenglan (1999) 'Rural health prepayment schemes in China: towards a more active role for government'. *Social Science & Medicine*, vol. 48 (7) p. 563.

[352] 'It is suggested that developing countries strengthen what is probably the most fundamental initial systemic asset they have: public finance.' Dov Chernichovsky (1995). 'What can developing economies learn from health system reforms of developed economies?' *Health Policy*, vol. 32 (1-3) pp. 79-91; see also Guy Carrin (ed.) (2008) *Health systems policy, finance, and organization*, Elsevier Press: Amsterdam, especially the chapter by Lewis and Musgrave.

insurance enrolment was high under periods of Party command of the health care sector, but low in periods of Ministry of Health command.

This chapter argues that the departure from what we would expect in the Mao period can be explained by the responsibility for enrolment in social health insurance (SHI) schemes moving from the supervision (and financing) of the Ministry of Health to the supervision (and financing) of the local Party. Chapter 3 demonstrated how the Chinese system is likely to preference Party decrees over state decrees, and demonstrated how the system gives far greater institutional powers to local Party secretaries.

This chapter shows how the analytical framework accurately describes the development and decline of rural social health insurance schemes in the Mao period. High enrolment in social health insurance schemes is associated with Party control, and with decrees that targeted local Party secretaries. Holding local Party heads accountable for ensuring the implementation of social health insurance schemes forced them to mobilise the local state to ensure that there was high levels of enrolment. This was unlike other attempts at health reform from Beijing led by the Ministry of Health or other actors. This 'Party-led development' model shows how, when given a specific order, the central state can use personnel incentives, local control and Party organs to ensure that the local Party head will implement a policy.

What emerges is the importance of local government institutions. While Mao's power (and his *diktat*) was paramount, his orders still needed to be implemented by individuals at the lower levels choosing to follow them.[353] And so the mechanisms used to enforce Mao's power had an enormous influence on implementation. For local governments, despite Mao's power, central mandates were rarely accompanied by central funding.[354] The local state needed to choose to enrol citizens in social health insurance schemes in preference to choosing to undertake other mandates and policies; and this occurred in a period when funds were tight. The prioritisation of health insurance enrolment was achieved by making the Party head, rather than representatives of the Ministry of Health or delegate, responsible for enrolment targets. This method of local state mobilisation and policy implementation was the same for social health insurance provision during both the Great Leap Forward and the Cultural Revolution. During other times in the Maoist period, social health insurance was implemented only in areas that had either the will or the surplus funds available to support the policy — a rare occurrence, and thus coverage was minimal.

To establish these claims, the chapter examines China's rural health service delivery model; its rural payment model; and its political incentives model during the Maoist period. It reveals that the need to establish a health system created institutions that led

[353] In other words, and while there isn't space to fully do it justice, it's important to note that this concept of Mao as completely paramount does not negate the use of a rational actor approach. See for example Tang Tsou's concept of 'totalism' in Tang Tsou (1994) 二十世纪的政治 ('Twentieth Century Politics'), Oxford University Press: Hong Kong.

[354] Obviously, this is analysed case-by-case for the relevant periods in this chapter, but generally see: Frederick Teiwes and Warren Sun (1999) *China's Road to Disaster: Mao, Central Politicians, and Provincial Leaders in the Unfolding of the Great Leap Forward 1955-1959,* East Gate Books: New York, especially pp. 22-23 and 58-64; Roderick MacFarquhar and Michael Schoenhals (2006) *Mao's Last Revolution*, Harvard University Press: Cambridge, MA.

to recurring tensions over who paid for health services, over what level of access to health services was considered acceptable and over whom would control access to health services. These institutions preferenced the Party in the implementation of social health insurance schemes. Future chapters will show how the development of this system then affected later attempts to implement policy.

Early Maoist health care: 1950 to 1958

In pre-Communist China, the health system in the rural areas focused mainly on traditional medicine.[355] At the time of Communist Party ascension to power, there were around seven times more doctors of traditional medicine than Western medicine.[356] The greatest health system needs were judged to be lowering the high rates of infectious disease and child mortality; during the immediate pre-Communist period, as Sidel reports, 'most deaths in China were due to infectious diseases, usually complicated by malnutrition'.[357]

Following the Party's rise to power and the establishment of the People's Republic of China (PRC) in 1949, the newly-established leadership outlined its priorities on health care the following year:

(1) the needs of workers, peasants and soldiers (面向工农 *mianxiang gongnong*)

[355] Ruth Sidel and Victor Sidel (1982) *The Health of China*, Beacon Press: Boston.
[356] Mary Young (1988) 'Impact Of The Rural Reform On Financing Rural Health Services In China', *World Bank Report,* number 31568, World Bank: Washington DC, p. 22 'By 1949 there were 276000 doctors of traditional medicine who provided the bulk of therapeutic medical care to the Chinese people and 38000 doctors of Western medicine'; note that data for this was provided directly to the World Bank by the China's central Ministry of Health, see footnote 14 on page 22.
[357] Sidel and Sidel (1982), *op cit.*, p. 26

(2) prevention as the first priority (预防为主 *yufang weizhu*)

(3) unification of Chinese and Western systems of health (结合中西医 *jiehe zhongxiyi*).[358]

To meet these priorities, the Chinese state used two different systems. The first system was led by the Ministry of Health. The Ministry of Health was charged with creating a new system for the provision of health care. The goals of the health system were to introduce further services, beginning at the county level; to integrate Western medicine with the existing system, especially with regards to Western drugs; to increase the number of doctors and health personnel; and to create more public health capital works projects.[359] The health system was characterised by the public provision of health services through all levels of government, and a three-tier "step-up, step-down" system. A health system bureaucracy was decreed by a central decision (*jueding*) and developed under the command of the Ministry of Health. [360]

At the bottom of the tiers were the brigade[361] health stations, which served an average of around 1000 people across China.[362] These health stations provided basic

[358] See Kim Taylor (2011) *Chinese Medicine in Early Communist China, 1945-1963: A Medicine of Revolution* (Needham Research Institute Series), Routledge: Basingstoke, or the 1951 decree of responsibilities, outlined in the authoritative Central Governing Body *jueding* (1951) 政务院关于一九五一年度财政收支系统划分的决定 (Central Governing Body decision on the 1951 division of fiscal responsibilities).
[359] Taylor (2011), *op cit.*
[360] Central Governing Body (1951) 政务院关于一九五一年度财政收支系统划分的决定 ('Central Governing Body decision on the 1951 division of fiscal responsibilities') formulated the system of hospitals, prevention, work units etc; this decision also allocated which level of government had budgetary and political responsibility for each part of the system.
[361] Note that, as there were a wide array of political units in China, I have chosen to use the rank of each of the units rather than try and describe the unit itself. In other words, anything at 县级 (*xianji*) is called a 'county'.

curative care, distributed both Western and traditional medicine, and provided preventive services such as family planning and communicable disease surveillance.[363] Health stations were subsidised by the commune or county should they operate at a deficit, and the funding for all preventive services and some drugs were, in theory, to be provided by higher political levels (the commune, county, or province, depending on the good).[364]

The next level up — the second tier of treatment — were the commune health centres. These provided a wider range of services including basic inpatient[365] and outpatient services, epidemic prevention services, public health program delivery and the provision of basic maternal and child health care. The commune health centres had a close relationship with the brigade health stations — they supervised and trained the brigade health stations, and patients for the commune health centres were, in theory, to have been referred from the health stations should the health station believe that their condition needed higher-level care. Depending on the wealth of the commune, health centres could range in size from a couple of beds to a small hospital of some 50-odd beds.[366] Payment for services at the commune health centre was to come from patients,

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[362] Feng Xueshan, Tang Shenglan, Gerald Bloom, Malcolm Segall, and Gu Xingyuan (1995) 'Cooperative medical schemes in contemporary rural China', *Social Science & Medicine*, vol. 41, no. 8, pp. 1111-1118.
[363] Xingzhu Liu and Junle Wang (1991) 'An Introduction to China's Health Care System', *Journal of Public Health Policy*, vol. 12, no. 1, pp. 104-116.
[364] Central Governing Body (1951) 政务院关于一九五一年度财政收支系统划分的决定 ('Central Governing Body decision on the 1951 division of fiscal responsibilities'); Dean Jamison (1985) 'China's health care system : policies, organization, inputs and finance' in *Good Health at Low Cost,* edited by Scott B.Halstead, Julia A. Walsh, and Kenneth Warren, Rockefeller Foundation: New York, pp. 22-53.
[365] Largely simple surgeries; some abortion services were also available (e.g. Mary Young (1989) 'Impact of the rural reform on financing rural health services in China', *Health Policy*, vol. 11, no. 1, pp. 27-42.)
[366] Dean Jamison, John Evans and Timothy King (1984) *China, the health sector,* World Bank: Washington DC.

although a percentage of the health personnel's salary was subsidised from the county Ministry of Health budget.[367]

The final tier of treatment in this model was the county hospitals (which in turn could refer patients upwards to municipal or even provincial-level hospitals). The hospitals were owned and operated by the county government and often staffed by physicians with four to five years of medical training.[368] The county hospital provided inpatient and outpatient services, technical support and supervision for commune health centres and brigade health stations. County hospitals were, in theory at least, forced to provide five basic inpatient specialty services.[369] Patients at county hospitals were to have been referred up by the commune health centre. The typical county hospital had over a hundred beds and nearly two hundred staff members.[370]

The system was designed to work relatively seamlessly between the different health care provider units. Each higher-level body provided training and specialist knowledge to the level below. Each level could refer patients up to the next level of treatment should they feel that it was necessary. The costs for treating patients at each level were largely borne by that level of government.

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[367] Cui Yueli (1982) 'An Introduction to Rural Health Services in China', in World Health Organisation (eds) *Interregional Seminar on Primary Health Care*, World Health Organisation: Geneva, table six, p. 33; note that the commune under observation for the WHO study (in Yexian county, Shandong) had around 60% of the salaries paid by the county.

[368] See for example the discussion in Feng Xueshan, Tang Shenglan, Gerald Bloom, Malcolm Segall, and Gu Xingyuan (1995) 'Cooperative medical schemes in contemporary rural China', *Social Science & Medicine*, vol. 41 (8) pp. 1111-1118.

[369] These five basic specialty services were obstretics-gynaecology, pediatrics, internal medicine, general surgery and radiology. See the 1952 central decision 中央人民政府政务院关于一九五二年农业生产的决定 (clauses 2 and 10) for more on how the divisions were calculated.

[370] Sidel and Sidel (1982), *op cit.*; WHO (eds) (1982), *op cit.*

But this Ministry of Health-led system described above was very different from the Party mass public health campaign system. The Party system focused on using health "campaigns" (with techniques of mass mobilisation of voluntary labour) and combining these with other political campaigns.[371] These Party campaigns, or "Patriotic Health Campaigns" began in 1951 with Zhou Enlai's pronouncement[372] of a program combining health work with mass movements to create health campaigns (*weisheng gongzuo yu qunzhongyundong xiang jiehe* 卫生工作与群众运动相结合),[373] calling on China to 'patriotically clean up communities and homes and to eliminate flies and mosquitoes'[374] in a so-called "mass movement" of public health against 'American germ warfare'.[375] Other campaigns were launched to combat major infectious diseases.[376] In rural China, health campaigns were combined with development campaigns.[377] The campaigns established that the Party, rather than the Ministry of Health, led local health movements and mass campaigns.[378] More importantly, the Party campaigns could be

[371] These campaigns included the Patriotic Health Movement (爱国卫生运动) and the Four Pests Campaign.
[372] A fourth priority was added at the instruction of Zhou Enlai in 1952, after the Patriotic Health Campaign was launched China's engagement in the Korean War.
[373] Chen Haifeng (1992) *Zhongguo weisheng baojian shi*, Shanghai: Shanghai kexue jishu chubanshe, pp. 80–82.
[374] Bu Liping (2014), 'Anti-Malaria Campaigns And The Socialist Reconstruction Of China, 1950–80' *East Asian History,* vol. 39, pp. 24-48.
[375] Ibid.
[376] Such as cholera, smallpox, tuberculosis, schistosomiasis, and malaria. Chen Haifeng (1992) *Zhongguo weisheng baojian shi*, Shanghai: Shanghai kexue jishu chubanshe, pp. 107–27.
[377] Including the development of land reclamation, irrigation construction, and environmental improvement of sanitary conditions for both humans and livestock. Judith Shapiro (1991) *Mao's War Against Nature: Politics and the Environment in Revolutionary China*. Cambridge University Press: Cambridge, pp. 46-50.
[378] Aided by the failure of the then ruling government system in 1951 to be specific in the critical central decisions establishing the health system responsibility and the allocation of tasks to each part of the government system in the 1951 decision that established the system (the Central Governing Body (1951) 政务院关于一九五一年度财政收支系统划分的决定 ('Central Governing Body decision on the 1951 division of fiscal responsibilities') decision). Another part of this was obviously Mao's own preferences as well — Mao saw health care as part of every day life ('If a person doesn't exercise but only eats well, dresses well,

assigned to the Party Secretary at the relevant level, holding them accountable for the success or failure of the campaign.

Within the Chinese system, patriotic campaign goals were of far greater political importance than health system goals — solely because patriotic campaigns were considered a Party priority. Their progress was monitored by the Party, and the Party provided considerable incentives — including *inter alia* propaganda, nationwide poster programs, use of official media and access to Party funds — to aid in the implementation of these campaigns.[379] The campaigns functioned vertically. They were initiated at the national level but implemented by Party members locally following decrees passed down from the centre. Responsibility for the campaigns was assigned to the Party leadership group of the relevant political area — in this case, the commune — and the designated Party authority could be ordered to be personally responsible for their success or failure. These designated authorities could then mobilise the relevant public health bodies in the local state.

Party mechanisms co-ordinated the campaign — and the different government interests — at every level of the administrative system. While mass movements could be initiated by the Ministry of Health, they had to be approved and disseminated by the

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lives comfortably, and drives wherever he goes, he will be beset with a lot of illnesses. Excessive attention to food, clothing, housing, and means of transportation are the four underlying, causes of illness among high-level cadres.', Jan 24, 1964); and therefore as more of a Party matter than a Ministry matter; see also discussion of 1950 speech and 1965 'Ministry of Urban Gentlemen' speech in other parts of this chapter.

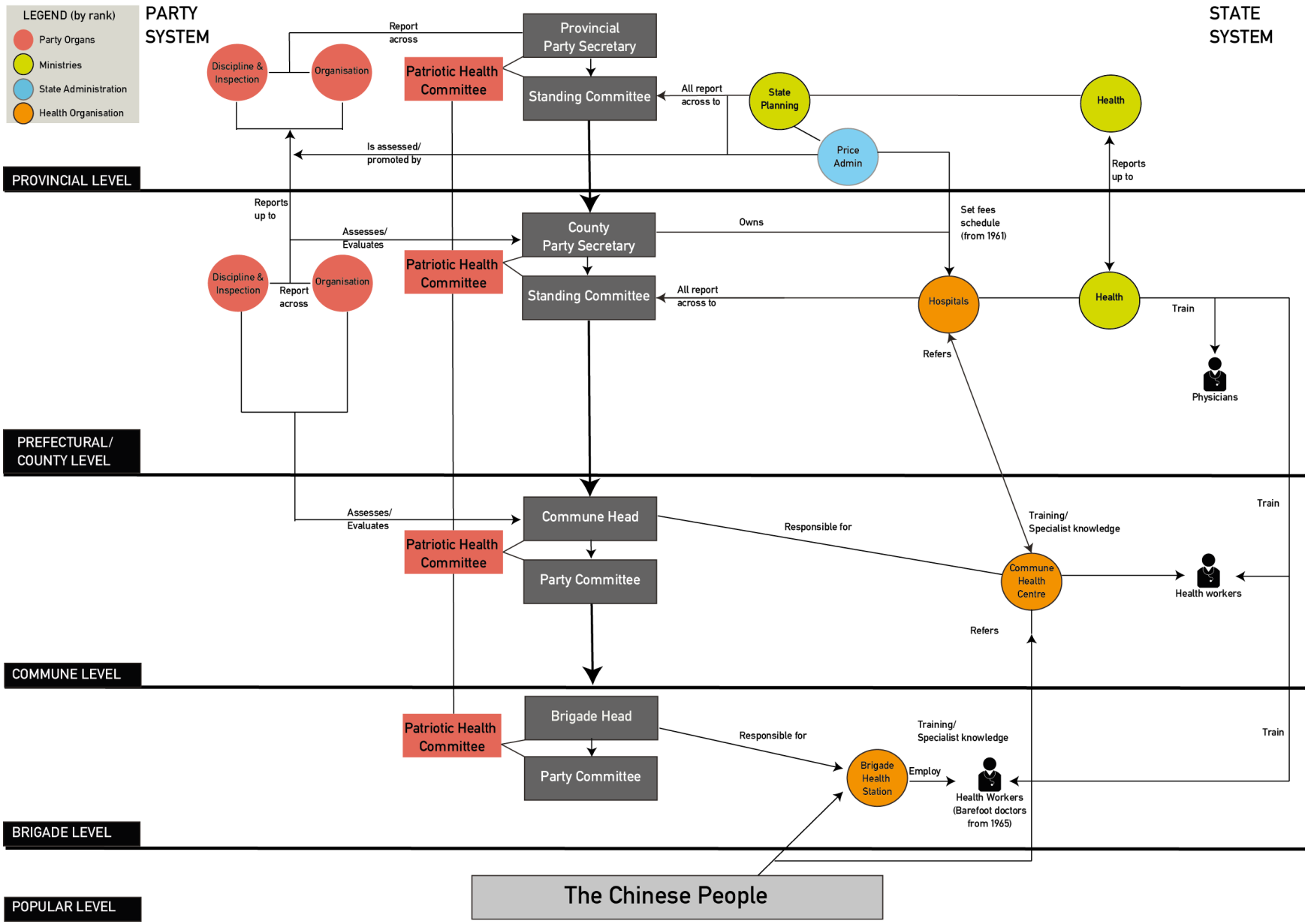
[379] 侯勤文(1970) 毛泽东思想照亮了我国医学发展的道路，红旗，(Hou Qinwen (1970) 'Mao Zedong Thought lights up the path of our nation's medical study and development', *Red Flag,* March, pp. 1-16.

Party.[380] Professional and social organisations such as the Red Cross, the National Federation of Women, and the Labour Union also participated in campaign activities.[381]

These two different systems, Party and government, each with different political organisation and incentives, both undertook tasks that were declared to be 'health' work. But these different systems had different targets, different reports, different parties held responsible and were evaluated by different systems. The structure of the system is graphically represented in Figure 8 below (note the small differences between rural and urban systems). Importantly, with the exception of the addition of the barefoot doctors — discussed at greater length later in this chapter — this division of health care provision remained for the rest of the Maoist period. It continues to be more or less the same in China today.[382]

[380] For example when the Ministry of Health called for a national anti-malaria campaign in 1952 to reduce the cases of malaria and the death rate, the cooperation of other government ministries at the centre, such as education, culture, propaganda, labour, and agriculture, was necessary to have the Party in Beijing declare the campaign a mass movement, and pass the commands down to local levels to implement.
[381] Discussed also in China Health Economics Institute (2006) 农村卫生改革与发展研讨会论文集, Beijing.
[382] Indeed, patriotic health campaigns are still used today, but the local Party head is no longer held as tightly accountable for their success or failure.

Figure 8: Provision of health services vs Party movements in the Maoist period
Source: Author's own research and schema



The first attempt at social health insurance: 1960-1962

The difference in structures between Party-led patriotic campaigns and Ministry of Health-led health system development produced a variety of outcomes across the Chinese system. For example, attempts by Mao to change the health care sector used Party mechanisms — appeals to local government Party secretaries, and altered evaluation criteria for local government Party officials — rather than using the government system under the management of the Ministry of Health (and ultimately, the State Council). It also influenced the development of institutions in the local system.

Explaining why requires some context on the shifting structure of political units of the 1950s and early 1960s. Initially, rural agricultural production largely occurred at the household level. But this was seen as inefficient,[383] and the Party mandated, first in 1955, that households join with other households to create larger cooperative farms.[384] Hence, China went from having some 500 cooperative farms in 1955 to 753,000 cooperative farms by 1957.[385] In the Great Leap Forward (*dayuejin)* that followed, Mao and his followers decided to turn these advanced cooperative farms into people's communes.[386] Zealous cadres created communes all over China in a matter of 3 months. From the end of August to the end of 1958, the 753,000 collective farms[387] were amalgamated into 23,630 communes,[388] each with average of over 5,000 households, or over 99 per cent of total rural households in China in 1958. What private property rights to land and assets that remained were eradicated.[389] Membership in the commune became mandatory, with all rural citizens instructed to eat in communal kitchens. These communal kitchens, or food halls, were also used to conduct primary health campaigns such as the 'four antis' campaign described above.

[383] While these collectives allowed the household to voluntarily pool labour, large projects such as irrigation canals required yet greater labour pooling.
[384] Yifu Lin characterizes three main forms of collective that existed in rural China during this period: a 'mutual-aid team', where neighbours pooled labor, capital and livestock on a case by case basis; an 'elementary cooperative', in which 20-30 neighbours pooled all assets together into a joint scheme and shared income using a number of different methods; and an 'advanced cooperative', where 30 or more households operated a collective and all 'income' was divided as work points amongst the team, with the value of the work points being determined by the annual income of the collective. Justin Yifu Lin (1990) 'Collectivization and China's agricultural crisis in 1959-1961', *The Journal of Political Economy*, vol. 98, no. 6, pp. 1228-1252.
[385] Ibid.
[386] For the judgment on the encouragement, see the conclusions of Frank Dikötter (2014) *The Tragedy of Liberation: A History of the Chinese Revolution, 1945-57*, Bloomsbury: London; for the activities see for example Mao Zedong (1958) 'Sixty Points On Working Methods – A Draft Resolution From The Office Of The Centre Of The CPC', February 2, 1958.
[387] Justin Yifu Lin (1990) *op cit.*, p.1251.
[388] Dali Yang (1995) *Calamity and Reform in China: State, Rural Society, and Institutional Change Since the Great Leap Famine*, Stanford University Press: Palo Alto CA, p. 23.
[389] John Fairbank (1986) *The Great Chinese Revolution, 1800-1985*, Harper & Row: New York, p. 283

Table 1: Average size of political institution (person) 1950-1959

Year	Mutual Aid Groups	Agri Producer Coop (APC)	Advanced APC	People's Communes
1950	4.2	10.4	32	
1951	5	12.3	30	
1952	5.7	15.7	184	
1953	6.1	18.1	137	
1954	6.9	20	59	
1955	8.5	26.7	76	
1956	12.3	48.2	199	
1957		44.5	157	
1958				5443
1959				5008

Source: Dali Yang (1995) *Calamity and Reform in China: State, Rural Society, and Institutional Change Since the Great Leap Famine,* Stanford University Press, p.23

This chopping and changing of rural structures resulted in a large expansion in the number of health facilities. Each of the newly-created communes was to have a clinic, with administrative and policy control vested in the Commune Party Committee.[390]

The commune health clinics were led and controlled solely by the commune Party Committee. This system avoided the Ministry of Health and instead directly charged the commune Party Committee with the constitution of health centres.[391] This was partly in reaction to Mao's decree to build health facilities in the newly-formed communes. Local Party heads 'perceived (probably correctly) that they were evaluated on the basis of their

[390] As decreed by the Central Committee; Mao Sixty Points. On the confirmation by the Central Committee of this draft, see David Lampton (1977) *The politics of medicine in China: the policy process, 1949-1977*, Westview Press: Boulder, Colorado, p. 91.
[391] Mao Zedong (1958) 'Sixty Points On Working Methods – A Draft Resolution From The Office Of The Centre Of The CPC', clauses 1 and 4.

performance in transforming rural areas … Because free medical care was thought to be a tangible incentive for high levels of collectivisation, it was one of the first welfare functions initiated.'[392]

The delegation of authority for commune health clinics to the Party was also likely in response to Mao's dissatisfaction with local leaders delegating health system functions to the Ministry of Health and not getting the outcomes Mao desired. For example, when Mao launched a "Four Pests" campaign in 1955 attempting to control malaria, schistosomiasis and other infectious diseases,[393] and devoted great personal credibility to the campaign,[394] many of the tasks were allocated to local health bureaus by Party leaders. But the achievement of these tasks took a number of years to penetrate[395] through to the countryside.[396] It took until 1957[397] to finally be implemented to Mao's satisfaction. And when this was achieved, it was not through the state (Ministry of Health) system. Rather, local Party heads were ordered to 'override' health professionals and prioritise the Party campaign to eliminate the four pests, rather than ensuring that the Ministry of Health's professional health system priorities were implemented.[398]

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[392] David Lampton (1977) *The politics of medicine in China: the policy process, 1949-1977*, Westview Press: Boulder, Colorado, p. 79.
[393] Ruth Sidel and Victor Sidel (1982) *The Health of China*, Beacon Press: Boston.
[394] It had three approving comments, or *pishi*, attached — as a comparison, the entire Cooperative Medical Scheme was launched with just one! See Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke p.25 as well.
[395] See Vivienne Shue on state penetration, Vivienne Shue (1980) *China in Transition: The Dynamics of Development toward Socialism*, University of California Press: Berkeley, pp. 213-217 and p.329
[396] Former Minister of Health Qian Xinzhong: 'until the winter of 1957, there was still a considerable part of the countryside that the government failed to mobilise' Qian Xinzhong (1992) *中国卫生事业发展与决策,* 中国医药科技出版社: Beijing（*China's health work development and policy,* China Medical and Drug Science Press: Beijing*)*, , p. 171.
[397] *Ibid*.
[398] Mao Zedong (1958) 'Sixty Points On Working Methods – A Draft Resolution From The Office Of The Centre Of The CPC' clause 51: 'Develop a patriotic public health campaign centering on the elimination of the 'four pests', and have monthly inspections this year, so that the groundwork of [this campaign] may be

Either way, at Mao's command, formerly fee-for-service local district health centres and township clinics were transformed by local Party secretaries into commune health centres.[399] By end of 1958, the number of commune or below level health facilities had jumped to around 43,600, double the number of communes.[400] These centres were financed largely through commune and county budgets, and offered simple procedures and drugs virtually free of charge.

The provision of free health care, including drugs, led to the problem of overuse and over-provision of services in some areas.[401] The problem was worsened by the fact that Party cadres enjoyed preferential access to treatment, and there were complaints about a conflict of interest. This caused great difficulties for local budgets. Most localities lacked the funds to support the health system day-to-day.[402] Short budgets also increased the division between state and Party structures. While patriotic campaigns required very little funds, relying largely on the 'mobilisation of the masses',[403] health system funding (that is, funding for health service delivery not organised through mass campaigns) had to be

laid. Other pests may be added to the list according to local conditions.' See also Yanzhong Huang, *op. cit.* p.30 on the four pests campaign — 'attacks against the 'conservative' health professionals, and subsequent rapid 'cure' of the diseases as Party functions overrode state function'.

[399] Yanzhong Huang (2012) *op cit.,* p. 32

[400] See Gu Xin (2006) *诊断与处方：直面中国医疗体制改革*，社会科学文献出版社: Beijing (*Pathologies and cures: directly reforming the Chinese health care system,* Social Sciences Press: Beijing).

[401] This was the major problem with the 政社合一 ('unification of politics and society') system; the idea of 'overprovision' may be how the system itself described matters — see for example Cao Pu (2012), *op cit*., pp 44-46 for the official view — and indeed, the centre argued that the combining of government and society in the Great Leap Forward was 'a huge boon for the development of cooperative health care, as it meant that there could be funds regularly coming in', but for the cash-strapped local governments that actually had to pay for the services, 'overprovision' was likely to just mean provision of some form of service. Thanks to Anthony Garnaut for pointing this out, and for a number of elucidating thoughts on the topic in general.

[402] David M. Lampton (1972) 'Public Health and Politics in China's past Two Decades', *Health Services Reports*, Vol. 87, No. 10, pp. 895-904.

[403] Zhuanxing Institute(2012) *新农合作医疗：问题与展望*, 传知行社会经济研究所:Beijing, (*NCMS: Problems and Prospects*, Zhuangxing Institute Press: Beijing) p. 3.

found from the same limited pools of money that all other local government interests in China were fighting for. Even after the Great Leap Forward, spending on culture, education, health care, and science accounted for only 8% of local budgets in 1960, and only 12% of the (limited) total local budget in 1962.[404] Budget shortages limited the provision of health care, particularly advanced health care; there simply were not the funds. Exhortative (and fiscally cheap) Party campaigns were able to be provided with solely the cost of labour, and were far more likely to appear more attractive to local governments.

Party-led Social Health Insurance

A similar split between state and Party system occurred with the development of social health insurance. Cooperative medical schemes had already appeared in some parts of China in the mid-1950s.[405] These schemes were based at the commune level, with expenses for medical care jointly shouldered by the communes and by commune members. Funds for the scheme were taken from a cooperative welfare fund was financed by a small annual fee paid by commune members, plus funding from the commune public welfare fund (*gongyi jin*公益金) taken from revenues from agricultural production. These early cooperative experiments organised some post-treatment health insurance for patients, and also built some health care stations that directly paid providers to offer treatment for the brigade/village.[406]

[404] Table 3.2, New China Fifty Years' Government Finance Statistics (2000), Economic Science Press: Beijing.
[405] Known as Cooperative Medical System, their structure was similar to the final one used.
[406] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p. 27

But there was a complicated relationship in these early trials between what should be done and who should pay for it. For households, health insurance fees were not always very popular.[407] Contributions were deducted before any income from collective work was distributed back to the household.[408] This compulsory deduction of fees made contributing to the social health insurance scheme much more a political question than a question of individuals voluntarily joining a scheme; should the collective determine that you should contribute, you would be unable not to. But with this household contribution also came higher expectations for local citizens as to how much medical care could be accessed. And these higher expectations also created fiscal burdens for local governments. For, while theoretically insurance schemes could increase the funds available to the local health care system, the increase in expectations they engendered could also bring far greater use of pharmaceuticals (some of which were assessed as unnecessary),[409] an increase in the rates of hospitalisation,[410] and a sharp rise in costs for the local government.[411]

So in response to any sort of push for a social health insurance scheme, communes favoured narrow coverage plans that would reduce the amount of contribution made by the commune for major medical work,[412] and told citizens that significant medical work would be performed at the county hospital. Subsequently, minimising referrals to the county hospital would thus lower the costs for the (usually cash-strapped) commune.

[407] Macy Foundation (1974) *Medicine and society in China,* Josiah Macy Foundation: New York
[408] Jane Duckett (2011), *The Chinese State's Retreat from Health: Policy and the Politics of Retrenchment*, Routledge: Basingstoke, p.28 'household contributions were deducted from a production team's income before the end of year allocation to members — and a CMS fee then submitted to the brigade.'
[409] Sidel and Sidel (1982), *op cit.* p.47 'must pay 5 to 10 fen per visit copayment. Reported that in early days of cooperative medical services there were 'unnecessary visits and requests for tonic herbs'
[410] Lampton (1977), *op cit.* p.50
[411] Local governments had to foot the bill for patients actually being treated.
[412] Lampton (1977), *op cit.* p.235 Limited and variable benefits for those requiring referral to higher-level hospitals.

Lampton[413] argues that this template made it easier to control waste and over-utilisation; and it minimised the amount that well-to-do brigades had to subsidise poorer units. It also meant that insurance funds would not run out of funds.

But using such a structure meant that schemes were largely *ad hoc,* and they had to be initiated by the local government itself. Hence, by the time collectivisation in communes was mandated by Mao in 1958[414] there were various attempts at community-led health insurance across the country, but no approved national scheme.[415] As a result, and as shown above also as a result of the fact that any form of social health insurance scheme was likely to be expensive for the local government, most communes did not institute schemes. National social health insurance was virtually non-existent.

Mao, unhappy with this situation and with the lack of response to the mention of collective health care (including insurance) in the 1958 collectivisation decree, decided in 1960 that he would introduce a national health insurance system. In February of 1960, the Central Committee released a guiding implementation document on rural health care (a *wenjian*) that described exactly how local governments should interpret the 1958 collectivisation mandate, including the guidance to develop health insurance schemes.[416] As this health care *wenjian* specified the terms of the 1958 decree, it was clear that these health care directives should be implemented by party standing committees (PSCs), as they

[413] Lampton (1977), *op cit.* p.232-3
[414] Usually thought to be based on Mao's visit to Henan, but the exact date is contested.
[415] Feng Xueshan, Tang Shenglan, Gerald Bloom, Malcolm Segall, and Gu Xingyuan (1995) 'Cooperative medical schemes in contemporary rural China', *Social Science & Medicine*, vol. 41 (8) pp. 1111-1118. 'The first recorded CMS in the Union Agriculture Corporation, Henan Province and the first health station (Mishan joint health station) in Mishan Town, Shanxi Province were instituted', p. 1111.
[416] 中共中央以中发（60）70号文件, 1960年2月2日 (Central Committee Doc. No. 70 of 1960, issued 2 February).

were the bodies that were to implement the 1958 decree. However, Mao clearly felt that this Central Committee guidance was insufficient. In March 1960, Mao issued a personal decree (*pishi*) and ordered that all PSCs must 'immediately implement the commands of the February guiding document',[417] and that they should 'restart the patriotic public health movement which has been in decline during the Great Leap Forward, and be sure that achievements are to be made within the period from 1960 to 1962'.[418] Mao's decree made clear that he would hold all members of the PSC at each level personally accountable for initiating collective health care, including social health insurance.[419] Mao's March 1960 *pishi,* in combination with both the authoritative Central Committee *jueding* of 1958 and the Central Committee's detailed implementation instructions of February 1960, made clear that local Party heads (and not the Ministry of Health) would be held to account for not following central health care decree.

A central part of this new movement of health care was the establishment of cooperative medical insurance (CMS).[420] The basic structure of the cooperative medical scheme was as follows:

- Compulsory prepayment by residents. Depending on the benefit structure of the plan and the local community's economic status, 0.5 to 2 per cent of a peasant family's

[417] '立即将中央二月二日批示的文件发下去，直到人民公社' ('instantly carry out the February 2nd Central Committee decree, (work) directly to the people and society'), Mao Zedong (1960) 中央关于卫生工作的指 ('Directions for the Central Committee regarding health work'), 16 March, available online http://www.xiejiaxin.com/maozedong/dljo36.htm

[418] *Ibid.*

[419] '要求各级党委高度重视农村合作医疗问题'. ('Require that each level of Party Standing Committee put great measure in (solving) rural health care issues'). *Ibid.*

[420] e.g, Xu Yunpei: 'at present the ideal medical care system for commune members… is collective medical care. Under this system, the expenses for medical care are jointly shouldered by individual members and the commune, and the funds are pooled collectively.' quoted in Lampton (1977), *op cit.* p. 231).

annual income (be that work points or grain contribution) was to be paid into the fund as a premium.

• Brigade contributions. Each brigade contributed a certain portion of its income from collective agricultural production or rural enterprises to a welfare fund, and a portion of this fund was used to finance health care by transferring funds to the commune (the level above).

• Commune contributions. The commune was 'to fund the health care itself by setting funds aside' and was forced to mandatory community health insurance to individuals.

• Government subsidies. Subsidies from higher levels of government funded the compensation of health workers and capital investments.[421]

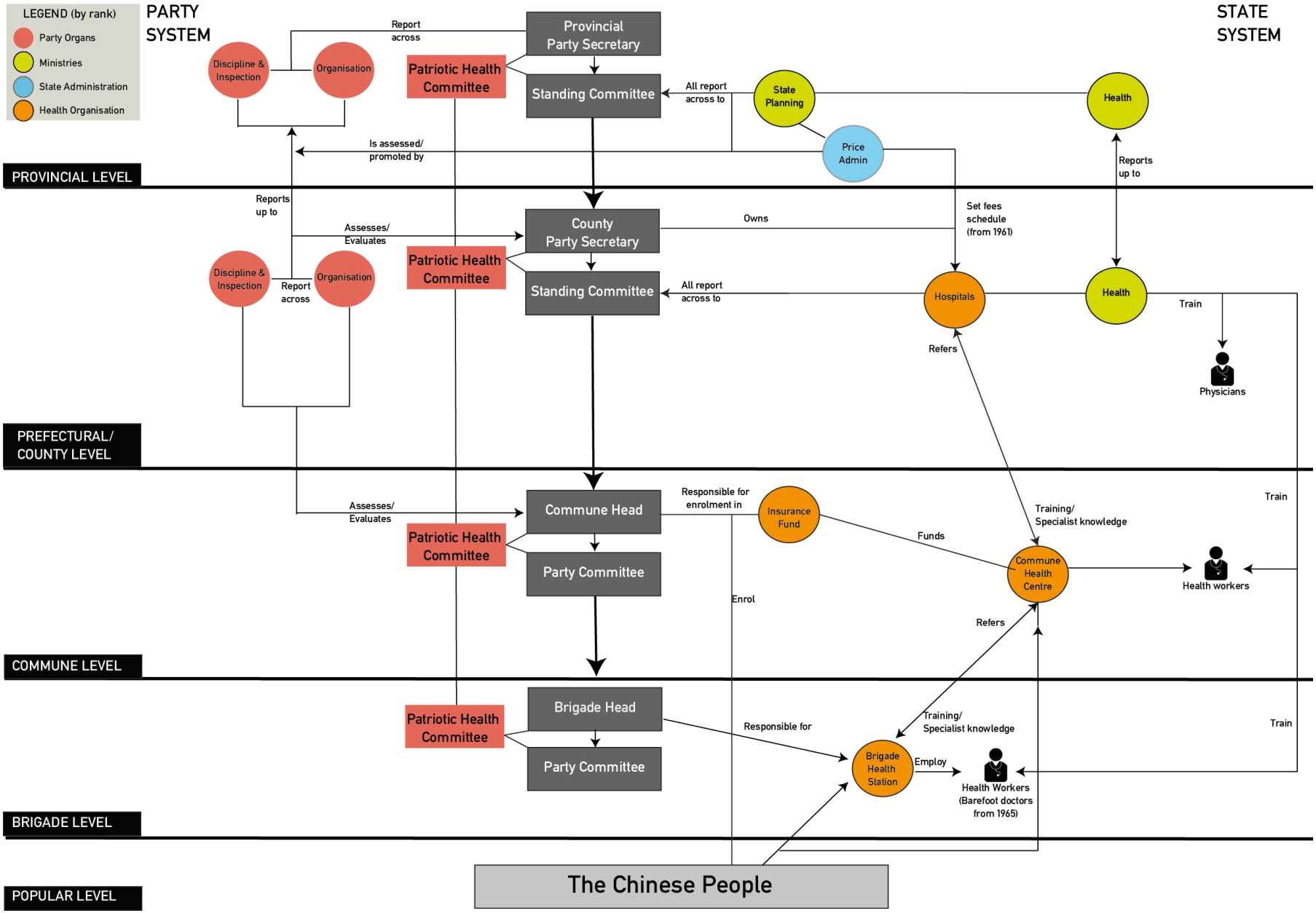
These medical cooperative schemes were based on the principle of voluntarism '*canhe yi ziyuan wei yuanze*'.[422] Yet, whether the scheme was voluntary for peasants to join or not, it was not at all voluntary for the local state to enrol peasants in the scheme; as of Mao's *pishi* of 16 March the commune Party secretaries were under strict instructions to introduce the insurance scheme, and indeed, higher level Party secretaries and committees were also under strict instructions to ensure that commune Party secretaries introduced the insurance scheme.[423] This was similar to many other developments in collective

[421] Bloom G. (2001) *China's rural health system in transition: towards coherent institutional arrangements?* Paper presented at the conference on 'Financial sector reform in China' organized by the Centre for Business and Government John F. Kennedy School of Government Harvard University, USA, 11–13 September 2001.
[422] Zhuanxing Institute(2012) *新农合作医疗：问题与展望*, 传知行社会经济研究所:Beijing, (*NCMS: Problems and Prospects*, Zhuangxing Institute Press: Beijing), p. 3.
[423] See above on the chronology and background of this decision to hold Party standing committees accountable, but note also that Mao's *pishi* were reinforcing the collective decree of February (中共中央以中发（60）70号文件, 1960年2月2日 (Central Committee Doc. No. 70 of 1960, issued 2 February) .

financing at the same time which also appeared far from voluntary.[424] The mandated insurance schemes then changed the system of health care, and health financing, as can be seen in Figure 9 below which describes the institutional system used to attempt to establish social health insurance schemes during the period 1958 to 1962. Particularly important was the use of Party bodies to hold commune secretaries accountable for ensuring that local citizens enrolled in social health insurance schemes, as per Mao's March 1960 instructions.

[424] Some writers claim that, at least initially, farmers and their leaders had some choice about whether to collectivize; see Justin Yifu Lin (1990) 'Collectivization and China's agricultural crisis in 1959-1961', *The Journal of Political Economy*, vol. 98, no. 6, pp. 1228-1252. Compare this judgment with Yanzhong Huang: 'Whether or not the decision to pool farm tools and cooperate during planting and harvest was voluntary, it is certain that, once Mao Zedong decided to organize rural China into communes, there was no choice whatsoever.'

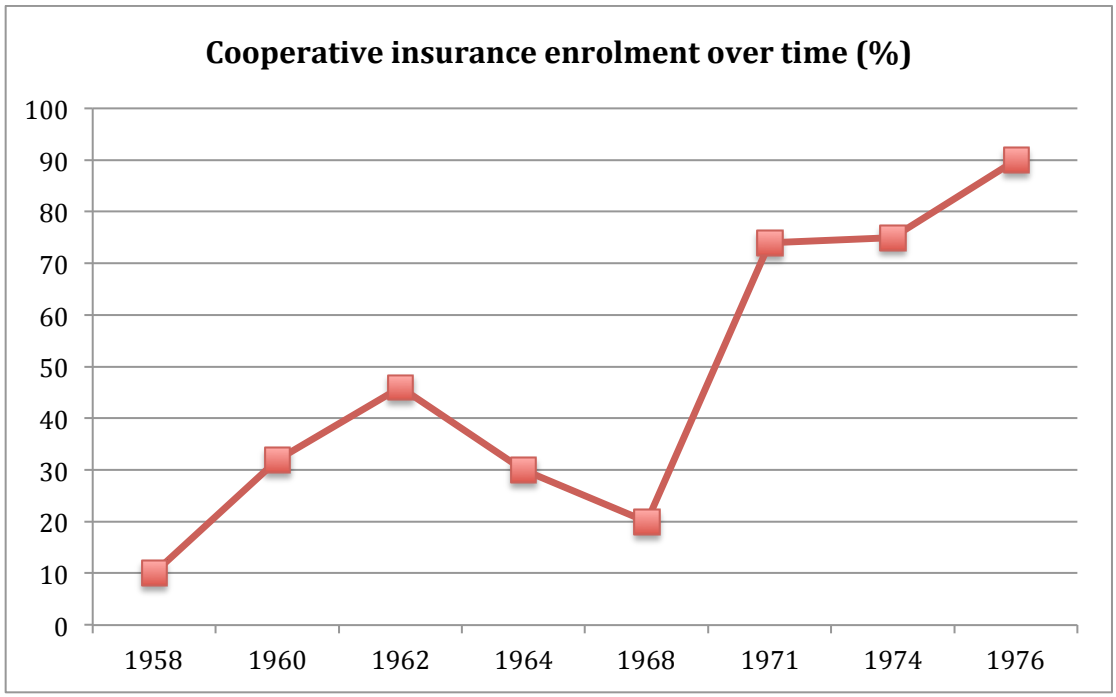
Figure 9: Social Health Insurance schemes between 1958 and 1962
Source: Author's own research and schema



These strict instructions to local leaders meant that, in spite of the scheme's being nominally voluntary, and the fact that millions of peasants were starving at the time and thus unlikely to wish to join the scheme,[425] the first-ever attempt at a national rural health insurance scheme was taken up incredibly quickly. In 1959, the start of health system reform, around 10 per cent of rural residents had health insurance. Figure 10 below shows that by the end of 1960, the year the scheme was announced and rolled out by Mao, 32 per cent of rural residents had health insurance. By 1962, when the scheme was officially discontinued, 46 per cent of rural residents were enrolled in the national social health insurance scheme.

[425] Estimates vary wildly from 13 million to over 46 million — clearly consideration of this debate is well beyond the grounds of this thesis, but the fact that many, many people died of starvation is undoubted.

Figure 10: Percentage of rural residents enrolled in cooperative insurance schemes in China 1958-1976



Source: 张晓 and 刘蓉(2006) *社会医疗保险概论* [Outline of Social Health Insurance], 中国劳动社会保障出版社: Beijing, p.223.[426]

The key to this rapid society-wide enrolment in these two years was Mao's mobilisation of local leaders. By decreeing that all PSCs at each level must 'put great stock' in solving health care problems, the vertical lines of command discussed in Chapter 3 meant that each PSC held the PSC the level below it accountable. In essence, by targeting each PSC, Mao added social health insurance enrolment to the assessment criteria for the commune Party head (as the bottom of this chain of vertical command).[427] And, as Figure 9 above

[426] Data matched against 李德成(2007) *合作医疗于赤脚医生研究*, unpublished PhD Thesis, Zhejiang University, p. 44. Note that there is a difference in values between the data in these two sources and the values for 1973 in Shaoguang Wang (2009) 'Adapting by Learning: The Evolution of China's Rural Health Care Financing', *Modern China*, 2009 vol. 35, no. 4, p. 383, and thus the 1973 data was not used.
[427] Discussed above at some length. Another point of triangulation is that Chinese commentators also see this as a *political* decision, and thus one that (given the context of the period) would necessitate See also 曹普

showed, Mao used the Party mechanisms of program implementation rather than state mechanisms. He mandated that the head of each political level (the Party secretary), should 'take charge' (*guashi*) of the health care campaign, including the institution of cooperative health insurance.[428] Households were forced, or encouraged, to enrol by the commune, often through the communal kitchen program mentioned above.[429] The county Party secretary monitored enrolment in the commune[430] through tracking the contributions to the commune account by household. Clearly, this did not mean that households necessarily enrolled. But it did mean that commune Party secretaries had to ensure that funds were in the account to make it look as though the peasants had enrolled. This shows the power of Mao's command — and the ability of local Party leaders to monitor and ensure compliance.

It is important to note that the argument here is not that the extension of the health care system was effective in achieving broad health objectives. The expansion of the

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(2014) *新中国农村合作医疗史*, 福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou) pp. 44-46, who argues that '合作医疗在发展中虽曾用政治手段和行政命令强制推行' ('the development of cooperative medicine was strengthened and advanced by using political methods and administrative decrees'); see also Tao Li's official Party history of the period (2011) '中国共产党对医疗保障制度的探索与经验', 当代中国史研究, ('An investigation and study of the Chinese Communist Party's social insurance system', *Modern China History Study*) vol. 8, available online: http://theory.people.com.cn/GB/82288/83854/83867/15430719.html

[428] Mao Zedong (1960) 中央关于卫生工作的指 ('Directions for the Central Committee regarding health work'), 16 March, available online http://www.xiejiaxin.com/maozedong/dljo36.htm

[429] See both Cao Pu (2014) *op cit.,* p.45 and Tao Li (2011), *op cit.* who both note that the commune Party secretaries tried to meet the criteria imposed on them discussed above through using the communal mess halls to force people to enrol in SHI schemes. This idea of schemes not really being voluntary, and commune Party secretaries having considerable control is also party of a broader theme at the time. Agricultural workers were forced to work under constant monitoring and were no longer rewarded for their marginal input into production — see for example D. Gale Johnson (1998) 'China's Great Famine: Introductory Remarks,' *China Economic Review*, vol.9, no. 2, pp. 103–109.

[430] Itself a considerable feat, as for example imperial China did not go formally past county — for a brief overview see Tang Tsou (1991) 'The Tiananmen tragedy: the state-society relationship, choices, and mechanism in historical perspective' in Brantley Womack (ed.) *Contemporary Chinese Politics in Historical Perspective*, Cambridge University Press: Cambridge, p. 270.

commune and of state control of grain was disastrous for society, with mass starvation.[431] Rather, the argument is that enormous increases in enrolment in social health can be stimulated by central decree and the mobilisation of the local state, but to succeed it had to hold the local Party secretary accountable.

How Mao's actions sidelined the Ministry of Health

The absence of Ministry of Health input into the 1960-1962 program is notable. The program was announced in substance and promise by the Central Committee in February.[432] In March 1960, Mao specified the official beginning of the program, and the form of the health insurance program. Showing the Party-led nature of the program, the Ministry of Health did not issue any of its own mandates or guidelines until August, more than six months after the initial commitment to health care had been made.

The lack of input was part of a broader sidelining of the Ministry of Health within the Chinese political system. For example, normally a provincial Ministry of Health bureau would answer to two superior units: the central-level Ministry of Health and the provincial government.[433] In the early 1950s the Ministry was entrusted with administrative leadership with the provincial health departments by having a primary say over issues such

[431] Unsurprisingly, this judgment is contrary to the literature on the topic within China, which argues that 'production and health care were inextricably linked — thus the growth in rural health insurance post Lvshan in 1960'. 曹普(2014) *新中国农村合作医疗史*, 福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p. 62.

[432] 中共中央以中发（60）70号文件, 1960年2月2日 (Central Committee Doc. No. 70 of 1960, issued 2 February).

[433] A Doak Barnett (1967) *Cadres, Bureaucracy, and Political Power in Communist China*, New York: Columbia University Press; Franz Schurmann (1966) *Ideology and Organization in Communist China*, Berkeley: University of California Press; Harry Harding (1984) *Organizing China,* Stanford: Stanford University Press.

as lower-level personnel appointments and payroll expenditures for staff. Yet, beginning around 1960, amid central efforts to expand local autonomy and streamline state institutions, the Ministry transferred its direct administrative functions, including the *nomenklatura* authority, to provincial governments. The weakening clout of the Ministry of Health, then, led to institutional changes in the rank of Ministry of Health offices at the county level; *chu* became *ju*. This was a substantial change — *chu* can independently contact units, while *ju* had to go through the administration office (*ban gong ting*) of any given political level.[434] So, by having to go through the adminstrative office (*ban gong ting*), all contact with lower-level commune hospitals was thus subject to the mandate of the commune Party secretary, rather than the Ministry of Health.

Figure 11 below describes how these changes altered policy. Health policy was now led by Mao; his speeches set the direction of health care, and set the incentives for different actors. While a Ministry of Health existed under the direction of the State Council, few reports consider it an important Ministry. It was, rather, seen as an executing agency for Mao's decrees. The more significant body was the Patriotic Health Campaign, which had stronger targets for local leaders, as Mao's 1960 *pishi* which linked successful implementation of collective health care with 'restarting the patriotic public health campaign', and said that each level of Party Standing Committee would be held accountable for ensuring health affairs are given the 'highest priority'.[435] Figure 11 below highlights the more direct accountability measures implemented under the Patriotic

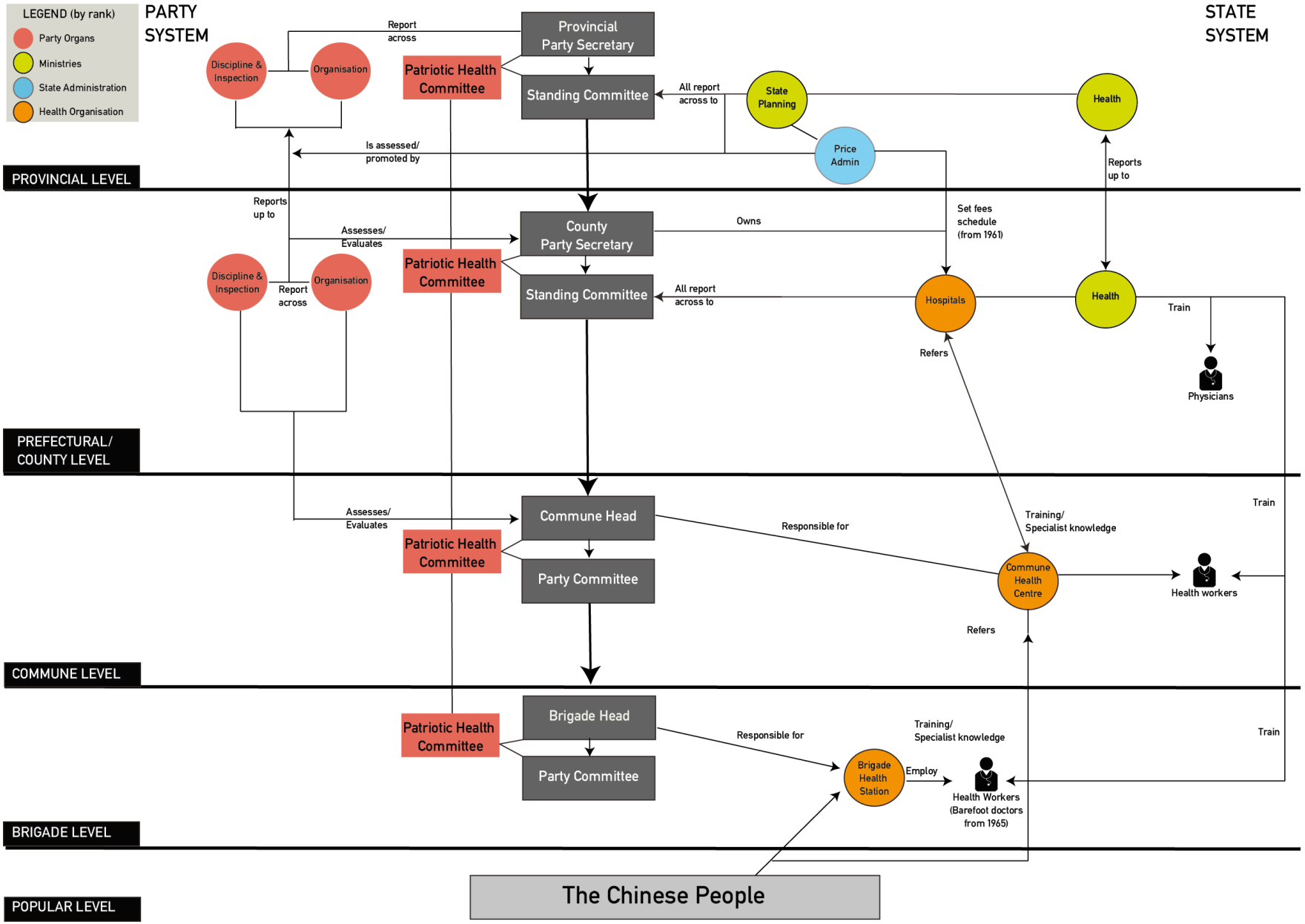
[434] Lampton (1977), *op cit.* p.48
[435] Mao Zedong (1960) 中央关于卫生工作的指 ('Directions for the Central Committee regarding health work'), 16 March, available online http://www.xiejiaxin.com/maozedong/dlj036.htm; see also discussion above.

Health Campaign structure. Mao's leadership over the health care system made health policy implementation a matter for local leadership rather than Ministry leadership. While the Ministry controlled training, administration and day-to-day policy changes, the major shifts in Chinese rural health policy — the 'four pests' campaign,[436] the cooperative medical scheme, the barefoot doctors — came directly from Mao to local Party Standing Committee leadership in 1960.

This led to a more or less two-tier system, where Party goals were implemented much more effectively than health system goals. Mao himself completely bypassed the Ministry of Health for implementing what he personally saw as health system priorities. He twice created his own Party leading small groups (LSGs) for different diseases; his creation of these priority LSGs forced provincial and county Party committees to also establish matching LSGs.[437] Thus, while health system goals were monitored by the Ministry of Health their implementation relied on considerable support and leadership from local Party Standing Committees. Figure 11 illustrates — note how the Party structures (most notably the Patriotic Health Campaign, pictured in red) have far more direct lines of accountability and authority for local leaders than any program the Ministry of Health may be able to create.

[436] A major campaign to eliminate animals that Mao saw as causes of communicable diseases (flies, rats, sparrows, mosquitoes); see Judith Rae Shapiro (2001). *Mao's War Against Nature: Politics and the Environment in Revolutionary China*. Cambridge University Press: Cambridge for more on the campaign.
[437] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.28-29

Figure 11: Provision of health services vs Party movements in the Maoist period
Source: Author's own research and schema



Mao's decisions changed the health system itself, making it even more Party-focused. Administrative and policy control over health care decisions remained with the Party (at the level of the Commune Party Committee).[438] This gave the Party Secretary the power to judge which patients could access higher-level specialist care. Authority for assigning staff to different tasks or work units and authority for assessing the performance of staff was transferred from Ministry of Health provincial bureaus to the provincial government directly.[439] And the administration of capital construction and capital-raising activities for health facilities was also directly transferred to local government Party Standing Committees.[440] This meant that the local governments at each political level had control over the activities of the health care sector. Such relations were later enshrined in the Chinese constitution,[441] and greatly tightened the local government's control over the activities of the health sector.

This Party-state divide had a major influence on health care provision. The brigade had no incentive to minimise health care costs, as sending citizens to the commune level health sector and the county hospital was, for the brigade, relatively cost-free. There was a soft budget constraint for health care providers—the brigade or commune reimbursed the patient or the provider for the cost of treatment, and these funds were allocated by the Party secretary. But, the Ministry of Health — which only had a mandated presence at the

[438] This also shows the limited amount of input of the Ministry of Health.
[439] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.20
[440]卫生部红色造反团 (1968) 农村卫生工作两条路线斗争大事记 1949-1966, (Ministry of Health Red Rebel Group (1968) *A record of the two-line struggle in rural health 1949-1966*) 天津市卫生系统劳动卫生斗批改联络站: Tianjin.
[441] Chinese Constitution, Article 107: various levels of subnational governments at or above the county level adminster the economy, science, culture and public health. Note that this means that they can issue their own decrees, as long as they do not 'contradict central laws'.

county level,[442] and thus as Chapter 3 showed in the abstract, had very little ability to affect the behaviour of the brigade or commune Party secretary, was still responsible for the health system at large, and, more specifically, responsible for controlling the behaviour of local health care providers. In other words, local Party leaders could run up a health care spending charge, and the county Ministry of Health budget would have to foot the bill. Usefully for these local Party leaders, this fiscal situation joined with the Ministry of Health's strategic focus on making county hospitals the lynchpin of treatment to further shift costs to the Ministry of Health county budget, and away from the local level budgets.

This mixed institutional environment saw the Ministry of Health lose much of its sway over public health care. The Ministry of Health focus in the health system was on developing the county as the hub of public services. By 1952, almost all counties had health facilities.[443] The county health bureau was responsible for the performance of local health services. It prepared plans and allocated the annual government budget. Under some Ministry direction, county hospitals supervised commune and brigade facilities and provided referral services, training and high-level tertiary care. This reflected the Ministry of Health's belief that the county was the optimal treatment level; a belief that Lampton notes continued throughout the 1950s and 1960s.[444]

[442] See Central Governing Body (1951) 政务院关于一九五一年度财政收支系统划分的决定 ('Central Governing Body decision on the 1951 division of fiscal responsibilities') clause 9.
[443] Wang Shaoguang (2008) 学习与适应: 中国农村合作医疗体制变迁的启示 ('Learning and Adaptation: Inspiring China's Collective Health System Reform') , Tsinghua School of Public Policy and Management working paper, available online: http://e-sociology.cass.cn/pub/shxw/shgz/shgz54/P020090226562771095016.pdf: '1952年底，全国90%以上的地区建立了县级卫生机构，县级卫生院达2123所' ('At the start of 1952, more than 90% of counties nationwide had built county-level health structures, and there were 2123 county hospitals').
[444] Lampton (1977), *op cit.* p. 159.

The county-level bias mean that the Ministry of Health's response to requests to minimise costs while dealing with rising demand became to make the *county* hospital responsible for provider behaviour. Vice-Minister of Health He Biao pronounced in 1960 that county hospitals were to be the hub of curative care in the countryside: 'To strengthen the rural medical and health organisations … the county hospital must be the centre'.[445]
But this county-level focus put the Ministry of Health directly into an institutional conflict it could not win. In the Ministry of Health model, county hospitals acted as the highest point of care and the local state's public health mechanisms (that is health care providers at levels below the county hospital) acted as gatekeepers for these hospitals. In other words, the people who were meant to control costs didn't answer to the county Ministry of Health bureau. Rather, the gatekeepers answered to the commune or brigade Party Secretary, who, as Chapter 3 showed, controlled all the institutions governing the gatekeepers' lives — including their ability to be promoted, be paid, or otherwise enjoy a comfortable life. Making local health providers the gatekeepers, and thus trying to make them deny treatment to brigade or commune level citizens put the Ministry of Health's interests against those of the local Party heads. The Ministry of Health was unlikely to win in this clash of interests.

1962-1968: Mao's retreat from health leads to falling enrolment

The fortunes of the Ministry of Health were then to change, albeit not necessarily for the better. The end of the Great Leap Forward then saw the responsibility for health care spending (and for health insurance) transferred back to the Ministry of Health, but there

[445] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p. 38.

was no transfer of public monies to allow the Ministry to meet its responsibilities. Indeed, if anything, the Ministry of Health was put in a worse position politically — and social health insurance scheme enrolment then collapsed.

Some political context may first be required. Due to the severe crisis in rural agricultural production during the Great Leap Forward, the shift to large communes as the key unit of production (and thus insurance) was reversed. By the end of 1961, most of the Great Leap Forward's structural political unit policies had been reversed.[446] The brigade (rather than the commune) then became the basic unit of accountability in Chinese rural politics. Communes were reduced in size.[447] And the Ministry of Health was made responsible for local health care services again; which meant that it had to fund the cost of health services.[448] In August 1962, the responsibility for ensuring enrolment in social health insurance was taken away from the Commune Party Secretary and moved instead to the county Ministry of Health office.

But this shift in responsibility put the Ministry of Health in an invidious position. Mao's precept that communes shrink in population size led to a reduction in the

[446] For example, production decisions were decentralized to those production teams with an average size of 20-30 households, income distribution reverted to being more like the 1956 system, and communal kitchens were disbanded.

[447] In May 1961, new " draft regulations" (often also called the "60 articles") were issued which cut the size of the average commune by two thirds. These noted: 'The scale of the people's commune at the various levels should in every case be such as to benefit production ... and ought not to be excessively large. In general, the people's commune should be equivalent in scale to the original hsiang or large hsiang (ed. — village)'. Central Committee (1961) 'Draft Regulations for Work in Rural People's Communes' (农村人民公社工作条例修正草案(1961年6月15日), clause 5. Available online: http://www.chinadmd.com/file/6t6vrw6vpctrwtpcezeipuzx_1.html.

[448] See the July 1961 Central Committee *jueding* 中共中央、国务院关于进一步压缩社会集团购买力的决定 ('Central Committee and State Council Decision on reducing the purchasing power of large communes') which gives responsibility for building preventive stations to MoH, but does not give them the ability nor power to impel people to join (clause 3.1 and 3.5).

communes' ability to finance any local health care.[449] However, while there was then a fall in the number of commune hospitals,[450] the growth had already been explosive (see Table 2 below). So as Chinese society emerged from mass starvation,[451] more people were likely to seek care, but communes had no funds and no central funds were forthcoming.[452] This led to a significant structural shift in the delivery of care model.[453] The Ministry of Health was held responsible for whether or not these underfunded hospitals remained as going concerns — and so Ministry of Health officials were forced to confront the demand for expanded service on one hand with the need to reduce costs on the other hand.[454]

In response, the Ministry made commune clinics run by doctors the principal form of grassroots unit,[455] so that doctors rather than Party leaders could refer patients to higher levels of care. The Ministry argued that this would 'elevate the role of doctors, make it easier for people to see a doctor, reduce the burden on the state and on the collective (and brigade)'.[456] As the Ministry was responsible for doctor training,[457] they believed that a shift

[449] From a first principles basis — if you have a smaller political unit but have the same expectation of service delivery units, then your ability to finance those delivery units will necessarily be smaller. See Table 2 in the main text above.
[450] The number of commune clinics fell from 43600 in 1958 to 26200 in 1960. Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.32.
[451] The so-called *guncaidai*, or eating sticks as food period.
[452] 'Chinese communist budgetary policy is not Keynesian but rather very fiscally conservative — faced with a deficit of two billion yuan in early 1962, restricted from borrowing money from abroad by principles of self-reliance, inhibited from raising money domestically by fears of inflation, the leadership probably saw no alternative to a policy of fiscal retrenchment and economic rationalisation. This entailed 'chopping down' all recent capital outlays (eg local factories and schools and health care facilities) that could not be justified in terms of cost-benefit analysis.', Lowell Dittmer (1977) '"Line Struggle" in Theory and Practice: The Origins of the Cultural Revolution Reconsidered' *The China Quarterly*, vol. 72, p. 683.
[453] See for example: Wang Sheng (2012) 1949 ~ 1978 年农村医疗 卫生制度的历史考察, 中国近现代史研究, ('1949 ~ 1978 rural health system history study', *China's Modern History Study),* vol. 4, pp. 21-28.
[454] David Lampton (1977) *The politics of medicine in China: the policy process, 1949-1977*, Westview Press: Boulder, Colorado, p. 110.
[455] Qian Xinzhong (1992) *中国卫生事业发展与决策,* 中国医药科技出版社: Beijing（*China's health work development and policy,* China Medical and Drug Science Press: Beijing*)*, pp. 55-6.
[456] 曹普(2014) *新中国农村合作医疗史*， 福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou) p. 74.

to more doctor-driven referrals would be more 'professional', and in the interests of the Ministry rather than in response to directives from local Party leaders.

The Ministry of Health's thinking was clear. Their goal was to have doctors in charge of referrals upwards rather than Party officials. But it was a relatively futile aim — the doctors who were meant to act as gatekeepers to allow only the needy to access higher-level care were outranked by local Party officials. So, according to Party rank, local officials were able to override any medical decision made by a doctor who was also a Party member (exact numbers are unavailable, but there were many, many doctors who were also Party members). This situation gave local Party officials the ability to override health professionals, and access care whenever they wished — and so the system was structurally unable to contain costs. This structural problem was what led to Chinese writers arguing that cooperative health insurance could never work as too many people 'took advantage of the system'.[458] Indeed, a study from the Central Party School in Beijing itself declared that the people 'taking advantage of the system' were 'local Party heads'.[459]

So in many ways, despite the Ministry of Health being given more responsibility, health system decisions were still largely based on decisions made by local Party leaders. Commune Party secretaries had complete control over labour mobilisation, propaganda,

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[457] Lampton, *op. cit*. pp.229-230. This role continued even through the Cultural Revolution, where commune and county hospitals did much of the barefoot doctor training (aided by PLA). The community themselves decided who should be trained as a barefoot doctor. These barefoot doctors usually came from the county level (and thus were not people who would otherwise be dragged off into rural production).
[458] 张自宽 (2011) *亲历农村卫生六十年*, 中国协和医科大学出版社: Beijing (Zhang Zikuan (2011) *Personal experience of 60 years of rural health care,* China Cooperative Medical Science University Press: Beijing).
[459] 曹普 (Cao Pu) (2014) *op cit.,* p. 71.

financing and other local inputs.[460] Commune Party secretaries could veto referrals to higher level facilities (county-level hospitals).[461] So, as the costs for patients needing foreign drugs and advanced medical techniques (available at the county hospital) were covered by the communes, the commune Party leadership basically held the ability of citizens to access high level health treatment in their hands.[462]

On the other hand, the Ministry of Health faced a number of difficult trade-offs, and was unable to control costs. Commune clinics, having risen exponentially in number (see Table 2 below, noting the difference between 1957 and 1962), lacked staff, and often lacked funds. Many commune health programs were already insolvent without outside subsidy.[463] There was regular cost inflation due to the rising cost of physicians and Ministry of Health funds being insufficient to match these rising costs.[464] Clinicians were forced to see 30-50 patients per day, and patients were reported as often requesting scarce foreign medicines.[465]

[460] For overview of county Party powers, see, A Doak Barnett (1967) *Cadres, Bureaucracy, and Political Power in Communist China*. New York: Columbia University Press; Franz Schurmann (1966) *Ideology and Organization in Communist China*. Berkeley: University of California Press; Harry Harding (1984) *Organizing China.* Stanford: Stanford University Press; for specific reference to the delegation of health care powers, see Mao Zedong (1958) 'Sixty Points On Working Methods – A Draft Resolution From The Office Of The Centre Of The CPC', clauses 1-4 inclusive.
[461] A Doak Barnett (1967) *Cadres, Bureaucracy, and Political Power in Communist China*. New York: Columbia University Press, p.221.
[462] Cao Pu (2010), *op cit.*
[463] Lampton (1977), *op. cit* p.137; Sidel and Sidel (1982), *op cit.* p.43; Feng Xueshan, Tang Shenglan, Gerald Bloom, Malcolm Segall, and Gu Xingyuan (1995) 'Cooperative medical schemes in contemporary rural China', *Social Science & Medicine*, vol. 41 (8) pp. 1111-1118
[464] Sidel and Sidel (1982), *op cit.*
[465] David Lampton (1977) *op cit.*, p. 112.

Table 2: Number of health organisations (1949-1970)

Year	Total	Hospitals	County and above hospitals	Clinics
1949	3,670	2,600	2,600	769
1952	38,987	3,540	3,540	29,050
1957	122,954	4,179	4,179	102,262
1962	217,985	34,379	5,300	172,708
1965	224,266	42,711	5,445	170,430
1970	149,823	64,822	6,030	79,600

Source: 陈育德（2000）中国城镇医药卫生体制改革指导全书 ('A comprehensive volume and guide to reforming China's township and city health and medicine system'), 中国物价出版社:Beijing, p. 260.[466]

The situation then became yet worse for the Ministry of Health. Doctors left local practice: by 1964, 90 per cent of senior health workers and 73 per cent of intermediate were at or above the county level.[467] Short on budget, and with investment dropping, local governments were often unable to subsidise the facilities.[468] The situation was dire enough for the Ministry of Health to decree that commune hospitals could undertake forms of privatisation.[469] The Ministry forced hospitals to begin to undertake profit and loss accounting, and also to undertake independent budgeting — a decision that made

[466] Data cross-referenced against I. G. Cook and T. J. Dummer (2004) 'Changing Health in China: Re-evaluating the Epidemiological Transition Model.' *Health Policy,* vol. 67, no. 3, p. 333
[467] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.38
[468] 'Most brigades ended up subsidising up to 50% of the collective health care costs', S D White (1998) 'From" Barefoot Doctor" to" Village Doctor" in Tiger Springs Village: A Case Study of Rural Health Care Transformations in Socialist China.', *Human Organization*, vol. 57, no. 4, p. 483.
[469] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.74.

hospitals in Maoist China border on being "market actors", and a decision that would earn the Ministry of Health Mao's considerable ire during the Cultural Revolution.[470]

A number of confusing policy positions was the result of all this reform. The Ministry tried to boost the status of traditional medicine within rural areas so that rural people would settle for treatment in rural areas rather than flooding the urban facilities.[471] This had the benefit of saving costs, as traditional medicine practitioners had a much lower wage than Western-style physicians.[472] Similarly, the Ministry tried to stop funding elements of the health system that were solely under Ministry control (such as health training)[473] and instead focus their efforts on parts of the health system that could also be funded by other ministries[474] (such as medical research) in order to get some desperately needed funds.[475]

Within this dire public finance situation, the Ministry of Health was also responsible for organising and funding social health insurance schemes. The Ministry of Health reiterated that cooperative health insurance would be 'voluntary' for communes and brigades.[476] But, with the August 1962 decree, local Party leaders were not held responsible

[470] David M. Lampton (1972) 'Public Health and Politics in China's past Two Decades', *Health Services Reports*, Vol. 87, No. 10, pp. 895-904.
[471] Sidel and Sidel (1982) *op cit.,* p. 113
[472] David Lampton (1977) *The politics of medicine in China: the policy process, 1949-1977*, Westview Press: Boulder, Colorado, p.53 — Lampton argued that it was 1/5 to 1/10th that of Western-style physicians
[473] *Ibid*, p.56: he notes that medical research boomed in 1954-1957 whereas training did not, as there were far greater funds available for research under a different ministry
[474] But as the costs of growing herbs and traditional medicine remedies were growing rapidly, the Ministry of Health changed the rules from funding these drugs themselves to instead forcing the Traditional Chinese Medicine Administration to fund them.
[475] Lampton (1977), *op. cit*. p.136
[476] Hence, any areas that could attract funding from other ministries, or could be jointly claimed with other ministries, such as educators and researchers — were cut far less by the Ministry's control over the health sector. *Ibid,* p.163

for ensuring enrolment. And the Ministry of Health's institutional weakness meant that even had they wished all Chinese peasants to enrol in health insurance, they would still have been unable to issue binding mandates to commune Party secretaries, who technically outranked them. With local Party secretaries not held responsible for ensuring up-take, enrolment declined sharply.[477] Without the Party secretary being able to force local citizens to enrol, and without the Party system providing Party secretaries with the incentive to carry out this enrolment, there were few incentives for locals to join social health insurance schemes.

The failure of the Chinese health system to enrol citizens in the 1962-1968 period to enrol citizens is significant. That is because, policy-wise, there appeared little shift in China's health insurance policy between the high enrolment and low enrolment periods. Brigades were still meant to establish, and run health insurance funds.[478] Funds still came from multiple sources, and all communes had to have a risk pool.[479] In line with the 1960 mandate,[480] these funds were then be pooled into a joint fund — the insurance risk pool remained at the commune level, and communes remained in charge of determining the rules of the insurance funds.

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[477] Enrolment, which had shot up to 46 per cent in 1962 fell to 30 per cent in 1964 and then steadily declined. Zhuanxing Institute (2012) 传知行社会经济研究所，'新农合作医疗：问题与展望', (*NCMS: Problems and Prospects*, Zhuangxing Institute Press: Beijing) p. 3

[478] As one cadre noted: 'it is better to put cooperative medical funds under the central control of production brigades, so that they can keep their hands on such money and ideological work. Apart from this, the expenditure of too much money on some patients also affects the consolidation of the cooperative medical scheme.' David Lampton (1977) *The politics of medicine in China: the policy process, 1949-1977*, Westview Press: Boulder, Colorado, p. 232-3

[479] As of 1960; see Central Committee declaration of February that year — 1960年2月2日，中共中央以中发（60）70号文件.

[480] 'CMS policy came from a 1960 proposal on pooling and co-sharing at the commune level.' Lampton (1977), *op cit.,* p. 235.

But while the policy structure remained the same, the accountability structure for health insurance enrolment changed. Unlike 1960-62, ultimate accountability for enrolment was not left with local government Party secretaries but with the Ministry of Health.[481] Social health insurance policy remained almost identical. Social health insurance enrolment fell dramatically.

1968-1976: Mao's demands for local accountability lead to high enrolment

Mao was unhappy with the transition away from Party-led health care to Ministry-led health care. He saw fixing health care as a political task for him and the Party.[482] In 1965, Mao unleashed an extraordinary public broadside at the Ministry of Health,[483] criticising all doctors — who he accused of 'insufficient class consciousness', and of being the 'real scapegoats' — and exhorting them to 'go to the countryside'.[484]

[481] For a longer discussion on the Ministry of Health's accountability system, see Cao Pu (2010), *op cit.*
[482] "必须把卫生、防疫和一般医疗工作看作一项重大的政治任务…决不应该轻视工作，为在医疗卫生工作中加强党的领导，并把医疗卫生工作作为党的一项政治任务作了明确的定位" ('Must take health, epidemic prevention, and ordinary health tasks and treat them as a very important political task ... must not slight any work, for public health is an important part of strengthening Party leadership (of society), and we must put health work in an incredibly clear position as a vital Party led-work task'); Mao Zedong (1965) 'Speech on Public Health', 26 June.
[483] The Ministry of Health was referred to as the 'Ministry for Urban Landlords', a strong (and indeed, possibly deadly) critique at the time; see Mao's 'Speech on Public Health' June 1965; Yang Su 'Collective Killings in the Cultural Revolution'; Feng Jicai 'Ten Years of Madness: Oral Histories of China's Cultural Revolution'.
[484] *Dao nongcun qu* — taken from Mao's 'Speech on Public Health' June 1965 and then made into a directive of the Central Committee in September 1965 (e.g. Central Committee (1965) 中共中央批转卫生部党委 '关于把卫生工作重点放到农村的报告' ('Central Committee orders to the Party Committee of the Ministry of Health 'Memorandum regarding strengthening health work and taking it to the countryside'), 21 September 1965, available online: http://cpc.people.com.cn/GB/64184/64186/66676/4493770.html

But while Mao was clear in his focus on the need for greater resources to flow to the countryside,[485] his recommendations were vague.[486] He thought that the ratio of beds in the rural and urban areas should be rebalanced, and he endorsed the idea of 'barefoot doctors' — workers trained in rudimentary public health procedures who worked partly in the fields as normal laborers, and partly as basic care givers. Yet, even following his pronouncements, there were only limited numbers of barefoot doctors, who were trained in Shanghai and largely stayed in the Shanghai region.[487] And these barefoot doctors still needed to be fed, supported and paid by local governments around the country if they were to become effective. These local governments, who as the argument above suggested had such difficulty funding health care that they allowed the Ministry of Health to establish quasi-private hospitals in communist China, lacked any political incentive to fund these barefoot doctors, and were content with merely trialing pilot programs.

Thus, the barefoot doctors campaign was not fully implemented until 1968. This is because, in spite of Mao's broadside, and his enormous clout at the time, the political incentives for local leaders health implementation did not change in the period 1966 to 1968, and no one was held responsible[488] for implementing the rollout of barefoot doctors

[485] Ironically, the idea of barefoot doctors came from… Shanghai. ("赤脚医生"的叫法，就是首次在上海市川沙县江镇公社出现的') ('The naming of "barefoot doctors" first appeared in Jiangzhen commune, Chuansha county, Shanghai'); Anonymous (2011) 毛泽东发怒成为626指示 催生"赤脚医生",中国共产党新闻网, ('How Mao's 26 June comments encouraged the birth of the barefoot doctors', Chinese Communist Party Web) 24th August, available online: http://news.xinhuanet.com/politics/2011-08/24/c_121902920_2.htm

[486] As part of the general program of going to the countryside, but with relatively achievable targets — ie, they only wished for 60% coverage by 1975. See Central Committee (1965) 中共中央批转卫生部党委 '关于把卫生工作重点放到农村的报告', ('Central Committee orders to the Party Committee of the Ministry of Health 'Memorandum regarding strengthening health work and taking it to the countryside')21 September 1965, available online: http://cpc.people.com.cn/GB/64184/64186/66676/4493770.html

[487] Anonymous (2011) *op cit.*

[488] Mao gave inspection tasks to the Ministry of Health, but the Ministry was then disbanded in 1966; '1965年1月，毛泽东和中央又批转了卫生部关于组织巡回医疗队下农村基层的报告.' ('In January 1965, Mao and the

until 1968.[489] It was not until 1968, after three years' trial in Shanghai, that an article written about them in Party magazine 'Red Flag' (红旗 *hongqi)* was published nationally by the Propaganda Department, at which point the idea was formally given Mao's blessing.[490] In November 1968 the People's Daily announced Mao's decision to 'send health workers down to the countryside', arguing that 'apart from the food problem, seeing doctors is the greatest need!' Unsurpisingly, given the collapse of all recognisable governance structures,[491] Mao's mooted remedy for this second 'greatest need' was Party-based, not Ministry-based.[492]

Mao used both the political system and the healthcare system — Party committees were to provide incentives through the leading revolutionary committees (the Party Standing Committee equivalent during the Cultural Revolution), the health facilities were to provide care, and the army and the Party would be responsible for sending vast numbers of doctors to the countryside.[493] Hence, a major difference between the 1960 and 1968 scheme was the

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Central Committee's memo ordered the Ministry of Health to organise inspection teams and send them to the countryside'. *Ibid.*

[489] The senior Ministers in charge of health (or at least interested) at the time were all purged from the Party and any form of public leadership devoted to the Party.

[490] According to official Party narrative, this was in response to comments in the People's Daily: 毛泽东仔细阅读了9月14日的《人民日报》上发表的这篇文章，并批示道："'赤脚医生'就是好." (Mao was reading the People's Daily on 14 September, and he expressed in response to an article that "barefooot doctors" are good). Anonymous (2011) 毛泽东发怒成为626指示 催生"赤脚医生",中国共产党新闻网, ('How Mao's 26 June comments encouraged the birth of the barefoot doctors', Chinese Communist Party Web) 24th August, available online: http://news.xinhuanet.com/politics/2011-08/24/c_121902920_2.htm

[491] For example, there were no Central Committee decisions (none!) after the 22 May 1965, and until 1979.

[492] "必须把卫生、防疫和一般医疗工作看作一项重大的政治任务…决不应该轻视工作，为在医疗卫生工作中加强党的领导，并把医疗卫生工作作为党的一项政治任务作了明确的定位" ('Must take health, epidemic prevention, and ordinary health tasks and treat them as a very important political task ... must not slight any work, for public health is an important part of strengthening Party leadership (of society), and we must put health work in an incredibly clear position as a vital Party led-work task'); Mao Zedong (1965) 'Speech on Public Health', 26 June.

[493] Party historian Cao Pu argues that it was three hooks (三挂) that allowed the CMS to work: the structure, the people, and the system:合作医疗（制度）农村保健站（机构）和数量庞大的赤脚医生（人员）成为解决广大农村地区就医问题的三件法宝 ('Cooperative health care (system), rural health stations (mechanisms), and an

shift in supply of services from the city to the countryside, with over 1.5m urban residents, including some half a million People's Liberation Army doctors[494] providing essentially free medical care to the rural medical system. This alleviated some of the fiscal pressures that the former Ministry of Health had faced (described in the section above).

The Cultural Revolution push to send young people to the countryside — as well as the commitment of the PLA to send troops to the countryside — meant that there was a large pool of workers able to be trained as primary healthcare workers, or barefoot doctors. Estimates in 1975 put it that 1.1m previously untrained city officials and PLA members[495] went to the countryside to do healthcare work; these workers greatly boosted the supply of health care workers within China.

Sending workers to be barefoot doctors led to enormous increases in health professionals. As Table 3 below shows, while village health professionals increased during the Cultural Revolution, the greatest increase was in the numbers of workers in local government health centres. Note that these estimates suggest that there were a further 250,000 'barefoot doctors' working part-time on health care who were not classified as village health professionals due to their status as agricultural workers.[496]

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immense number of barefoot doctors (personnel) became the three talismans in solving the problem of seeing a doctor in the vast rural areas (of China)'), Cao Pu (2014), *op cit.,* p. 236.

[494] Anonymous (1976) '11th Anniversary of Chairman Mao's Directive on Medical and Health Work Marked' *Peking Review*, No. 28, July 9, 1976.

[495] *Ibid.*

[496] Note also that these estimates are likely to be underreported rather than over-reported — there was a strong incentive to undertake health work as the work points were more amenable to medicine than to rural labour.

Table 3: Number of health employee by rural health organisation (1962-1980)

Year	Clinics	Health Centres	Health Centre Professionals	Health Centre nurses	Health Centre Admin	Village health professionals
1962	172708					
1965	170430	36965	245361	13096	30934	1218266
1970	79600					
1975	80739	54026	620861	69698	110861	1559214
1980	102474	55413	775413	66237	137143	1463406

Source: : 陈育德(2000) 中国城镇医药卫生体制改革指导全书 [A comprehensive volume and guide to reforming China's township and city health and medicine system], 中国物价出版社:Beijing, p. 260.[497]

The barefoot doctors or *chijiao yisheng* 赤脚医生 — were trained at the county or commune level, and then supplied to production brigades.[498] They could 'earn' half their work points from primary health care[499] and earn the other half from doing tasks as specified by the production team (these tasks could also include healthcare). But barefoot doctors primary health care work was usually rewarded more highly than their agricultural work, giving them an incentive to focus on primary health care.[500] Barefoot doctors themselves were instructed to be 'poorly educated' — Party conscious, rather than health

[497] Data cross-referenced against S Hillier and Z Xiang (1994) 'Health and rural health insurance in China' in R Krieg R & M Schadler (eds.) *Social security in the People's Republic of China*, *papers presented at the workshop on social security in the PRC*, Hamburg, February 5-7, pp. 159-177.
[498] A. Smith (1974), 'Barefoot doctors and the medical pyramid', *British Medical Journal*, vol. 2, pp. 429–32.
[499] Primary health care was defined as 'public health measures', weeding out 'frivolous' cases, and referral to higher level providers. .
[500] Sidel and Sidel (1982), *op cit.,* p.39. 'Points received by barefoot doctors were on the high end of the scale — 8 to 10 points out of ten for their work'

care trained.[501] Perhaps more importantly for commune Party secretaries, the barefoot doctors could also act as 'gatekeepers', keeping patients away from the commune and county health services, and greatly reducing costs for the local state.

Using the barefoot doctors as gatekeepers also boosted the Party's control over the health sector. Barefoot doctors were Party-trained; a major part of training at commune and county-level hospitals was in 'Party thought'.[502] And they were regularly given refresher courses by PLA medical staff (although the quality and depth of this "training" remains unspecified in Party documents).[503]

This increase in Party control changed treatment at the secondary and tertiary levels of healthcare provision. Having gatekeepers trained in medical assessment minimised some of the asymmetry of information problems for production team heads. The production teams decided who would or would not access higher-level medical services. All medical expenses over 100RMB had to paid for by individual patients upfront. Following that, the individuals had to negotiate with their political unit (usually the production team) in order to gain reimbursement. This turned access to health care into a *political* question. If your

[501] Mao Zedong (1965) 'Speech on Public Health', 26 June: '医学教育要改革，根本用不着读那么多书……高小毕业生学三年就够了，主要在实践中学习提高，这样的医生放到农村去，就算本事不大，总比骗人的医生与巫医要好，而且农村也养得起.' ('Medical education needs reform, essentially it's useless reading so many books ... A couple of years of junior high school is enough, the main thing is to improve their practice. This type of doctor goes to the countryside, even if their skills aren't great, they are still better than these swindlers and witch doctors (*ed.* — referring to current doctors), and the countryside can actually afford them').

[502] See for example the many essays in Anonymous (1971)毛泽东的哲学思想：照亮了我国医学发展的道路，人民出版社: Beijing (*Mao Zedong Philosophy and Thought: Shining a light on the path of China's medical development*, People's Press: Beijing).

[503] 北京医学院革命委员会 (1969) *农村卫生工作队医疗手册,* (Beijing Research Hospital Revolutionary Committee (1969), *Manual for rural health work teams*) 北京医学院革命委员会: Beijing. There was also no mention in the 1965-66 documents collated in: 卫生部红色造反团 (1968) 农村卫生工作两条路线斗争大事记 1949-1966, (Ministry of Health Red Rebel Group (1968) *A record of the two-line struggle in rural health 1949-1966*) 天津市卫生系统劳动卫生斗批改联络站: Tianjin.

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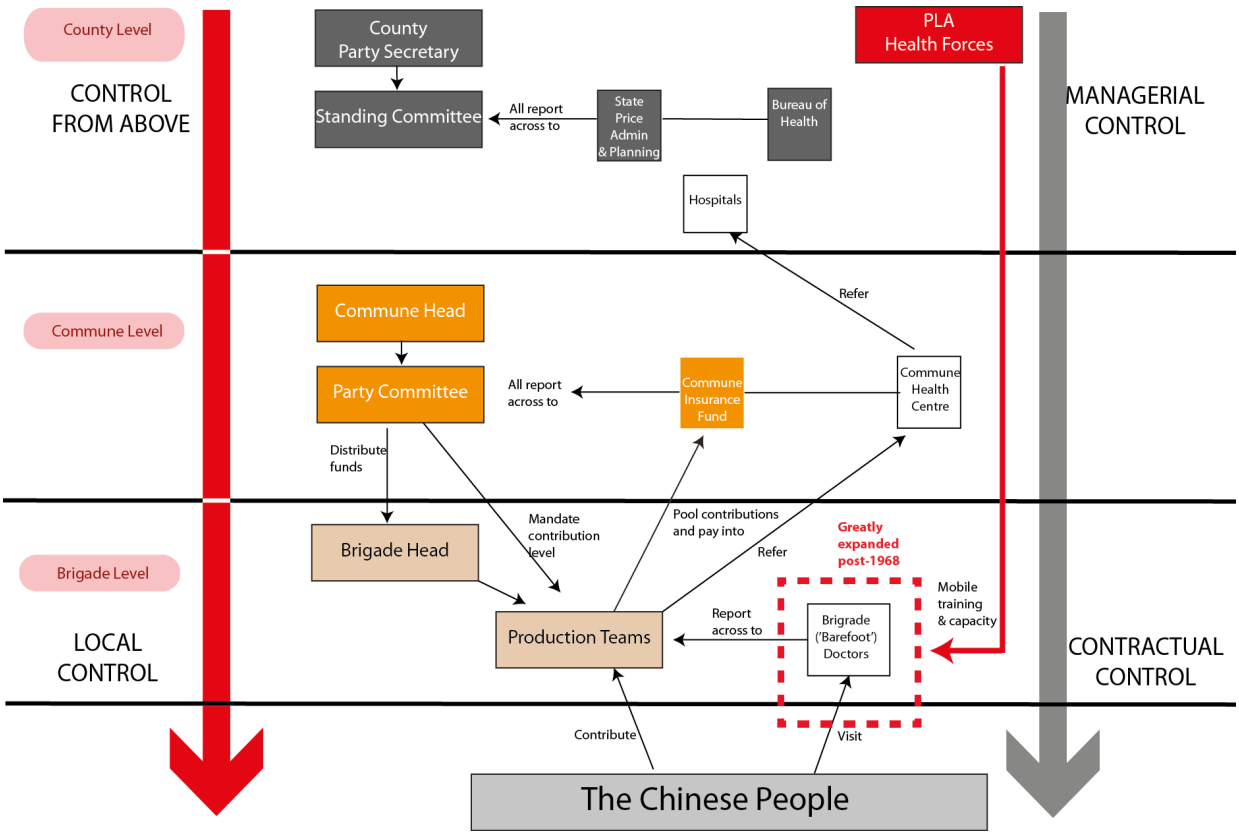
production team didn't like you — say you had poor 'class standing' — or your production team lacked funds, then your treatment would not be reimbursed at all.[504] This redoubled the 'Party-led' nature of the health care system.

The availability of greater numbers of gatekeepers and primary health providers also made the Chinese system more of a 'step-up, step-down' system. Each level of provider had clearly defined and strong roles: county hospitals were responsible for training and critical care (when patients could either afford the treatment upfront, or when it was approved by both their production team and commune); the commune hospital/clinic was responsible for many medical and surgical procedures, with extensive outpatient services (and referrals from barefoot doctors); and the barefoot doctors, while seen as less skilled and qualified, received a great deal of training via the influx of PLA staff, and the focus on primary health services. Figure 12 below describes the structure of the rural health system at the time. Of particular note is the impact of PLA and brigade level involvement in the provisions of health services, and the role of the commune Party Secretary and Party Committee in the management of health insurance. In this way, primary health care was the responsibility of one's work team, and insurance and secondary or tertiary level care was the responsibility of the commune, funded (at least in theory) by the commune health insurance scheme.

[504] David Lampton (1977) *The politics of medicine in China: the policy process, 1949-1977*, Westview Press: Boulder, Colorado, pp. 232-233.

Figure 12: Rural Community Medical Scheme system 1968-1978



Source: Author's own research and schema (see Chapter 2).

But in spite of these system level shifts in the provision of health services, and in the structure of the rural health system, it was not until 1968 that Mao supported social health insurance. So while enrolment had collapsed following the shift of responsibility to the Ministry of Health, health insurance became wildly successful again after Mao's 1968 decrees. At the peak of the Cooperative Medical Scheme's (CMS) popularity, 90 per cent of the rural population was covered. Social health insurance schemes organised at the village level funded over 50 per cent of total health expenditures.[505]

[505] Statistics taken from Party history recollections, e.g. 张海鸿 (2011) '新中国以来医疗卫生事业的发展轨迹', 团结 (Zhang Haiou (2011) 'The Development Path of China's Health System', *United* (magazine), vol. 2. Available online: http://minge.gov.cn/txt/2011-05/12/content_4194508.htm

It is difficult to attribute this success to changes in health policy. The 1968 scheme was very similar to the 1960 scheme: subsidised insurance, which made basic drugs and treatment provided at the production team and brigade level free. The enrolment process remained the same as the 1960 program: individuals go to their work unit (that is, brigade or production team), register, produce card to get treatment, government deducts from income.[506] There were also limited insurance reimbursements (based on commune fiscal capacity and brigade will) for anyone requiring referral to higher-level hospitals.[507]

There were some differences in policy design. For example, there were three kinds of CMS plans that were considered 'allowable': Under plan A, production brigades established their own public welfare fund and assumed responsibilities for covering the medical expenses of the brigade members. Under plan B, the commune was the risk pooling unit, with brigades making specific contributions. Plan C allowed a commune and a composite brigade to jointly run the CMS scheme (this was very similar to the 1960 scheme). But, crucially, in all these plans, the commune Party secretary had ultimate accountability for the number of citizens enrolled in the schemes.[508] By the end of 1971,

[506] Zhuanxing Institute(2012) *新农合作医疗：问题与展望*, 传知行社会经济研究所:Beijing, (*NCMS: Problems and Prospects*, Zhuangxing Institute Press: Beijing), p. 4.
[507] Li Decheng (2007) 合作医疗与赤脚医生研究（1955—1983) ('A Study on Cooperative Medicine and the Barefoot Doctors'), PhD Dissertation, Zhejiang University, p.65.
[508] Through Mao allocating the health system tasks he wished performed to be 'important political tasks', (必须把卫生、防疫和一般医疗工作看作一项重大的政治任务…决不应该轻视工作，为在医疗卫生工作中加强党的领导，并把医疗卫生工作作为党的一项政治任务作了明确的定位" ('Must take health, epidemic prevention, and ordinary health tasks and treat them as a very important political task ... must not slight any work, for public health is an important part of strengthening Party leadership (of society), and we must put health work in an incredibly clear position as a vital Party led-work task'); Mao Zedong (1965) 'Speech on Public Health', 26 June), and through these political tasks then being allocated to the revolutionary committees, (usually) headed up by the Party secretary. 吴毅 (1997) '人民公社时期农村政治稳定形态及其效应—对影响中国现代进程一项因素的分析', 天津社会科学, (Wu Yi (1997) 'An analysis of how the structure and behaviour of stable rural governance in the people's commune era is a factor influencing the current Chinese process', Tianjin Journal of Medical Science and Society), vol. 5.

CMS had been implemented in 70 per cent of the brigades, covering more than 500 million enrollees.

The fact that the 1968 policy looked so much like the 1960 policy, in which enrolment peaked and then troughed with a change in responsibility despite the policy remaining the same, suggests that the 1968 policy was successful in securing enrolment due to political reasons. I argue that it was a shift in local incentives that explains why the CMS succeeded in ensuring such high enrolment. There were a number of factors aiding high enrolment, but by far the most important was full Party support, beginning with Mao's dictums to 'take CMS to the countryside' and his comments that 'CMS is good'; this made the CMS into a political task that was conveyed as a measurable directive.[509]

In giving this political directive, Mao ensured that local leaders were held personally responsible to the Party. The Ministry of Health was completely sidelined. As shown above, it was already a weak ministry, and it was heavily attacked in the Cultural Revolution, to the point where it was disbanded for all intents and purposes.[510] From 1968 to 1973, the Ministry of Health was not a participant in the policy process. Indeed, Mao himself only made two comments (*pishi*) on health care in 1968 — one on barefoot doctors in Chuansha[511] and one on the CMS in the People's Daily. Following that, leadership of health sector reform was taken over by Party structures, who then reverted to the 1960-62

[509] 侯勤文(1970) 毛泽东思想照亮了我国医学发展的道路，红旗, Hou Qinwen (1970) 'Mao's thought shines a light on the path of China's medical development, *Red Flag*) March, pp. 1-16.
[510] Cultural revolution started with the Ministry of Health, and it was one of the most affected ministries. This was initially pointed out by Geremie Barmé, and the author thanks him for this suggestion.
[511] See 侯勤文(1970) 毛泽东思想照亮了我国医学发展的道路，红旗, (Hou Qinwen (1970) 'Mao's thought shines a light on the path of China's medical development, *Red Flag*) March, pp. 1-16.

system of holding commune Party secretaries accountable for enrolment.[512] Responsibility for enrolment in the scheme (and responsibility for keeping the CMS as a going concern) was allocated to Cultural Revolution Leading Small Groups — with representatives of the Red Guards, the PLA and a representative of the 'Party, government and fiscal services' nexus (党政财务) given joint leadership of CMS.[513]

In this way, Mao's single blessing was more than enough to change the entire incentive structure for the local Party apparatus.[514] The instructions to each Party committee were clear: 'Party committees at all levels must treat as an important matter consolidating and developing CMS, as well as training barefoot doctors. Leaders should personally take charge of the work, mobilise masses and do all they can to ensure all brigades are covered (*ed. — that is, are enrolled*) by CMS by August 1 this year.'[515] With that, as the first WHO

[512] Through Mao allocating the health system tasks he wished performed to be 'important political tasks', (必须把卫生、防疫和一般医疗工作看作一项重大的政治任务…决不应该轻视工作，为在医疗卫生工作中加强党的领导，并把医疗卫生工作作为党的一项政治任务作了明确的定位" ('Must take health, epidemic prevention, and ordinary health tasks and treat them as a very important political task ... must not slight any work, for public health is an important part of strengthening Party leadership (of society), and we must put health work in an incredibly clear position as a vital Party led-work task'); Mao Zedong (1965) 'Speech on Public Health', 26 June), and through these political tasks then being allocated to the revolutionary committees, (usually) headed up by the Party secretary. 吴毅 (1997) '人民公社时期农村政治稳定形态及其效应—对影响中国现代进程一项因素的分析', 天津社会科学, (Wu Yi (1997) 'An analysis of how the structure and behaviour of stable rural governance in the people's commune era is a factor influencing the current Chinese process', Tianjin Journal of Medical Science and Society), vol. 5.

[513] 吴毅 (1997) '人民公社时期农村政治稳定形态及其效应—对影响中国现代进程一项因素的分析', 天津社会科学, (Wu Yi (1997) 'An analysis of how the structure and behaviour of stable rural governance in the people's commune era is a factor influencing the current Chinese process', Tianjin Journal of Medical Science and Society), vol. 5.

[514] '在那个年代，毛泽东的批示就是"最高指示' ('during this period, Mao's tick of approval was the highest tick of approval'); *ibid.,* see also: Li Decheng (2007) 合作医疗与赤脚医生研究（1955—1983), ('A Study on Cooperative Medicine and the Barefoot Doctors') PhD Dissertation, Zhejiang University, pp. 108-110.

[515] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.43

study mission to China noted: 'the RCMS (*sic*) was fully integrated with the wider political organizational units of the state.'[516]

Centrally, the Party used all the methods at its disposal to encourage Party leadership of social health insurance programs. In 1968, the Party used the People's Daily to claim that all local Party leaders should support the CMS, using Guangdong province's Dafengshan county model.[517] Following Mao's approval (*pishi)* of the CMS model as practiced in Leyuan commune (乐园), the People's Daily broadcast that the Leyuan model should be taken up by all parts of China.[518] By 1976, representatives of every province of China except Taiwan had visited Leyuan to 'study the program', in total, over 50,000 people visiting during the period 1968 to 1976. The Party used its control of propaganda to promote the CMS. From end of 1968 to August 1976, 108 articles were published in the central People's Daily on the importance of the CMS[519] — even though Mao himself made no further comments in public support of the scheme.

At the local level, this governance system meant that the acting Party secretary (be that the actual Party secretary, or the head of the Cultural Revolution LSG at the local level) was charged with ensuring the success of the CMS. The instructions to local governments on the CMS noted: 'once it is entered into the **Party** committee as an important agenda item,

[516] WHO (1983) *Rural Health Services in China*, Inter-regional seminar on Primary Health Care, World Health Organisation: Geneva. See also Andrea Bernardi & Anna Greenwood (2014) 'Old and new Rural Co-operative Medical Scheme in China: the usefulness of a historical comparative perspective', *Asia Pacific Business Review*, p. 1-26

[517]曹普(2014) 新中国农村合作医疗史， 福建人民出版社：福州, p. 100

[518] Mao Zedong (1968) 卫生战线的大革命, *People's Daily,* 13 December, p. 1. Also available online: http://www.ziliaoku.org/rmrb/1968-12-13-1

[519] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.244

it must be especially discussed and followed'.[520] Each county had to hold a meeting twice a year to discuss the CMS. As with the health campaigns of the late 1950s and 1960s, the CMS was designated as a mass movement (*yundong*). Finally, in spite of the chaos, the CMS was constantly supported in Party mass media outlets,[521] and was given legitimacy by PLA and Red Guard leaders' (as well as the local Party chief) being held to account for their success in implementing the CMS.

Party structures were thus able to force enrolment in health insurance schemes. Whereas in the 1960s membership was entirely voluntary and on an individual basis, from 1971 once a brigade had voted to join the system (a decision made by the brigade Party secretary), all members of that brigade found themselves automatically a part of the scheme and their payments would be automatically deducted from their work points.[522] Membership of the CMS was not theoretically obligatory, but the political structures in place greatly encouraged it.

The reversion of Party control had impacts on other parts of the health care system. Drug control was also enacted, and the responsibility for meeting the costs of drug funding was shifted away from the Ministry of Health to the local Party.[523] Drug prices had a great

[520] Anonymous (1975) 合作医疗遍地开花—怎样办好合作医疗 ('Cooperative health blossoming everywhere — how we got health care right'), 3rd volume, 人民卫生出版社:Beijing, pp. 31-32.
[521] As noted above, from the end of 1968 to August 1976, there were 108 People's Daily articles published on the importance of the CMS. Recent Chinese scholars have, if anything, emphasised further the importance of Mao — see for example Li Decheng (2007) 合作医疗与赤脚医生研究（1955—1983), ('A Study on Cooperative Medicine and the Barefoot Doctors') PhD Dissertation, Zhejiang University, especially pp. 113-120.
[522] 张怡民(1999) 中国卫生50年历程, 中医古籍出版社: Beijing, (Zhang Qiamin (1999) *50 Years of China's Medical Process,* China Medical Historical Books Press: Beijing) p. 1021.
[523] E.g Development Research Centre of the State Council researcher Wang Liejun: 王列军 (2005) '对中国农村医疗保障制度建设的反思与建议, 中国发展评论, (Wang Liejun (2005) 'Some contrary thoughts and suggestions regarding the building of China's rural medical insurance system', *China Development Commentary,* vol. 1,

impact on the solvency of the rural health insurance fund: the CMS annual fee paid by peasants was based on the previous year's medical expenses paid by the commune; as drugs were a major part of commune health centre costs (given that labour was essentially free), if clinics were able to use traditional medicine and herbs that were grown locally, they could save a lot of money.[524] Thus, with the dissolution of the trust that managed drugs in 1969 and the shift of responsibility for drug provision to the Party leadership, the role of homegrown Chinese medicines used by barefoot doctors increased and the overall cost of drug provision also went down.[525]

All of these factors presented a complex situation, in spite of the achievements of the Chinese health system in parts of the Mao period. While holding local Party leaders to account for high enrolment may have ensured that the CMS looked like an effective program, it also maintained the local Party leaders' enormous control over health resources. Under CMS local cadres were able to receive far better benefits, as they had the final say in appointing barefoot doctors or in appointing the managers of the CMS funds. Reports on the collapse of cooperative medicine cited corruption as the number one problem of the Maoist system.[526]

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p. 5. Note that the local Party in this case was usually a 'Cultural Revolution Leading Small Group', which was itself to be 'loyal to the Party'. See senior cadre Wu Yi: 吴毅 (1997) '人民公社时期农村政治稳定形态及其效应—对影响中国现代进程一项因素的分析', 天津社会科学, (Wu Yi (1997) 'An analysis of how the structure and behaviour of stable rural governance in the people's commune era is a factor influencing the current Chinese process', Tianjin Journal of Medical Science and Society), vol. 5.

[524] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p. 46.

[525] This was the 三土四自 (*santu sizi*) program, whereby barefoot doctors and other primary health care staff would grow or collect local medicines to be used for primary care. See Cao Pu (2014), *op cit.,* p. 247.

[526] Yuanli Liu, William C L Hsiao, Qing Li, Xingzhu Liu, and Minghui Ren (1995) 'Transformation of China's rural health care financing', *Social Science & Medicine*, vol. 41, no. 8, p. 1088.

Secondly, for large periods between 1958 and 1978, increased availability of curative treatments at county plus the commune levels led to overburdening of doctors, and cooperative health insurance schemes being bankrupted by the expense of referral and treatment. While the Party propped up CMS funds throughout the Mao period, there were still reports of excessive demand for services, high rates of referral to commune and county facilities and growing requests for expensive drugs. As a result, the CMS risk pools were frequently overburdened financially,[527] and the lack of support for the risk pools in the post-Mao period leading to schemes being 'established in spring and abandoned in autumn' (*chunban qiuhuang* 春办秋荒).

Conclusion

This review of China's attempts to introduce social health insurance in the Maoist period leads to a number of tentative conclusions. The first is that Party incentives were powerful tools for state implementation of policy. The successful up-take of CMS shows that mobilising the local state can lead to successful implementation through accountability and competition with other local government leaders for Party favour.

But it is important to note that this chapter has only examined enrolment in social health insurance, and that local state mobilisation has other significant ramifications and collateral effects. Moreover, a scrambled system of institutions was created in the Maoist period that meant that while the state was able to enrol many millions of peasants in health

[527] 曹普(2014) *新中国农村合作医疗史*，福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou) also argued that this led to them collapsing nationwide in the 1980s.

insurance schemes, it was unable to change other parts of the health care system. These institutions embodied decisions that made the local Party secretary responsible for leading health care reform and marginalised the state system and the Ministry of Health. The next chapter will show how the differing institutions governing the implementation and administration of health insurance policy (political cadres of brigades, and particularly communes) and between the implementation and administration of health care policy (providers, drug providers, medical training provision and capital expenditure for hospitals) combined to create an institutional environment in which no actor could be held responsible for health policy. This institutional structure then created many of the institutions for the provision of social health insurance that are still present even today. [528]

For example, as this chapter has shown, there appears a complex relationship between increases in enrolment and the benefits gained by access to greater levels of primary care. Should peasants have wished to allocate greater income to healthcare (which was not forbidden under the pre-1978 system), then they would have been more capable of doing so in the period 1971 to 1976 due to a large relative increase in rural income (albeit from a low base). But the local state, as noted above, forced individuals to go through 'gatekeepers' before they could access tertiary-level care — and thus an increase in demand for health care also raised the costs for the local state. The increasing amount of spending occurring in the rural areas on health care during the period 1973-1977 led to the central government's contributing subsidies to bail the local governments out of trouble[529]

[528] The 'success of NCMS pilots was where there were CMS structures and this led to the rapid adoption of NCMS as people were comfortable with the concept.' *Ibid.*, p. 5.
[529] David Lampton (1977) *The politics of medicine in China: the policy process, 1949-1977*, Westview Press: Boulder, Colorado, p.239

And, in the post-Mao period, the relationship between greater access and higher cost mentioned above was not alleviated by an increase in supply. While many barefoot doctors stayed in the health sector post-Mao, a considerable number did not.[530] Even those that did then came in for considerable criticism — Deng Xiaoping in particular thought that they needed upgrading and professionalisation.[531] Moreover, the Cultural Revolution attacks on the Ministry of Health led to a major drop in professionalism and skills. As of 1966, medical colleges admitted no more students. In 1969, there was the readmission of students on a 'trial basis'; after that time the colleges graduated the same number of students as pre-Cultural Revolution, but intake was based on 'revolutionary criteria' and the course length was halved. Only in 1977 did medical colleges again admit students solely on basis of grades. So while 1975 saw the return of some professionalism in allowing commune clinics to hire more skilled doctors, it also saw much higher costs as the government needed to offer subsidies (up to 60 per cent of total wages) to collectively owned commune health centres to keep them afloat.

Hence, while the state could ensure the enrolment of peasants in health insurance schemes through changing the political incentives for local Party secretaries, this system was unable to last. In the post-Mao period, health insurance schemes collapsed. Schemes lost the ability to raise funds, lost peasant enrolments, and the local state was unable to

[530] Barefoot doctors fell from 1.8m in 1975 to 1.5 in 1980. WHO (1983) *Rural Health Services in China*, Inter-regional seminar on Primary Health Care, World Health Organisation: Geneva, p.41.
[531] Deng, apparently, walked out on a film on the Cultural Revolution as it felt it unnecessarily valorised barefoot doctors. He is also quoted as saying: 'The barefoot doctors have only just begun; their knowledge is slight. They can only treat a few common sicknesses. After some years, they will put on straw shoes; that is, their knowledge will have grown. A few years more, and they will wear cloth shoes.' Roger Garside (1981) *Coming Alive: China After Mao*, New York: McGraw-Hill Book Company, p. 71.

support public facilities, which were then forced to turn to the market to raise revenues. Thus, while this chapter shows the power of the Party when it wishes to mobilise the local state, the following chapter shows the difficulty of using these techniques to ensure patient welfare and to maintain a financially viable health insurance scheme for local governments over the longer-term. Despite state ownership of the organisations within the health sector continuing in the post-Mao period, the collective health system was about to undergo a massive shock, and collapse. The next chapter discusses.

Chapter 5: The 'retreat of the state' from insurance

A difficulty with any political analysis is the absence of counterfactual cases. Counterfactual cases not only describe possible causality, but also help identify hidden variables and biases.[532] For a study of health insurance policy successes, it is valuable having a counterfactual case to help explain health insurance failures. Knowing why schemes collapse is as important for understanding policy as explaining why schemes succeed.

This chapter discusses how the Cooperative Medical Scheme (CMS), the success of which was discussed in the previous chapter, collapsed. This collapse will be used as a counterfactual case. It appears a robust counterfactual case as many of the mechanisms that could form valid explanations for the success of the CMS also appear to be present and unchanged during the collapse of the CMS. Analysing the collapse of the CMS using similar techniques to our analysis of the development of the CMS provides much greater depth to any conclusions drawn from the analysis.

There are many reasons given for the collapse of the CMS. One argument is that it was due to China's economic reform leading to privatisation of services, and public health insurance was seen as irrelevant in this reform.[533] Other descriptions of the collapse

[532] Morgan and Winship (2007) Counterfactuals and Causal Inference: Methods and Principles for Social Research, Cambridge University Press: Cambridge, pp. 6-33.
[533] See for example Ofra Anson and Shifang Sun (2005) *Health Care in Rural China: Lessons from HeBei Province*. Aldershot and Burlington: Ashgate.

examine machinations within central politics.[534] And Chinese domestic explanations span a gamut of reasons, most of which argue in one form or another that the CMS collapsed because citizens did not like it.[535]

The most extensive analysis of the political elements of the collapse of health care can be found in the work of Duckett.[536] Applying the concepts of Immergut[537] and Cook,[538] Duckett argues that the collapse of the CMS was due to a failure of the Ministry of Health to step in to save it during a period of ideological disenchantment with Party-led schemes. She argues that the Ministry of Health failed to support the CMS at the crucial moment, and instead chose to leave the decision on whether or not the CMS should continue to local governments, who abandoned the scheme. Yet Duckett's work has itself provoked challenges within academic literature. Most notably, it has been criticised by Klotzbücher as not accounting for local responses to policy changes, as lacking Chinese data, and as not explaining how the changes to behaviour of the Ministry of Health taking place at the central level were then passed down through the system.

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[534] Yanzhong Huang argues that it was due to a weak Ministry of Health. See Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p. 18 'the post-Mao state rebuilding aggravated a fragmented organisational structure, leaving the MoH in a weak position, unable to adequately define policies and to fully exercise its roles.'

[535] 张自宽 (2011) *亲历农村卫生六十年*, 中国协和医科大学出版社: Beijing (Zhang Zikuan (2011) *Personal experience of 60 years of rural health care,* China Cooperative Medical Science University Press: Beijing).

[536] Jane Duckett (2001) 'Political Interests and the Implementation of China's Urban Health Insurance Reform.' *Social Policy & Administration*, vol. 35, no. 3, pp. 290-306; Jane Duckett (2003) 'Bureaucratic Interests And Institutions In The Making Of China's Social Policy', *Public Administration Quarterly*, vol. 27 (Spring) pp. 210-238; Duckett (2011), *op cit.*

[537] Ellen M. Immergut (1992) *Health Politics, Interests and Institutions in Western Europe,* Cambridge University Press: Cambridge.

[538] Linda Cook (1993) *The Soviet Social Contract and Why It Failed: Welfare Policy and Workers' Politics from Brezhnev to Yeltsin,* Russian Research Center Studies Book (86), Harvard University Press: Cambridge, MA; see also Linda Cook (2007) *Postcommunist Welfare States: Reform Politics in Russia and Eastern Europe*, Cornell University Press: Ithaca, NY, although this looked more at the idea of state capacity than state retrenchment.

This chapter applies the institutional framework introduced in previous chapters and applies it to the collapse of health care with particular reference to this debate. The chapter also introduces new data to the debate over which mechanism (or lack thereof) best explains the collapse. The clash in the literature between Klotzbücher and Duckett mentioned above is mainly over the mechanisms driving the collapse of the CMS.[539] For Duckett, the mechanisms are in the central system. For Duckett's critics,[540] the mechanisms must be in the local system.

To help resolve some of these questions, this chapter applies the analytical framework developed in chapter 3 to the collapse of social health insurance in the 1980s. Applying the framework to Party and state records, and adding data on the early 1980s obtained through fieldwork and archival research, allows the process of decision making, and Duckett's model, to be analysed more closely.

This chapter uses previously untranslated data from Central Party School projects to reveal that CMS schemes kept going for a number of years following the restructure of the healthcare system (and also following public critiques of the CMS) in 1979. This was because there was no official repudiation of the earlier decisions to make enrolment a political incentive, and because health insurance remained attached to Party programs in the form described in the previous chapter. Local Party secretaries were still held

[539] As such, given the methodology used in the thesis, I argue that there is also dispute underlying the causal claims of different analysts. See for example Peter Hedström (2005) *Dissecting the Social: On the principles of analytic sociology,* Cambridge University Press: Cambridge, p. 108 or more broadly, Jon Elster (2007) *Explaining Social Behavior: More Nuts and Bolts for the Social Sciences*, Cambridge University Press: Cambridge.

[540] Sascha Klotzbücher (2012) 'The Chinese State's Retreat from Health: Policy and the Politics of Retrenchment' *The China Quarterly*, vol. 208, pp. 1031-1033.

responsible for the maintenance of CMS programs. This did not change until 1982, when these 'hard administrative measures' holding the secretaries accountable for enrolment were repudiated, following which CMS schemes fully collapsed.

As Duckett suggested, leaving responsibility for social health insurance (SHI) to local leaders did indeed lead to the collapse of the CMS. But it also took major changes within China's governance structure, and central decrees, to alter the incentives for local leaders and to initiate the end of the CMS program. These changes, as identified using the analytical framework developed in Chapter 3, were decreed by the Central Committee, rather than the Ministry of Health. This does not diminish the importance of the role of the Ministry of Health over health policies; rather, it shows that the Ministry of Health was unable to change Party policies. The mechanisms that led to the collapse of SHI were controlled by Party governance structures and the Ministry of Health had no ability to change these mechanisms. Put more simply, when agricultural decollectivisation was decreed, the accountability mechanism ensuring high enrolment was removed — so rural social health insurance schemes collapsed.

The changing context of post-Mao health care

In 1978, China began the so-called 'reform period', and changed its rural land tenure system, its political structure, and its economic system. The former rural system, one where peasants working for collectives pooled their grain and sold it back to the government, was changed to a system whereby households were allocated land according

to the size of the household; the government taxed the production from this land; and households assumed responsibility for any grain surpluses or deficits they produced. The previous commune-based production system was thus transformed into an individual-based production system.[541]

As is extensively documented, this transformation had a number of benefits for the Chinese economy and society in general.[542] The change in the structure of rural production to household responsibility from collective responsibility — and the intermediate steps in this structural change — also changed the relationship between the Chinese state and health financing. Whereas brigades and communes previously funded health insurance through the mandatory tithing of agricultural production, the change to a more individual-based production system not only ended communes, brigades and teams as political units, but also forced the state to find different mechanisms for funding any social policy.

The shift to decollectivisation did not happen instantly. There were a number of years of intermediate steps. These affected rural health care greatly. Initially, in 1977-1978, the stance of the central Party was the need to uphold Mao's Sixty Points, and maintain almost full rural collectivisation.[543] As Chapter 4 showed, the Sixty Points decreed a set, Party-led structure of rural health service provision. Yet as others in the central Party pushed to move away from collectivisation (and thus Mao's Sixty Points), the status of health services

[541] More extensive outlines of this can be seen in: Justin Yifu Lin and Mingxing Liu (2007) 'Rural Informal Taxation in China: Historical Evolution and an Analytic Framework' *China World Economy*, vol. 15, no. 3, pp. 1-18; Barry Naughton (2007) *The Chinese Economy: Transitions and Growth,* MIT Press: Boston, MA, pp. 88-91 and 240-261

[542] *Ibid,* pp.210-222; Kate Zhou (1996) *How the Farmers Changed China*, Westview Press: Boulder, CO.

[543] See Teiwes and Sun (forthcoming) *Paradoxes of Post-Mao Rural Reform,* Routledge: Basingstoke, especially pp. 35-43.

fell into question. For example, the first Central Committee decision (*jueding*) made after the Cultural Revolution mandated local governments to 'protect health services' (*baozheng yiliao fuwu* 保证医疗服务), but also to 'choose the most effective policies, the key ones of which are economic measures and population control.'[544] This tension wasn't resolved until 1982, when Central Document No. 1 in January, and the decisions of the Twelfth Party Congress in October, decreed a shift to household responsibility.

The change to household responsibility brought a broader shift in ideology towards social services as well,[545] with the state espousing a 'family responsibility system' for the first time.[546] At its heart, this principle held that the family was the first line of social protection. As a corollary, the government becomes involved only 'when the family cannot take care of its own, and when government action can be effective'.[547] Most importantly, the burden of spending for social services falls initially on the individual.

This burden shifting was an expensive process for businesses and individuals. The percentage of health care expenditure paid by enterprises and agencies rose from 27.4 per cent in 1978 to 36.1 per cent in 1990. The percentage of costs borne by individuals rose from 20.4 per cent to 33 per cent.[548] According to the World Bank, public subsidies as a share of the total health spending sharply declined from 30 per cent in 1980 to about 19

[544] Central Committee (1979) 中共中央关于加快农业发展若干问题的决定 ('Central Committee Decision on Certain Questions Regarding Quickening Rural Industry Development') , clause 24
[545] Ezra Vogel (2011) *Deng Xiaoping and the Transformation of China,* Belknap Press: Cambridge, MA, p. 705
[546] Tony Saich (2008) *Providing public goods in transitional China,* Palgrave MacMillan: London, pp. 18-30
[547] Yuanli Liu and Keqin Rao (2006) 'Providing Health Insurance in Rural China: From Research to Policy', *Journal of Health Politics, Policy and Law*, vol. 31, no. 1, p. 75
[548] Yuanli Liu, William C L Hsiao, Qing Li, Xingzhu Liu, and Minghui Ren (1995) 'Transformation of China's rural health care financing', *Social Science & Medicine*, vol. 41, no. 8, pp. 1085-1093

per cent in 1988, while during the same period private payment increased rapidly from a 14 per cent share of the total spending in 1980 to 36 per cent in 1988.[549] Approximately 95 per cent of rural residents had to pay out-of-pocket fees for their health services.[550]

Enrolment in rural health insurance schemes diminished rapidly in this period. The end of the collective meant a diminished ability to use retained revenues from collectives to fund cooperative risk pools or to equalise costs of health care across different households. The previous relationship whereby Mao could, for periods, mandate the Party to ensure high enrolment in social health insurance (discussed in Chapter 4) and hold local Party leaders responsible changed. As local leaders were no longer encharged with the responsibility of ensuring enrolment, and moreover, no longer measured by the levels above for their ability to ensure enrolment, there was no incentive for them to support social health insurance. By 1986, village coverage had dropped to 4.8 per cent.[551]

All of these changes to the system left individuals with vastly different abilities to access care. In the wider society, there were great benefits from the new economic and political system — most notably, a major increase in household income.[552] But, unlike during the Cultural Revolution, there were no restrictions on individuals using this increased income

[549] Willie De Geyndt, Xiyan Zhao and Shunli Liu (1992) 'From barefoot doctor to village doctor in rural China', *World Bank Technical Paper*, no. 187, October, World Bank: Washington DC.
[550] Adam Wagstaff, Magnus Lindelow, Shiyong Wang and Shuo Zhang (2009), *Reforming China's Rural Health Care System,* World Bank: Washington DC.
[551] See Wang Shaoguang (2009) 'Adapting by Learning: The Evolution of China's Rural Health Care Financing', *Modern China,* vol. 35 no. 4, pp. 370-404
[552] Gordon Liu, using Shandong Economic Centre data, shows that the income of the rural villagers doubled in the first three years of the reform. G Liu, X Liu, and Q Meng (1994) 'Privatization of the medical market in socialist China: A historical approach', *Health Policy*, vol. 27, p. 163

to pay for health services.[553] And, with a higher capacity to pay, households preferred to attend higher-level hospitals or clinics. Surveys of the time showed that almost 20 per cent of villagers tended to forsake the rural health units and preferred to receive treatment in county hospitals or township health centres over their village health stations.[554] Local health care providers were allowed to charge enough to 'recoup their costs', a change that led to enormous cost inflation as the individual was forced to pay more for accessing health care.[555] The increases in demand for tertiary care were, at least to a degree, induced by farmers' rising income.[556]

This, in turn, created a growing pressure on urban hospitals,[557] as peasants used increasing capacity to pay to 'buy the best'.[558] The pressure on hospitals to serve these patients led to rapid rises in expenses. Government hospital operating expenses increased from 1.8 billion yuan in 1978 to 4.2 billion yuan in 1993. But this rise in hospital expenditure was not matched by an increase in government funding for insurance to cover

[553] Lampton, *op cit.*
[554] Gerald Bloom and Jing Fang (2003) *China's rural health system in a changing institutional context.* University of Sussex Institute of Development Studies: Sussex, UK.
[555] World Bank (1996) *China: Issues and Options in Health Financing,* Report No. 15278-CHA, World Bank: Washington DC.
[556] Total rural income doubled between 1980 and 1985 (from 191 yuan per capita to 397 yuan per capita), and then just about doubled again between 1985 and 1992 (from 397 yuan per capita to 784 yuan per capita). See New China Fifty Years' Government Finance Statistics (2000), Economic Science Press: Beijing, table 7.14 ' Per Capita Annual Income Of Urban And Rural Households And The Related Indices'.
[557] 'Between 1985 and 1993 annual inpatient days per 1000 urban residents increased by 12.8%, whereas the rural population experienced a 10.3% decline' — see Yuanli Liu, William C Hsiao, and Karen Eggleston (1999) 'Equity in health and health care: the Chinese experience', *Social Science & Medicine*, vol. 49, no. 10, p. 1352. They also showed that in 1984 the average waiting time for an outpatient visit to a provincial hospital would take a day, and the waiting time for inpatient hospitalization was around 80 days, double that before the 1980s
[558] Gordon Liu et al showed that an increase in rural income resulted in a major increase in demand for urban hospital visits, which they put down to people seeking higher-quality care. G Liu, X Liu, and Q Meng (1994) 'Privatization of the medical market in socialist China: A historical approach', *Health Policy*, vol. 27, p. 165

these higher costs. Government subsidies to rural CMS funds decreased from 89 million yuan in 1978 to only 27 million yuan in 1993.[559]

Without insurance, the cost of curative care gradually became beyond reach of the poor. A 1987 World Bank survey in 30 counties in Hubei province indicated that 55 per cent of households (up to 63 per cent in mountainous, poorer areas) indicated that price was too high and unaffordable to be a reason for not seeking health care when needed.[560]

These changes to the health system led to the emergence of different classes of peasants. Those who could afford health care treatment now received care from far better trained doctors, and had access to better health care supplies and nicer hospitals. Those who could not afford health care often did not seek professional help. Consequently in some poverty-stricken parts of the countryside, the percentage of the patients who should have been but were not hospitalised due to economic difficulties approached 80 per cent in some areas in the mid-1990s.[561]

The question remains though: within these shifts in the health care sector, how did health insurance specifically collapse, and why?

The 'retreat of the state' from health care

[559] Ibid.
[560] Mary E Young (1989) 'Impact of the rural reform on financing rural health services in China', *Health Policy*, vol. 11, no. 1, pp. 27-42 (note that Young was the leader of the World Bank study, and this publically available paper summarised the findings of the 1988 study).
[561] Wang Mengkui (2005) *China Human Development Report 2005*, Development Research Centre of the State Council of the People's Republic of China: Beijing (using data from the 1998 and 2002 Health Services Surveys), pp. 60-61.

The end of the CMS is often thought to have been a consequence of the shift away from the collective economy. The warnings began as early as 1984:

> The economic reforms have altered the peasants' incentives, weakened community organization, and lessened the central government's influence over local communities. The consequences of these changes are multifold: a decreased supply of barefoot doctors, disintegration of organised primary care, a decline in cooperative health insurance, reduced primary health care, and an increased demand for higher-quality medical care.[562]

This argument suggests that the end of the CMS was a by-product of major changes within the Chinese economy more generally (hence Hsiao's reference to 'economic reforms'). In the Maoist period, social health insurance schemes were primarily financed through cooperative health insurance and brigade welfare funds with occasional subsidies from commune or county government in the case of a deficit. Under the new individual-based economy, villages replaced the former brigades and production teams but were unable to automatically collect the surplus from agricultural production, making it much more difficult to finance CMS schemes. [563]

Hence, a possible argument for the collapse of the CMS is that collection of such insurance funds from individuals was extremely difficult since brigade members were less interested in participating in CMSs on a voluntary basis because they could afford better

[562] W C Hsiao (1984) 'Transformation of health care in China', *The New England Journal of Medicine*, Apr 5, vol. 310, no. 14, pp. 932-6.
[563] Central Committee Document 1 of 1983 mandated that while the 'state and collectives should run cultural and public health facilities, but it is more important to encourage farmers themselves to run them.' Thus health facilities were to be treated as in the tertiary sector, and state subsidies eliminated. See also Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke p.61.

quality care at higher level health facilities as their income increased. Under this argument, the CMS schemes fell away without external intervention.

A more governance-related approach can be seen in Duckett's work on the collapse of health care in the 1980s. Duckett characterises the move towards private rather than public funding of health care, the shift in health service delivery structure, and the collapse of rural social health insurance as being a state 'retreat from health'. Duckett sees the 'retreat' of the state from the health system as being due, *inter alia*, to the choices of the Ministry of Health. Duckett notes that health reforms were led by the Ministry of Health.[564] Health reforms were intertwined with economic reform.[565] The decision to defund health insurance was driven by the new top leadership's prioritisation of economic growth: giving local governments control over fiscal revenues was a mechanism for increasing their commitment to revenue-generating economic growth,[566] but it resulted in these governments choosing to 'defund' health.[567] According to this argument, the Ministry of Health failed to support health care programs sufficiently at the central level, thus allowing the central leadership to give local governments the freedom to choose whether or not to maintain health services (including health insurance schemes) as there were no supporters for health care.

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[564] Yanzhong Huang makes a similar argument, although he places the blame more with political individuals being brought in to run the health care department instead of medically-trained technocrats — see Huang on Cui Yueli, Yanzhong Huang (2012) *op cit.*, p.61.

[565] 'exploration of health policies and their relationship with economic reform … rational policy-making cannot explain why, under CCP rule and as the economy expanded, significant cutbacks in state provision and the steady commercialization of health services put treatment beyond the reach of growing numbers of people.' Jane Duckett (2011), *The Chinese State's Retreat from Health: Policy and the Politics of Retrenchment*, Routledge: Basingstoke, p.2.

[566] See Susan Whiting (2006) *Power and Wealth in Rural China*, Cambridge: Cambridge University Press for example.

[567] Duckett, *op. cit.*, pp. 16-19.

Duckett's argument is based on the idea of health politics being based on powerful interest groups being able to block or 'veto' decisions that they feel do not suit their interests.[568] In Duckett's model, urban doctors and hospitals were the primary interest group for the Ministry of Health,[569] and it was not in their interests to 'veto' changes to the CMS.[570] Moreover, the Ministry of Health 'needed to neither seek legislative approval nor make public its policy'.[571] This absence of societal stakeholders then made bureaucratic stakeholders stronger. They could abandon the CMS without facing significant challenges.[572] Similar to the arguments laid out in the previous chapter, Duckett saw the CMS, when it was successful, as being led by Mao[573] and not the Ministry of Health in

[568] 'A policy veto is most likely to come from the bureaucracy' *ibid:*106. The idea of veto actors is most notably explored by Ellen Immergut: see, for example, Ellen M. Immergut (1992) *Health Politics, Interests and Institutions in Western Europe,* Cambridge University Press: Cambridge or Ellen M. Immergut (1990) 'Institutions, Veto Points, and Policy Results: A Comparative Analysis of Health Care', *Journal of Public Policy*, vol. 10, pp 391-416. Note, however, that Immergut's work is primarily conducted in federal Western democracies.

[569] Much of Duckett's work on internal interests matches (and references) the memoirs of former Minister of Health Qian Xinzhong, a well-trained doctor who was returned to power in the post-Mao period after losing his role in the Cultural Revolution purge of the Ministry of Health following Mao's Ministry of Urban Gentlemen speech (see Chapter 4). This judgment is based in part on official writings (e.g. 中国卫生年鉴编辑委员会编 (1983) 中国卫生年鉴, 人民卫生出版社: Beijing, ('China Health Yearbook Editorial Committee Commission (1983) *China Health Yearbook,* People's Health Press: Beijing') p.26). Qian's work was also a major influence on the findings of Yanzhong Huang — see for example: 'Qian Xinzhong lost no time in calling for 'getting rid of the phenomenon of substituting professional and scientific management for Party leadership' Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.15.

[570] Jane Duckett (2011), The Chinese State's Retreat from Health: Policy and the Politics of Retrenchment, Routledge: Basingstoke, p.18

[571] *Ibid*.

[572] In Duckett's argument, this competition between different interests meant that central policy makers had the best of both worlds — able to push through retrenchment decisions that are usually difficult in decentralized polities, but also able to leave local governments to take the blame for underfunding and programmatic failures. The Ministry of Health wanted to support doctors but also wanted to leave problems to local governments.

[573] 'Mao had overridden the bureaucracy and taken a personal role in promoting CMS as part of his attempt to reverse urban bias, in line with his antipathy to the bureaucracy. But in failing to establish bureaucratic stakes in it and find better and more institutionalised sources of finance, he had effectively set it up for collapse.' *Ibid:* 72.

Beijing.[574] Thus the Ministry had no bureaucratic interest in the CMS,[575] and its interests lay instead with urban doctors and urban schemes.[576]

A related argument is that of Huang.[577] Huang argues that the post-Mao state rebuilding of the Chinese health system aggravated an already fragmented organisational structure, leaving the Ministry of Health in a weak position, unable to adequately define policies and to fully exercise its roles.[578] Duckett makes a similar argument with respect to urban health insurance programs in the 1990s, which were gradually extended to include ever-greater numbers of the urban population, and provided them with access to better levels of care than rural citizens due to the influence of the Ministry of Labour and Social Security (who controlled urban insurance).[579]

There is significant support for Duckett's arguments in Chinese literature on the period. For example, that there was a push for greater professionalism with the Ministry of Health's interests appears to not be in doubt. A review of Chinese language literature also supports Duckett's assertion that the CMS was consciously rejected as it was too 'leftist'. Chinese language criticism of the CMS rounded on it for not being 'modern', as the CMS

[574] 'by the 1970s, the Chinese state through the Ministry of Health, played a central role in organising an extensive national health system' *ibid:* 33.
[575] CMS schemes put funds in the hands of production brigades or communes rather than county government health departments; as such the Ministry of Health was unwilling to support it.
[576] In other words, the Ministry of Health preferred urban doctors to rural doctors opinion and entrenched their interests; *ibid:* 21.
[577] Outlined in Yanzhong Huang (2004) 'Bringing the local state back in: the political economy of public health in rural China', *Journal of Contemporary China*, vol. 13 (39) pp. 367-390 and
Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke
[578] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.18
[579] This situation was very fragmented: the MoLSS controlled the urban system, and did not want the *liudong renkou* ("floating population", or migrants) coming in; the Ministry of Finance supported co-payments; and the Ministry of Health did not want supply-side controls for doctor behaviour. The MoLSS were able to prosecute their interests more effectively, as opposed to the Ministry of Health in previous attempts to maintain rural social health insurance schemes. Duckett, *op cit.*

'focussed mainly on small injuries and small diseases'.[580] Chinese commentators thought that a 'part of development is the ability to deal with major diseases'.[581] In this way, letting the CMS go was 'unavoidable',[582] a part of 'general modernising reform',[583] and a temporary measure that the major provinces had already decided would be only for a short period of time.[584]

Also supporting Duckett's argument, some sources report that a number of ministries, as well as many communities, rejected rural health insurance because of its association with the political upheaval of the Cultural Revolution period.[585] Even today, the health insurance scheme of the 1960s and 1970s is seen in official Party documents as a 'leftist' political scheme.[586] It was thought that this was the case for a number of reasons: because it

[580] For an overview, see 曹普(2014) *新中国农村合作医疗史*，福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), pp 151-8

[581] *Ibid;* see also: 丁少群 and 君中立 (2005)'农村医疗保障：新型农村合作医疗该向如处去'，中国卫生经济, ('Ding Shaoqun and Jun Zhongli (2005) 'Rural Health Insurance: Where the NCMS should head', *China Health Economics'),* vol. 3, pp. 1-8

[582] 李德成 (2007) 中国农村传统合作医疗制度研究综述, 华东理工大学学报, (Li Decheng (2007) 'An overview of research into China's traditional rural social health insurance', *Huadong Ligong University Study Journal),* vol. 1.

[583] 张自宽 (1993) 中国的初级卫生保健要走自己的路, 中国农村卫生事业管理, (Zhang Zikuan (1993) ' China's early health insurance had to walk its own path', *China Rural Health Care Administration and Management),* vol. 5.

[584] 'China's bigger polities made clear that self-funding would only be for an even shorter period of time'冯宝美 (1987) 论农村合作医疗制度问题, 中国卫生事业管理, (Fang Baomei (1987) 'A discussion of problems of the rural health care system', *China Rural Health Care Administration and Management)* vol. 5.

[585] Tao Li for example saw the Cultural Revolution as a grave mistake, and as forcing a tremendous burden onto the state and SOEs — 受"左"的错误干扰和破坏很大，没有得到及时有效的修整，给国家财政和企业造成了沉重负担 ('suffering a "leftist" error was a great disturbance and mistake; it didn't have any efficiency advantages, and it created a tremendous burden for state finances and state-owned enterprises'). Tao Li (2011) '中国共产党对医疗保障制度的探索与经验', 当代中国史研究, ('The Chinese Communist Party's explorations and studies of the health insurance system', *Contemporary Chinese History')* vol. 8, available online: http://theory.people.com.cn/GB/82288/83854/83867/15430719.html. See also: Feng Xueshan, Tang Shenglan, Gerald Bloom, Malcolm Segall, and Gu Xingyuan (1995) 'Cooperative medical schemes in contemporary rural China', *Social Science & Medicine,* vol. 41 (8) pp. 1111-1118.

[586] Both Tao Li in Contemporary Chinese History and the Central Party School project on Social Health Insurance 1955—2003 (see 曹普(2014) *新中国农村合作医疗史*，福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p.261) made the same claim. This level of unity in senior Party journals and official publications would be impossible without some official sanction.

'used political methods and administrative orders to force implementation';[587] because it was unwanted by rural citizens;[588] because it put too great a burden on the state (both state enterprises and the administrative state).[589] Articles by officials working with the Ministry of Health protested that the Ministry did not advocate any form of CMS to senior Party cadres as they thought it was too 'left'.[590]

However, applying the analytical framework from Chapter 3 to Duckett's argument leads to slightly different conclusions. From the perspective of the Ministry of Health's rank and authority within the system, even if the Ministry of Health had wanted to retain the CMS, it would have been unable to 'veto' central command within the Party,[591] and it definitely would not have been able to impose any veto on local governments. The Ministry of Health is a relatively weak ministry. Regardless of what the Ministry of Health's interests were, it had a significant disadvantage in any bargaining situation with other ministries or interests due to its lower rank in the Chinese system. So while the central Ministry of Health could have signalled that it may have wanted to 'let health care go', it

[587] 曹普(2014) *新中国农村合作医疗史*，福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p.148.

[588] Much of this due to the 'Hunan experiment' (see later in this Chapter for further). Under this line of thinking, the CMS, due to its collection of fees, was seen as a burden on the peasants — for example, 吴砾星 (2006) 章彦武：农民减负"急先锋", *People's Daily,* 27 May on the importance of the 1978 Hunan experiment to central Party thinking that the CMS was 'unwanted'.

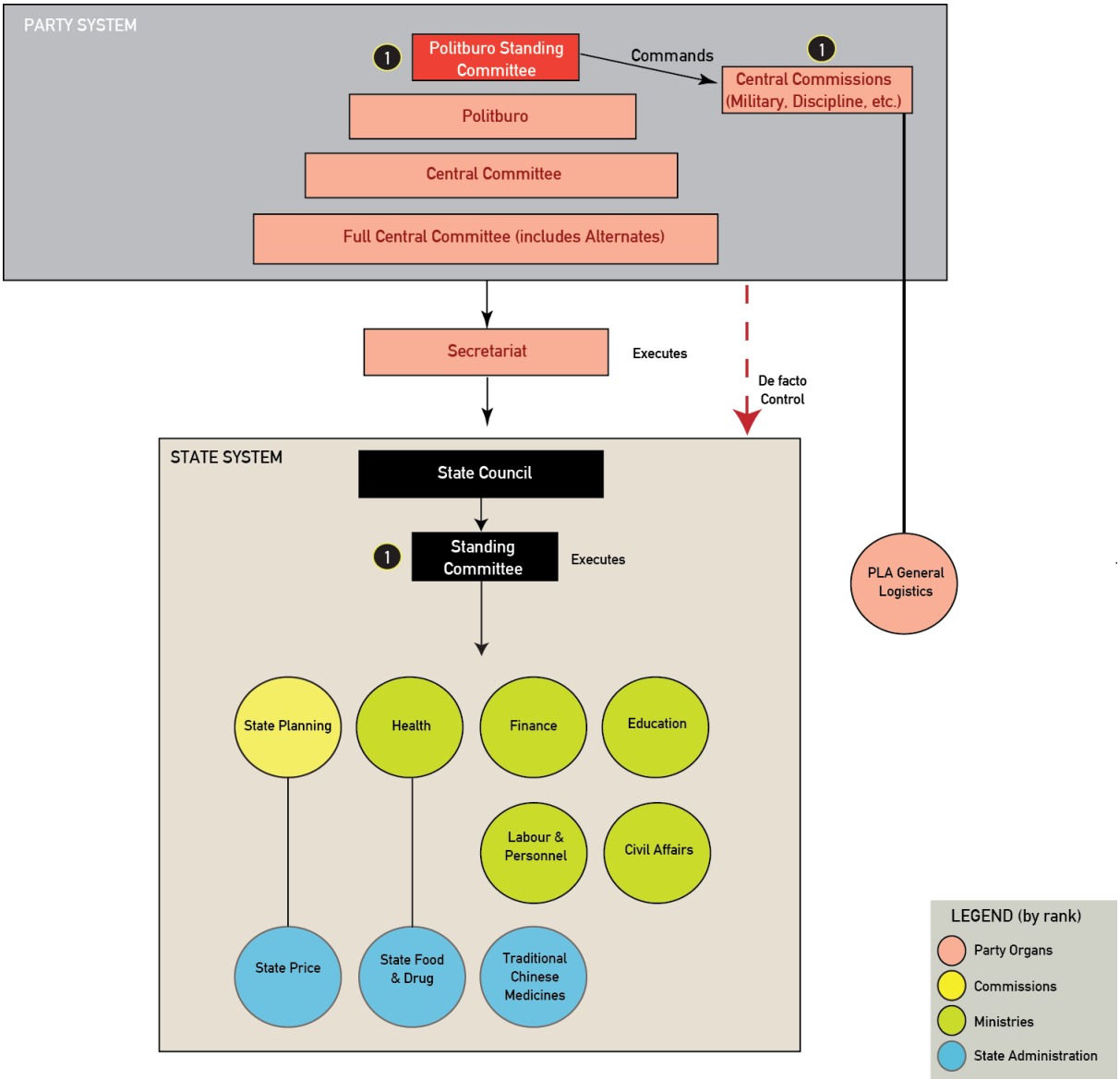
[589] Tao Li in particular focussed on how the CMS 'forced a tremendous burden onto the state and SOEs.' Tao Li (2011) '中国共产党对医疗保障制度的探索与经验', 当代中国史研究, ('The Chinese Communist Party's explorations and studies of the health insurance system', *Contemporary Chinese History')* vol. 8, available online: http://theory.people.com.cn/GB/82288/83854/83867/15430719.html. Other accounts concentrate on more popular sayings of the time, such as Zhang Zikuan's phrase: '上边不喊了，中间不管了，下边就散了' — 'the higher levels don't shout out, the middle levels don't care, the lower levels scatter' 张自宽 (1992) 在合作医疗问题上该澄清思想统一认识，中国农村卫生事业管理，(Zhang Zikuan (1993) 'We should clarify our thoughts and unify our thinking on the cooperative medical problem', *China Rural Health Care Administration and Management)* vol. 6, p. 18.

[590] See 张自宽 (2011) *亲历农村卫生六十年*, 中国协和医科大学出版社: Beijing (Zhang Zikuan (2011) *Personal experience of 60 years of rural health care,* China Cooperative Medical Science University Press: Beijing).

[591] Given that very few of the senior Party leaders agreed on the direction of rural reform, any health care interests would be second-order considerations at best. See for example Teiwes and Sun (forthcoming) *Paradoxes of Post-Mao Rural Reform,* Routledge: Basingstoke.

wouldn't make much difference if that preference wasn't communicated to local governments in a way that forced them to follow the order. Figure 13 below shows clearly the bodies that were involved in communicating any decision and their formal status by rank.

Figure 13: Central health care structures, 1980s



Source: Author's own research and schema (see Chapter 2)

As Duckett's own work notes, the Ministry of Health had to contend with many other ministries and commissions, all of which had their own vested interests to prosecute in the health arena. Almost all of these bodies clearly superseded the Ministry of Health by rank and standing. Each of these ministries, commissions and administrations have a specific role in the system. They were, as follows:

State Planning Commission: Decided resource allocation; approved developmental projects.

Ministry of Education: Responsible for medical education.

Ministry of Labour and Social Security: Managed all urban health insurance schemes.

Ministry of Finance: Monitored budgets, expenditures and project costs.

Ministry of Civil Affairs: Controlled relations with any NGOs, including NGO health providers.

State Price Administration: Mandated the prices of health treatment (including drug prices).

State Traditional Chinese Medicine Administration: Responsible for all policies regarding Traditional Chinese Medicine. Reported to the Ministry of Health.

State Food and Drug Administration: Administered laws, policies and regulations on pharmaceuticals.

People's Liberation Army General Logistics Department: Managed the military health facilities and is responsible for the administration of military health workforce.

This is not to say that the Ministry of Health did not have a view about the CMS. The ministry, in conjunction with a number of other central ministries, issued a 1979 draft statement on the status of the CMS. In it, it argued that the CMS was 'leftist', dissolved in some areas, used an inappropriate 'one size fits all' model, and were poorly managed and

supervised.[592] Yet in the same document it also noted that the CMS schemes had far greater powers over barefoot doctors in the communes,[593] and it made no efforts to dismantle the CMS schemes. This in many ways reflected the confused viewpoint about rural reform throughout the broader system.

More significantly, as Duckett herself noted, the Ministry of Health signalled to local governments that they were allowed to ignore the CMS from 1980,[594] although there was no 'order to abandon the CMS, but just a withdrawal of support'.[595] But, as the next section will show, this 1980 signal appeared to make little impact. The data does not show a dramatic fall in enrolment in 1980; rather, the fall came in 1983. This is because while the Ministry of Health could signal its preferences to both local governments and to local Ministry of Health bureaux, it could not change the incentives for local leaders to keep the CMS — the fact that the local leader may be held accountable for the CMS not being

[592] See Ministry of Health, State Food and Drug Administration, Ministry of Finance, Ministry of Agriculture (1979) 农村合作医疗章程(试行草案) (Rural Cooperative Health Regulations (Draft Document): '以集体经济为依托的合作医疗失去了主要的资金来源。此外，在"文化大革命"中推进与普及合作医疗时，也存在着形式主义、一刀切等问题，使得一些人把合作医疗当成"左"的东西而全盘否定。再加上合作医疗在运行过程中也存在着管理不善、监督不力等问题，导致合作医疗大面积解体，濒临崩溃。国家医药总局和中国供销合作总社联合下发通知.' ('relying on the collective economy to act as the main source of capital for cooperative health care is now finished. Furthermore, collective health care was pushed forwards and popularised during the Cultural Revolution, when there were also problems of "formalism" and "one size fits all reforms". This led to people regarding the CMS as being "left" and totally repudiating it. Besides the management of the CMS still needs to be perfected — there was insufficient supervision of the CMS, and so it has been dismantled or is close to collapse in many areas.')

[593] The 1979 draft comment instructs that county health bureau maintain and check barefoot doctors (clause 13): ('县（市）卫生行政部门，应对赤脚医生进行考核，经考试合格的发给证书'). It also notes that 'promotion and dismissal of barefoot doctors was also allocated to the cooperative medical scheme stations, although it had to be approved by the commune health station and the county health bureaux' ('选拔、调动、撤换赤脚医生要经过合作医疗管理委员会或管理小组讨论通过，征得公社卫生院的同意，经公社审查，报县卫生局批准').

[594] 'From 1980 MoH signalled to localities that they had the option to not implement CMS', Duckett (2011), *op cit.:* 66.

[595] The decision to scrap CMS was 'communicated down the political system via documents formulated by MoH and other ministries, but also through national meetings of health department leaders. There was no order to abandon CMS, but just a withdrawal of support.' *ibid:* 97.

present, and that accountability relationship being determined by the Party Standing Committee the political level above, rather than by the Ministry of Health.

Significantly, in Duckett's argument, the collapse of the CMS was:

> 'not simply because decollectivization defunded it, nor through legislative change as is usual in Western democratic welfare states. Instead, CMS' collapse was triggered by a change in central health policy that was conveyed through the health system by leaders' speeches and meetings as well as central Party-controlled press releases.'[596]

There was undoubtedly a change in central Party policy towards rural governance. But health care, and health insurance specifically, appeared more an inadvertent casualty of structural shifts in what local leaders were held accountable for. In spite of the many follow up documents and speeches in the wake of Central Document no. 1 in 1982, there appear no records of major speeches on health care in 1982, nor meetings that discussed specifically the CMS. Indeed, the next major health speech[597] was in 1985,[598] and then 1989[599] and 1990.[600] The latter two of these speeches decried the end of the CMS.

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[596] 'CMS' collapse was triggered by a change in central health policy that was conveyed through the health system by leaders' speeches and meetings as well as central Party-controlled press releases.' Duckett (2011), *op. cit.,* p.72

[597] As per Chapter 2, defined as one given by someone of full state rank or *zhengguoji,* such as a member of the Politburo or State Council Standing Committee.

[598]万里同志在1985年中央爱国卫生运动委员会第七次委员会扩大会议上的讲话 ('Comrade Wan Li's speech to the 7th meeting of the major Central Committee conference on the Patriotic Health Campaign') ; this was also the official announcement of the dismantling of the barefoot doctors.

[599]中共中央政治局委员、国务委员李铁映在1989年全国卫生厅局长会议上的讲话 ('Politburo member and State Councillor Li Tieying's 1989 speech to the conference of Ministry of Health Division Heads') ; available online: http://www.reformdata.org/content/19890531/25357.html

[600] 国务院总理李鹏接见全国卫生厅（局）长会议代表时的讲话 (1990) ('State Premier Li Peng's 1990 speech to an audience of Ministry of Health Division Head delegates'), available online: http://www.reformdata.org/content/19900819/5584.html

From a structural perspective, this argument about an accountability system-led decline appears logical. For example, Duckett argues that the Ministry of Health was the body charged with backing the CMS.[601] But she also notes that the Ministry's actions were constrained by their need to submit budgets to higher bodies, and have disputes mediated by central work conferences and other coordination mechanisms.[602] The central Ministry of Health could only offer 'guidance' to the levels below. Central policy initiatives were mainly guidance documents[603] that were expected to be 'fleshed out in the follow-up proposals, suggestions, or reports by sub-provincial governments, taking into account the local conditions in implementation.'[604] So, no matter whether it was in charge of the policy or not, once the central Party changed local incentives and accountability structures, there was little that the Ministry of Health could do to keep the policy going.

Indeed, while the Ministry of Health issued a plethora of commands, one could argue that it also suffered from an apparently conscious decision to move away from using Party structures to regulate and control health care and to instead use legal regulations. In the post-Maoist period, there was clearly a move towards greater use of law,[605] with the

[601] Mao took over health care from the Ministry of Health, but 'once Mao was no longer alive to support CMS, however, it lacked strong backing in the central party-state'; as opposed to the Ministry of Labor and Social Security, who had maintained control over urban insurance. Jane Duckett (2011), *The Chinese State's Retreat from Health: Policy and the Politics of Retrenchment*, Routledge: Basingstoke, pp 33-34.
[602] *Ibid*:40-41. The Ministry of Health submit budget to State Planning Commission, they drew up a plan, gave it to Ministry of Finance, discussed in central meetings, for disputes central work conferences would bring together different parties to make decisions. Note that this judgment is based on Lieberthal and Oksenberg (1988), pp. 110-111.
[603] A 指导性的文件 *zhidaoxing de wenjian;* although this category does not matter as much as the fact that it is a document (*wenjian*) issued by the Ministry of Health, and thus its binding nature (or lack thereof) is based upon the central rules of documentation. See Chapter 3 for discussion and a taxonomy of document type and impact.
[604] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.20.
[605] 依法治国 (*yifazhiguo)*; see for example, 曹普(2014) 新中国农村合作医疗史， 福建人民出版社：福州, (Cao Pu (2014) A History of New China's Rural Cooperative Medical System, Fujian People's Press: Fuzhou), p.252.

introduction of the 1978 drug law, the 1981 health standards law, and the 1983 health prevention stations law in the first five years of post-Maoist governance alone. But this increase in the use of legal regulation further fragmented the Ministry of Health's power. As Huang notes: 'In first five years post-Mao, 97 major laws and regulations[606] were introduced, compared with 93 in the previous 26 years…Most of these laws or regulations, however, were technical guidance for implementation and had relatively narrow jurisdiction. As the lines of crisscrossing authority became exceedingly complex and cumbersome, the policy autonomy of health officials was significantly curtailed.'

All of this means, I argue, that the Ministry of Health at the central level was unable to force governments at the local level to obey decrees. In other words, while it is true that there was, as Duckett notes, a central incentive to withdraw support for the CMS at the local levels in 1982,[607] as she also argues, the Ministry of Health had *already* withdrawn support for the CMS prior to its collapse (in 1980). I argue that this is evidence that Ministry of Health preferences at the central level were not necessary nor sufficient conditions for any local change in behaviour. Senior Party preferences changing so that local Party secretaries were not held accountable by the levels above were the significant factor. The following section describes in greater depth.

[606] This included tiaoli, guize, zhangcheng, guicheng, yuanze, tongze, jianze, or xize (rules and regulations), banfa (ways and means), fangan (plans), and biaozhun (standards) as well as administrative circulars. However, unlike the documents themselves, there appears little different in the word used to define the type of measure that should be untaken. See Chapter 3 for a taxonomy of the documents, and further discussion.
[607] Duckett (2011), *op cit.,* p. 97

Local incentives and the fall of the CMS

While the collapse of the CMS was described as being completely led by central *diktat,*[608] with the critical acts of the 'veto players' occurring at the centre, I argue that an examination of both local and central incentives shows that the local Party secretaries are far more able to veto any command than the Ministry of Health. I argue that the distinction between local incentives and central incentives is an important one, and that changes in these incentives at the local level appear both a necessary and a sufficient condition for policy to change.

To evaluate this argument, we need first to look at the interrelated idea that the decentralisation of health policy allowed local governments to provide better service (an idea that divides Duckett and her critics). Duckett's explanation for the collapse of the health care system (including the CMS, as discussed above) has been criticised by Klotzbücher. He argues that Duckett is too centrally-focused:

> However, I am not convinced that this central-level focus is sufficient to explain the collapse of the Cooperative Medical System (CMS), the basic programme of risk protection in the countryside. Duckett argues that the CMS collapsed because the health ministry refrained from support after 1982 when the ideological wind turned against this leftist policy of the Cultural Revolution. Unafraid of being punished (p. 68), there was an

[608] CMS' collapse was triggered by a change in central health policy that was conveyed through the health system by leaders' speeches and meetings as well as central Party-controlled press releases. Duckett (2011), *op. cit.,* p.72

> incentive (p. 97) for local levels to withdraw their support and to stop organising farmers into local schemes, resulting in the rapid collapse of the CMS. [609]

Klotzbücher's critique is based largely on Duckett's framework of how the centre related to the local government:

> This framework, with its implicit top-down implementation logic, is limited in a decentralized policy arena. Even during the Cultural Revolution, when administration by the Ministry of Health had broken down, the CMS continued to be operated and funded by commune and brigade cadres. Duckett describes this administrative framework and factors giving rise to autonomy of the collectives, but she does not readjust her framework on this basis. Centrally planned and orchestrated Party campaigns relating to the CMS, hygiene and health prevention work (which do not get a mention in Duckett's book) replaced state administration to overcome the distance between the central state and the collectives. The detailed analysis of weak state capacity and conflict between ministries presented in the case of the urban sector seems to be absent in the discussion of rural areas… Disaggregating the state into different levels would allow one to question the argument that fiscal crisis and the impact of the minister's opinion were the cause of state retreat at local levels.

Interestingly, the idea of the CMS being disbanded for ideological reasons in a *centrally-led* coalition is also contested somewhat in the Chinese literature. One of the major tenets of the idea of the CMS being 'leftist' was that the CMS was a 'one size fits all'

[609] Sascha Klotzbücher (2012) 'The Chinese State's Retreat from Health: Policy and the Politics of Retrenchment' *The China Quarterly*, vol. 208 pp. 1031-1033.

model.[610] In other words, the CMS was seen as too generalised and not matched to the specific needs of different areas of China.[611] It is important to note that this criticism of the CMS as being too generalised was largely made within China — the rest of the world, in which there was praise of the CMS as a 'model' scheme at global health conferences,[612] described the CMS as being 'decentralized and flexible, in keeping with the principles of self-reliance' and providing 'full opportunities for peripheral units to solve their own problems'.[613]

To help resolve this debate, the following section uses the analytical framework developed in previous chapters to take up Klotzbücher's suggestion that we 'disaggregate the state into different units' in order to analyse the retreat of the state from social health insurance. Undertaking this disaggregation supports Duckett's argument that central leadership preferences remain the most important factor, but it also shows that these preferences were necessary and sufficient only when they were able to alter incentives for local Party secretaries (rendering central Ministry of Health preferences null, as argued above) .

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[610] 一刀切 *yiqie dao* reforms

[611] According to a number of database searches, the critique as the CMS as being too 'one size fits all' was first outlined in the People's Daily: Anonymous (1982) '把大队卫生组织整顿好', 人民日报, ('Rectifying the organisation of production brigade health care', *People's Daily)* 11 July, p. 3. Note that this was not a complete lack of leadership — in the People's Daily article above for example, while arguing for more tertiary care, the Ministry of Health still argued that health care needed government management, but that it must be nuanced —using one size fits all policies were inappropriate. Rather, the government should 'let the people decide, and not use measures unifying by force' (应由群众自己选择，不要强求一律).

[612] See the World Health Organisation's Alma Ata 'Health for all' conference organiser Tejada de Rivero's comments in a World Health Organisation oral history: 'China was a world leader in the new approach to providing health for the people.'. Fiona Fleck (2008) 'Consensus during the Cold War: back to Alma-Ata', *Bulletin of the World Health Organization*, Volume 86, Number 10, October 2008, pp. 737-816.

[613] Recollection was reprinted in Robert Worden, Andrea Matles Savada and Robert Dolan (1987) *China: A Country Study*, Library of Congress: Washington DC, pp. 90-91. See also: Andrea Bernardi and Anna Greenwood (2014) 'Old and new Rural Co-operative Medical Scheme in China: the usefulness of a historical comparative perspective', *Asia-Pacific Review*, 2014 pp. 1-23.

There was clearly considerable interaction between the centre and localities in managing social health insurance. As discussed in Chapter 4, the Mao-era CMS was a locally-managed scheme. The Party promoted the CMS as being 'decentralised and flexible, in keeping with the principles of self-reliance' and as providing 'full opportunities for peripheral units to solve their own problems'.[614] But in reality the parameters of the scheme were specified by the centre, and more importantly, the incentives to ensure that the scheme continued as a going concern were provided by the centre. Local levels of government had constantly to battle the need to fulfil central mandates against the problems of ensuring enough funds in the system to fulfil other mandates. For something to become a priority, the local government had to be provided with incentives.

As Chapter 4 showed, the political incentives for the implementation of the CMS were focused on measuring and rewarding the local state leaders for the creation and maintenance of a social health insurance fund. Given this, this chapter argues that an institutional analysis of the changes to the incentives for local Party secretaries to support rural health sector offers another possible explanation of why the CMS scheme collapsed (as well as explaining why the CMS was implemented in the first place).

My argument is that the change in the rural structure of production to household responsibility from collective responsibility also changed the relationship between the Chinese state and health financing. When the former system of communes, brigades, and

[614] *Ibid*.

teams was replaced formally by a system of county, township, and village levels, there was also a shift in what local leaders in these new jurisdictions were held accountable for. This, as per the abstract framework outlined in Chapter 3, altered the institutional system of control, and changed the political incentives for local leaders to allow them to drop the scheme.

The position of the Ministry of Health within the local state was weak. As Figure 14 below makes clear, local state health bureaus answer to two different superior units: they report vertically to the Ministry of Health administrative unit in the political level above, and they report horizontally to the local state (headed by the Party secretary). As Figure 14 also makes clear, this is the case for all parts of the state administration apparatus (the right hand side, labelled 'State').

The declining power and authority of the Ministry of Health and its subnational equivalents were indicated in a speech made by Qian Xinzhong, Minister of Health in the early 1980s and a key source for Duckett[615] who, following the major political decisions of 1982 and 1983 (see section below), asked local health bureaucrats to work 'independently [from the Ministry of Health] and responsibly'.[616]

[615] Both his speeches in the 1983 Health Yearbook (中国卫生年鉴编辑委员会编 (1983) 中国卫生年鉴, 人民卫生出版社: Beijing, ('China Health Yearbook Editorial Committee Commission (1983) *China Health Yearbook,* People's Health Press: Beijing')), and his weighty 1992 memoir (Qian Xinzhong (1992) *中国卫生事业发展与决策,* 中国医药科技出版社: Beijing（*China's health work development and policy,* China Medical and Drug Science Press: Beijing*)* are cited regularly in Duckett (2011), *op cit.*

[616] 中国卫生年鉴编辑委员会编 (1983) 中国卫生年鉴, 人民卫生出版社: Beijing, ('China Health Yearbook Editorial Committee Commission (1983) *China Health Yearbook,* People's Health Press: Beijing'), p.45.

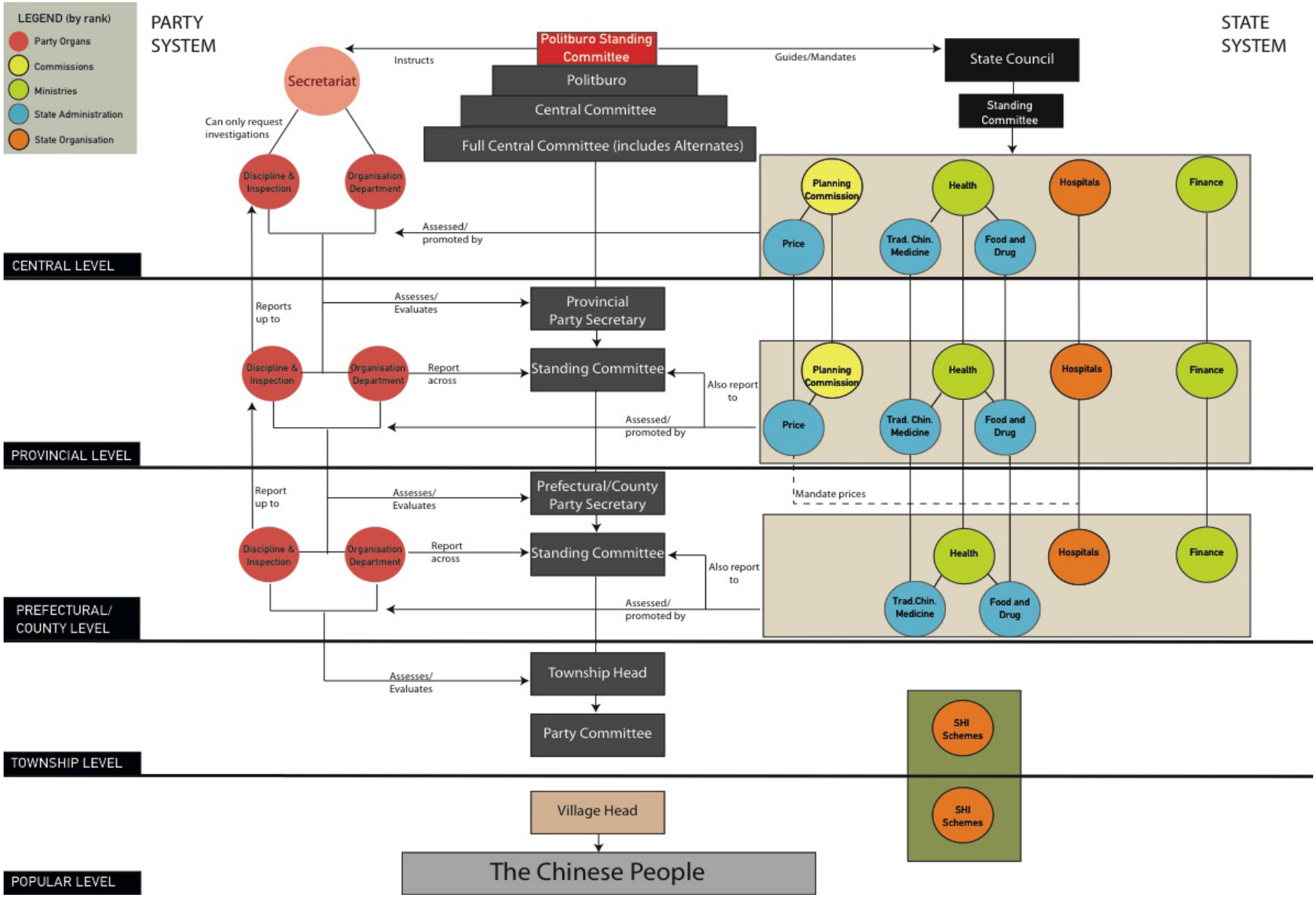
As per Qian's request, the local Party committee had high levels of control over whatever occurred in its purview, regardless of the policy area. This authority relationship was institutionalised in Article 107 of the 1982 Constitution: 'Various levels of subnational governments at or above the county level administer the economy, science, culture, and public health … and issue decisions and commands according to legally defined jurisdiction.' Note that this leaves the command of the health sector in the subnational governments (the highest body of which was the Party Standing Committee (PSC)).

The Party committee possessed almost total authority. As Huang notes, 'a policy proposal drafted by the local health bureau to carry out the "messages" of the upper-level bureaus, for example, had to be approved and *distributed by the local state* to be honoured by levels of the local state below and even to be honoured by other departments at the same political level.'[617] Former health minister Qian Xinzhong argued that local officials reported that they were 'afraid that they would be punished' (by local Party secretaries) should they not abandon the CMS.[618] This order could only come from the local Party secretary and from local leaders, as they are the only figures with the rank to issue such an order. Figure 14 below illustrates this relationship of authority.

[617] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p.20; quotes Qian Xinzhong (1992) *中国卫生事业发展与决策,* 中国医药科技出版社: Beijing（*China's health work development and policy,* China Medical and Drug Science Press: Beijing*).*

[618] Duckett (2011), *op cit.,* p.69: again quoting Qian Xinzhong 'where they had *not (sic)* abandoned CMS local officials reported, in the early 1980s, that they were afraid they would be punished.' Implicit in this is that Duckett sees the relevant local actors as only 'local officials who were responsible for implementing CMS' Duckett (2011), *op cit.,* p.70

Figure 14: Chinese rural health system in the 1980s
Source: Author's own research and schema



As Figure 14 shows, social health insurance schemes were left at the village level (some, albeit very few were left at the township level), with management of the schemes stationed at the township level (see the following section) and the county Ministry of Health nominally responsible for them. But, not only did the Ministry of Health at the county level mainly answer across to the county leadership, but also the Ministry of Health told local governments that they could choose to keep or release social health insurance schemes in 1980 (see the absence of accountability relationship in Figure 14). Only really the county leadership could set incentives down to the village head that would have forced them to maintain (or not) social health insurance schemes.

I argue that all of these factors make the local Party committee, rather than the central or even local Ministry of Health, more likely to decide the direction of the rural health system. It was difficult for the local Ministry of Health bureaus to attract sufficient organisational capacity and manpower to regulate hospitals and healthcare services effectively.[619] Even should they be able to do so, the interests of the local state could always trump health care interests. And occasionally, the interests of the local state decision makers could then also trump the interests of the broader public — an example can be seen in the regulation of pharmaceutical drugs, for example, where a number of Chinese studies

[619] Most popularly discussed by Gu Xin — see Gu Xin, Gao Mengtao and Yao Yang (2006) 诊断与处方：直面中国医疗体制改革 ('China's Health Care Reforms: A Pathological Analysis'), 社会科学出版社: Beijing, pp. 162-164 and pp. 230-233 (on NCMS). See also 刘克军 and 范文胜 (2002) '对两县90年代合作医疗光衰的分析', 中国卫生经济, (Liu Kejun and Fan Wensheng (2002) 'An analysis of the rise and fall of collective health care in two counties in the 1990s', *China Health Economics'),* p. 6.

noted that drug sales were difficult to regulate due to cooperative funds paying for drugs and cadres having preferential access.[620]

Finally, while applying a general analytical framework to the collapse of the CMS is useful, it is hard to analyse the collapse of the CMS without specific data. This is the major claim of the final part of Klotzbücher's comments on Duckett's model for example; he thought that her work both needed to be 'triangulated' against local sources and needed to use yearly statistics for CMS enrolment:

> This leaves the decision of the Ministry of Health at the central level to retreat from health provision as the exclusive explanation of changes at the local level. This is of doubtful explanatory power. Firstly, the CMS had already collapsed in some areas during the Cultural Revolution. One has to ask why local leaders should be more afraid to continue implementing the CMS in 1981 than during the Cultural Revolution, especially if the argument relies exclusively on the direction of the Minister of Health without any triangulation from other, local, sources. Furthermore, it is assumed that the CMS collapsed immediately following the minister's statement, whereas this must remain under debate, given that yearly statistics for CMS coverage are simply not available (p. 6).

However, recent developments have made yearly statistics for CMS coverage available. The data below comes from the Central Party School. These data were assembled by a team of researchers in the Party School in a project beginning in 2006, and were subsequently

[620]曹普(2014) *新中国农村合作医疗史*，福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou) p.251 outlines the problem of cooperative funds paying for drugs and cadres having preferential access to the drugs, or as the pithy phrase regarding SHI schemes went: '群众交钱，干部吃药' ('the masses cough up the money, the cadres take the medicine'). See also Qian Xinzhong (1992), *op cit.,* p.73.

presented and reported as part of a Central Party School report and subsequent Central Party School funded project. While there is a considerable array of differing statistics on the collapse of CMS, this set of data has some advantages. The first is that, unlike other sets of data which compile various newspaper reports to try and develop a national understanding,[621] these data were deliberately collected for a national project using Party data. The second advantage is that they show clearly what the Chinese system itself assesses CMS coverage to have been. This means that any numbers where the Party system is evaluating the performance of local government are likely to be inflated; this provides some confidence that underreporting is unlikely (as Party secretaries are likely to inflate numbers that they are being measured on).

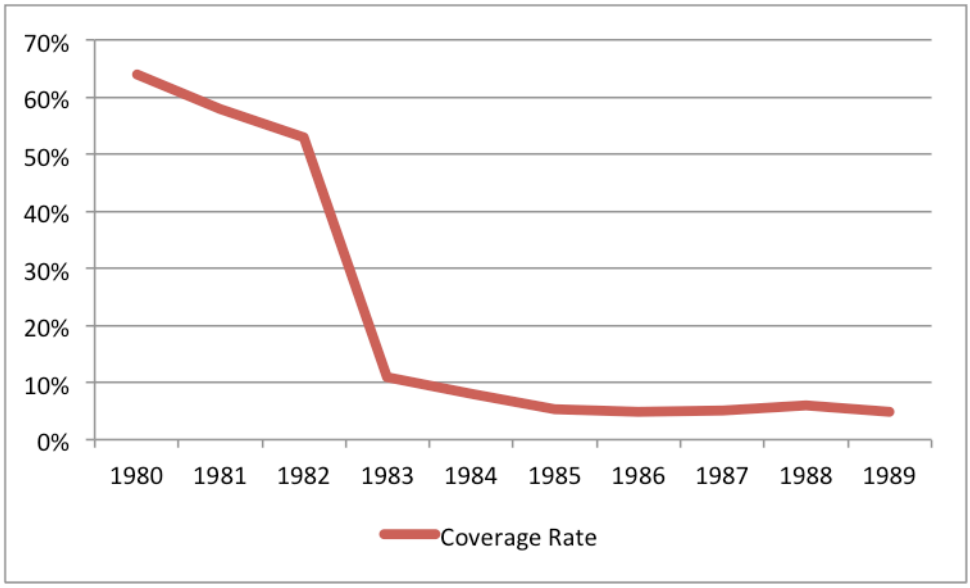
The data in Figure 15 show a dramatic drop in coverage of the CMS, especially between 1982 and 1983. These data support the argument that decisions taken in 1982 appear to be the critical ones for the provision of social health insurance (as was argued in Duckett's book, negating Klotzbücher's critique).[622] In the section below, I propose that these data show the decline of social health insurance to be as much a consequence of institutional changes as it was a consequence of economic change. When local heads were not being held responsible for maintaining enrolment in schemes, the schemes summarily

[621] See, for example, Jane Duckett (2011), *op cit.* p. 62 notes that 'less than 5% of villages had CMS in 1984'; and that Hossain argues that CMS went from being 17% of total spending in 1980, it had fallen to less than 6% in 1983; but then footnotes 5 and 6 from pages 126-127 quote 'the People's Daily 9 June 1978 says that most CMS stations in Qinghai dissolved before 1974; Song Shiyun says that 68.8% of administrative villages had CMS in 1980. People's Daily 28 June 1979 says that 80% of production brigades were implementing CMS; People's Daily 3 October 1979 says that 82% of brigades have CMS and clinics.' This is not to critique at all Duckett's work, but merely to note that the pastiche of different reports in different newspapers at the time were rather contradictory.

[622] 'retrenchment in rural risk protection took place through the rapid collapse of the cooperative medical system (CMS) between 1982 and 1984', p.97; the difference between her argument and this one being that she places the crucial decision that led to this retrenchment as being the tax reforms of 1980, whereas I argue that it is Central Committee Document 1 in 1982.

collapsed.[623] Figure 15 below shows the impact of 1979 and 1982 decisions clearly. The section that follows analyses each decision.

Figure 15: Social Health Insurance coverage, rural China 1980-1989



Source: 曹普 (Cao Pu) (2006) '1949-1989：中国农村合作医疗制度的演变与评析' [1949-1989：China's cooperative medical insurance system development and analysis], 中共云南省委党校学报, no. 5, p.43

An alternative explanation for the collapse of the CMS

The early drop in enrolment in 1979 was a reaction in certain provinces, rather than nationwide. Following a 1979 central report on the Hunan experiment (discussed above), the collection of cooperative medical scheme fees was seen as 'adding to the peasant's

[623] State subsidies stopped, dropping from 100m yuan in 1979 to 25.28m in 1987. See Wu Guoguang and Helen Lansdowne (eds.) (2009) *Socialist China, Capitalist China: Social Tension and Political Adaptation*, Routledge: Abingdon, p. 80.

burden'.[624] Moreover, it was seen as adding to the impost on state-owned enterprises, many of which were suffering from the shift to individual production.[625] In response, a number of Northwest provinces in particular decided to drop cooperative medical health insurance schemes,[626] making them 'blow away like a puff of wind', as one Chinese commentator poetically wrote.[627]

But, until 1982, social health insurance schemes were largely retained throughout the rest of China, largely due to the fact that, with the exception of the Northwest, Party brigade heads were still forced to maintain CMS schemes, and removing CMS schemes thus affected their evaluations from above — despite the Ministry of Health noting in 1979 and 1980 that they were ambivalent on the schemes and that from their perspective the schemes did not need to continue.[628] As Figure 15 above shows, the schemes did not collapse in 1979 and 1980. Reports in 1982 note that brigades were still forced to run CMS

[624] As Wang Shaoguang argues: '一些地方把办合作医疗看作是"穷吃富", 是"增加群众负担"' ('there were some areas that looked upon cooperative health as being "the poor propping up the rich" and as "increasing the burden of the masses") — Wang Shaoguang (2008) '学习机制与适应能力: 中国农村合作医疗体制变迁的启示', 中国社会科学, ('Studying the system and increasing responsiveness: the renaissance of the NCMS', *Chinese Social Science Study*'), vol. 6, p. 14; see also: 张自宽 (1982)'农村合作医疗应该肯定应该提倡应该发展：东北三省农村医疗卫生建放调查之四'，农村卫生事业营理，(Zhang Zikuan (1982) 'Rural cooperative health must be improved, must be encouraged, and must be developed: a survey of rural health development and letting go of rural health in three northwest provinces' *China Health Care Administration*') February and 郭清 (2008)人人享有卫生保健—庄严承诺30年, 健康报, (Guo Qing (2008) 30 years of a sincere promise of health care for everyone, *Health Times*)18 December, available online: http://www.jkb.com.cn/thinkingDiscussion/2008/1222/127190.html.

[625] Tao Li (2011) '中国共产党对医疗保障制度的探索与经验', 当代中国史研究, ('The Chinese Communist Party's explorations and studies of the health insurance system', *Contemporary Chinese History')* vol. 28, p. 8. Available online: http://theory.people.com.cn/GB/82288/83854/83867/15430719.html.

[626] No significant information was found on the structural reasons for this fall in the Northwest; and for reasons of space and an absence of data, this thesis is unable to provide a comprehensive explanation. Hopefully this lacuna can be filled in future research.

[627] '也被一阵风给吹掉了' ('and it fell away, as if blown by the wind'); 张自宽 (1982)'农村合作医疗应该肯定应该提倡应该发展：东北三省农村医疗卫生建放调查之四'，农村卫生事业营理，(Zhang Zikuan (1982) 'Rural cooperative health must be improved, must be encouraged, and must be developed: a survey of rural health development and letting go of rural health in three northwest provinces' *China Health Care Administration*') February, p.3.

[628] 'From 1980 MoH signalled to localities that they had the option to not implement CMS', Duckett (2011), *op cit.*: 66.

schemes, and that they remained part of the evaluation criteria for local Party secretaries — and that more than half the rural population were still enrolled.[629] It was not until 1983 that the effect of the removal of communes kicked in and local Party leaders were told to not support cooperative health insurance with any 'hard administrative measures', that social health insurance fully collapsed. This decision was based on the 1982 Central Committee decision on the rural economy[630] and the Central Committee's 1983 Document No. 1 (the decision on the rural economy was promulgated to force people to follow Document No. 1). As both of these decisions were binding, they forced the Ministry of Health to promulgate a response in 1983 that was specific to the health sector that addressed the problems raised in the Central Committee decrees.[631]

These documents raised a number of problems with rural agricultural economic policy in general; but as part of this outlined a major shift in strategy for how the party-state regarded health care. The decisions argued that the local party-state should try and pass responsibility for health to the people.[632] By passing the major burden of health responsibility to the people, these two decisions contradicted the 1979 changes to the Constitution that assigned responsibility for health care to local states — but also meant

[629] World Health Organisation (1983) *Primary health care : the Chinese experience : report of an Inter-regional Seminar,* World Health Organization Publications Centre: Geneva, pp 27-38.
[630] Central Committee (1983) 中共中央关于印发《当前农村经济政策的若干问题》的通知 ('Central Committee notice regarding the publication of 'Some questions regarding current rural economic policy').
[631] Ministry of Health (1983) 关于适应农村形势的发展健全农村基层卫生组织的意见 (征求意见稿), ('An opinion regarding building and organising national grassroots healthcare that is suitable to the state of rural development' (Draft Opinion)) reprinted in 中国农村卫生事业管理 (China rural health administration), (1983), vol. 1.
[632] Clause 13.2 of the Central Committee's Document No. 1 (the document released each year outlining the Central Committee's priorities) notes: 要加强农村各种文化、卫生设施的建设。这些文化卫生设施，国家办，集体办，更要鼓励和扶持农民自己办。("We must strengthen rural culture and the building of health care facilities. The state must build these facilities, the collective must build these facilities, but most of all, the peasants themselves must be encouraged and supported to build these facilities.') Central Committee (1983) '当前农村经济政策的若干问题' ('Some questions regarding current rural economic policy') *Central Committee Document No. 1*, available online: http://cpc.people.com.cn/GB/64162/135439/8134114.html

that local Party leaders would not be held responsible for local health care collapse. At the central level, this was taken to mean that China's unequal economic development in the household contracting period was making health insurance inequitable, and a burden on peasants.[633] Local Party secretaries were told that they were no longer responsible for health care.[634] Local health officials were told by the Ministry of Health to make enrolment voluntary, and to not use any administrative decrees or 'hard methods' to enforce cooperative medical schemes. Although local health officials had been told similar things in 1979 and 1980; the difference here was that the local Party heads — no longer responsible for health care — didn't have any incentive to keep the schemes going.[635] The schemes then collapsed.

The dismantling of social health insurance schemes occurred with an absence of flourish. The vital 1983 decision did not declare that all social health insurance should be disbanded dramatically, but rather (perhaps in a dog whistle to complaints that the CMS was 'leftist') noted that the CMS was a 'socialist collective welfare undertaking' and thus rural health insurance plans should be based on 'collective mutual assistance'.[636] The

[633] See for example the opinion *yijian* from the Ministry of Health (released to all local offices at the start of 1983, in the wake of Central Document No 1: 'because our economy is inbalanced, our health system is inbalanced, we need to see local conditions before launching CMS programs, we need to support voluntary enrolment as the word of the masses … you cannot use administrative decrees or any sort of hard methods to enforce cooperative medical systems' ('由于我国农村经济发展不平衡 … 不能用行政命令的办法去硬性推行某种形式的医疗制度'). Ministry of Health (1983) 关于适应农村形势的发展健全农村基层卫生组织的意见 (征求意见稿), ('An opinion regarding building and organising national grassroots healthcare that is suitable to the state of rural development' (Draft Opinion)) reprinted in 中国农村卫生事业管理 (China rural health administration), (1983), vol. 1.

[634] Clause 13.2 of the Central Committee's Document No. 1. Central Committee (1983) '当前农村经济政策的若干问题' ('Some questions regarding current rural economic policy') *Central Committee Document No. 1*, available online: http://cpc.people.com.cn/GB/64162/135439/8134114.html

[635] *Ibid.*

[636] 中国卫生年鉴编辑委员会编 (1983) 中国卫生年鉴, 人民卫生出版社: Beijing, ('China Health Yearbook Editorial Committee Commission (1983) *China Health Yearbook,* People's Health Press: Beijing') pp. 33-40.

central Ministry of Health repeated their stance that it would 'sponsor townships that want SHI, but not force them to have it'.[637] The Ministry of Health response came after the Central Committee's 1982 decree, and referenced the Central decree. As per the analytical framework, the Central Committee decree was binding and forced a response from lower ministries, including the Ministry of Health.

Once local governments were freed from social health insurance obligations they became disinterested in maintaining the schemes. The capacity of various areas to support social health insurance was vastly different,[638] and while the centre told those areas struggling for funds that any policy shift would be a short-term shift only, poorer areas were likely to gratefully accept the removal of further burden from their books.[639] Wealthier areas argued that forcing the local government to put money into social health insurance schemes was falsely egalitarian[640] — forcing all areas to have a basic level of service deprived rural residents of the ability to access more 'modern' medicine,[641] 'left the

[637] Ministry of Health (1983) 关于适应农村形势的发展健全农村基层卫生组织的意见 (征求意见稿), ('An opinion regarding building and organising national grassroots healthcare that is suitable to the state of rural development' (Draft Opinion)) reprinted in 中国农村卫生事业管理 (China rural health administration), (1983), vol. 1.

[638] 'Given that economic development is unequal, do we still want health insurance, do we persist with the principle of voluntarism.' Anonymous (1982) '把大队卫生组织整顿好', *People's Daily*, 11 July.

[639] 'China's bigger polities made clear that self-funding would only be for an even shorter period of time', 冯宝美 (1987) 论农村合作医疗制度问题, 中国卫生事业管理, (Fang Baomei (1987) 'A discussion of problems of the rural health care system', *China Rural Health Care Administration and Management)* vol. 5., p. 3.

[640] See for example Editorial (1979) 关于农村合作医疗、赤脚医生的几个问题, *People's Daily*, 7 February, which decried the 'egalitarianism and indiscriminate transfer of resources' of the CMS.

[641] 曹普(2014) *新中国农村合作医疗史*, 福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p.151.

countryside lacking doctors and drugs',[642] and the financial pressure of maintaining it indefinitely would have led to its collapse anyway.[643]

With these central decrees, and in repudiation of the CMS scheme of the Maoist period, the local leader was not held responsible for the initiation of any cooperative health scheme. Rather, ideas could come from the county health bureau, but implementation was left to the social administrative arm of the township government.[644] Fund management committees — in spite of their fundamental role in determining the performance of the health system at the local level[645] — only had to contain representatives of different parts of the township government.[646] The chairperson was not held accountable to higher levels of the Party or state for the performance of the health insurance fund or the enrolment in the scheme; rather, s/he had to report horizontally to the township Party secretary. And the deputy chair of the scheme was 'often the director of the health centre', with the social health insurance fund committee's office 'commonly situated in the health centre'.[647] So

[642] 张自宽 (1993) 中国的初级卫生保健要走自己的路, 中国农村卫生事业管理, (Zhang Zikuan (1993) ' China's early health insurance had to walk its own path', *China Rural Health Care Administration and Management),* vol. 5.
[643] 'It was unavoidable. And also, if the peasants loved it so much, why did it collapse?' 李德成 (2007) 中国农村传统合作医疗制度研究综述, 华东理工大学学报, (Li Decheng (2007) 'An overview of research into China's traditional rural social health insurance', *Huadong Ligong University Study Journal),* vol. 1.
[644] Feng Xueshan and others unusually specify a person as 'often responsible': a township government deputy responsible for social affairs. Feng Xueshan, Tang Shenglan, Gerald Bloom, Malcolm Segall, and Gu Xingyuan (1995) 'Cooperative medical schemes in contemporary rural China', *Social Science & Medicine*, 1995 vol. 41 (8) pp. 1111-1118
[645] 'The fund management committee has a number of responsibilities: to establish and implement regulations and contracts for service provision by health facilities; to determine the levels of contri- bution of the township government, village welfare funds and individual households; to establish the systems of reimbursement and of any direct payments to health stations and health centers; to col- lect the contributions, make payments and keep accounts; and to monitor the fulfillment of service regulations and contracts by health care providers, and award bonuses to, or criticism, health facilities or individual health workers according to their performance.' *Ibid:* p.1113.
[646] 'At the township level, the committee is likely to include representatives of the township government, the Communist Party, the health centre, the village administrative committees, village residents, and village health workers.' *Ibid: 115*
[647] *Ibid*.

neither the chair nor the deputy chair were in a position of leadership in local government able to provide incentives to force the scheme to function. This organisational structure fails to create any institutional or political incentive to ensure the social health insurance scheme exists (or does not exist).

As such, local political leaders did not need to make a decision, in either direction, on the merits of social health insurance. Rather, they delegated the decision to lower-level employees, who could be held responsible by the people should there be any unhappiness with the scheme. This was critical to the decline of social health insurance. As Young notes in her 1982 study of the rural health care system just prior to the change in accountability: 'Once the *political decision* is made to go ahead with a scheme, participation of villages and households is usually high. Normally, once a household joins a scheme, all family members must participate.' [648] The difference for the post-1982 period was that local Party leaders were not held responsible for making this 'political decision' forcing or encouraging residents to join.

As argued in Chapter 4, the CMS and the different campaigns launched in the Maoist period both had the benefit of using free labour, or of using what was essentially money allocated by the collective (as they received work points). The shift to decollectivisation changed the fiscal and political incentives for the local state. While the Party incentives (political incentives) remained similar in the period of the 'collapse of health care', the need to keep funding services without this free labour was a considerable burden on local

[648] Discussed in Mary Young (1989) 'Impact of the rural reform on financing rural health services in China', *Health Policy*, vol. 11, no. 1, pp. 27-42. Note that while the article was written in 1989, it discussed field visits that took place in very early 1982.

government. Local leaders could tolerate the burden of ensuring high SHI enrolment, and of maintaining the scheme, largely due to the fact that they were measured from above on how many people were enrolled.

So when Party political incentives were removed — most dramatically, in 1982 — local leaders very quickly focused their attentions on other central mandates that they needed to fund or support (such as population control or economic reform).[649] Under theories of decentralisation promoted by Klotzbücher, this should have led to an improvement in enrolment, as the service would be 'closer to the people'. But rather, the Party head of the local state was no longer held responsible by the Party for high enrolment — and there was no longer high enrolment. This did not mean that the Ministry of Health completely abandoned the CMS — it meant that the ministry abandoned the pretence that it was responsible for decisions regarding social health insurance.

How institutional problems affected the whole system

The collapse of the CMS was just part of a wide array of changes to the broader health care system. Many of these changes occurred simultaneously, or at least came quickly after the collapse of the CMS. In late 1982, Cui Yueli succeeded Qian Xinzhong as Minister for Health. Cui, who had a Party rather than a medical background, moved from 'putting the

[649] Central Committee (1979) 中共中央关于加快农业发展若干问题的决定, ('Central Committee Decision on Certain Questions Regarding Quickening Rural Industry Development') clause 24, said that health services should be maintained, but that economic measures and population control prioritised.

emphasis on the rural areas' to 'urban and rural areas receiv(ing) equal treatment';[650] his other focus was on attempting to ensure that 'all Chinese doctors have the opportunity to learn from the top Chinese doctors'.[651] Cui's initiation pronouncement was that health care institutions should 'act according to economic rules'.[652] He was emboldened by both a 1979 Central Committee decision (*jueding)*[653] and the 1983 Central Document no. 1 (and the 1983 Central Committee decision (*jueding)* that told all members of the local party-state to follow Document no. 1),[654] which made it clear that the 'state and collectives should run cultural and public health facilities, but it is more important to have farmers themselves run them'. Cui's ideological push merged with the desire to make health care providers self-supporting, on the argument that they should not necessarily always be subsidised by the state.

But, in wishing to force health care providers to be self-supporting, the central government created unclear governance frameworks. In spite of shifting some responsibilities onto the individual, and allowing health care providers to charge higher fees, the central state remained concerned that basic health care should be affordable. Hence, it retained control of some institutions (rules) at a *higher* political level, forcing

[650] Huang Yanzhong (2002) 'The Paradoxical Transition in China's Health System', *Harvard Health Policy Review*, vol. 3, no. 1, p. 32, available online: http://www.hcs.harvard.edu/~epihc/currentissue/spring2002/huang.php

[651] Editorial Board of Who's Who in China (1989) 'Cui Yueli', in *Who's Who in China: Current Leaders*, Foreign Languages Press: Beijing, p. 89. His other focus was on the promotion of Chinese medical science, a topic he continued until his death; e.g.: 崔月犁 (1987) 中国当代医学家荟萃, 吉林科学技术出版社: Changchun.

[652] 中国卫生年鉴编辑委员会编 (1983) 中国卫生年鉴, 人民卫生出版社: Beijing, ('China Health Yearbook Editorial Committee Commission (1983) *China Health Yearbook,* People's Health Press: Beijing'), p.14. Note that this is often attributed to Qian Xinzhong, but he had already been promoted to head the Family Planning Commission in May 1982, and the yearbook does not make perfectly clear whose speech it was.

[653] Central Committee (1979) 中共中央关于加快农业发展若干问题的决定, ('Central Committee Decision on Certain Questions Regarding Quickening Rural Industry Development'), clause 24.

[654] Central Committee (1983) 中共中央关于印发《当前农村经济政策的若干问题》的通知 ('Central Committee notice regarding the publication of 'Some questions regarding current rural economic policy').

local governments to bow to some central command. Pricing, for example, remained controlled by the provincial pricing authority. Probably influenced by its experience during the Maoist era (see Chapter 4), the central state decided to lower the price of services artificially but to allow facilities to set the price of drugs and high-tech tests above cost.[655] Reportedly, higher level leaders wanted to encourage village doctors to upgrade their skills,[656] and the Ministry of Health had long sought greater levels of tertiary care (which it largely controlled) in the Chinese health care system.[657] This structure was formalised by the State Council in 1985.[658]

The changes created a highly confusing institutional environment. The central government regulated prices, but did not give the local governments enough funds to cover ownership of public hospitals and clinics.[659] To make up for this, the central government delegated two rights to the local government: the right to specify staffing levels,[660] and the right to contract out hospital management to a director. The local government, often cash-strapped, was supposed to transfer enough to the hospital or clinic to cover staff salaries (as

[655] E.g. Karen Eggleston (2010) "Kan Bing Nan, Kan Bing Gui: Challenges for China's Health-Care System Thirty Years into Reform." In Jean C. Oi, Scott Rozelle, and Xueguang Zhou (Eds.). *Growing Pains: Tensions and Opportunity in China's Transformation*, Walter H. Shorenstein Asia-Pacific Research Center Books: Palo Alto CA.

[656] The barefoot doctors have only just begun; their knowledge is slight. They can only treat a few common sicknesses. After some years, they will put on straw shoes; that is, their knowledge will have grown. A few years more, and they will wear cloth shoes.' Roger Garside (1981) *Coming Alive: China After Mao*, New York: McGraw-Hill Book Company, p. 71.

[657] See Lampton (1977), *op cit.* on this argument in Maoist times; it is also a central claim of Duckett (2011), *op cit.*

[658] The 1985 document 62, approved by State Council, for example, changed the nature of healthcare organisation, allowing physicians to provide tertiary services for profit in order to subsidise the provision of basic services at a loss (以福补助*yi fu bu zhu*); this was the State Council decision which also formalised the dismantling of 'barefoot doctors' .

[659] 'state subsidies stopped, dropping from 100m RMB in 1979 to 25.28m in 1987, and after that they just stopped subsidising'. Huang Yanzhong (2012), *op cit.*, p. 53.

[660] Gu Xin (2006) *诊断与处方：直面中国医疗体制改革*, 社会科学文献出版社: Beijing (*Pathologies and cures: directly reforming the Chinese health care system,* Social Sciences Press: Beijing), pp. 228-229.

they provide the services). The director had some (limited) say over what staff could do, but had no control over pricing of services, the basic rate of pay of his/her staff, nor the number of staff in his/her clinic or hospital. A simplified version of this is set out in Figure 16 below.

Under the new system, hospitals received limited funds from the state. They had to generate revenue shortfall from user fees. As the prices of services were set below cost, these fee contributions had to come from goods and services which were allowed to be provided *above* marginal cost — drugs and high-tech diagnostic tests, usually.[661] Physicians were given a responsibility contracts to ensure that they meet their targets. These contracts were heavily weighted towards revenue generation.[662] Hospitals or clinics were then able to provide physicians additional incentives should tasks not be fulfilled.[663] This reflected a shift, in many ways, that was the opposite of shifts in other countries towards mechanisms which attempted to *control* the number of tasks or operations physicians performed (in order to avoid supplier-induced demand through information asymmetry).

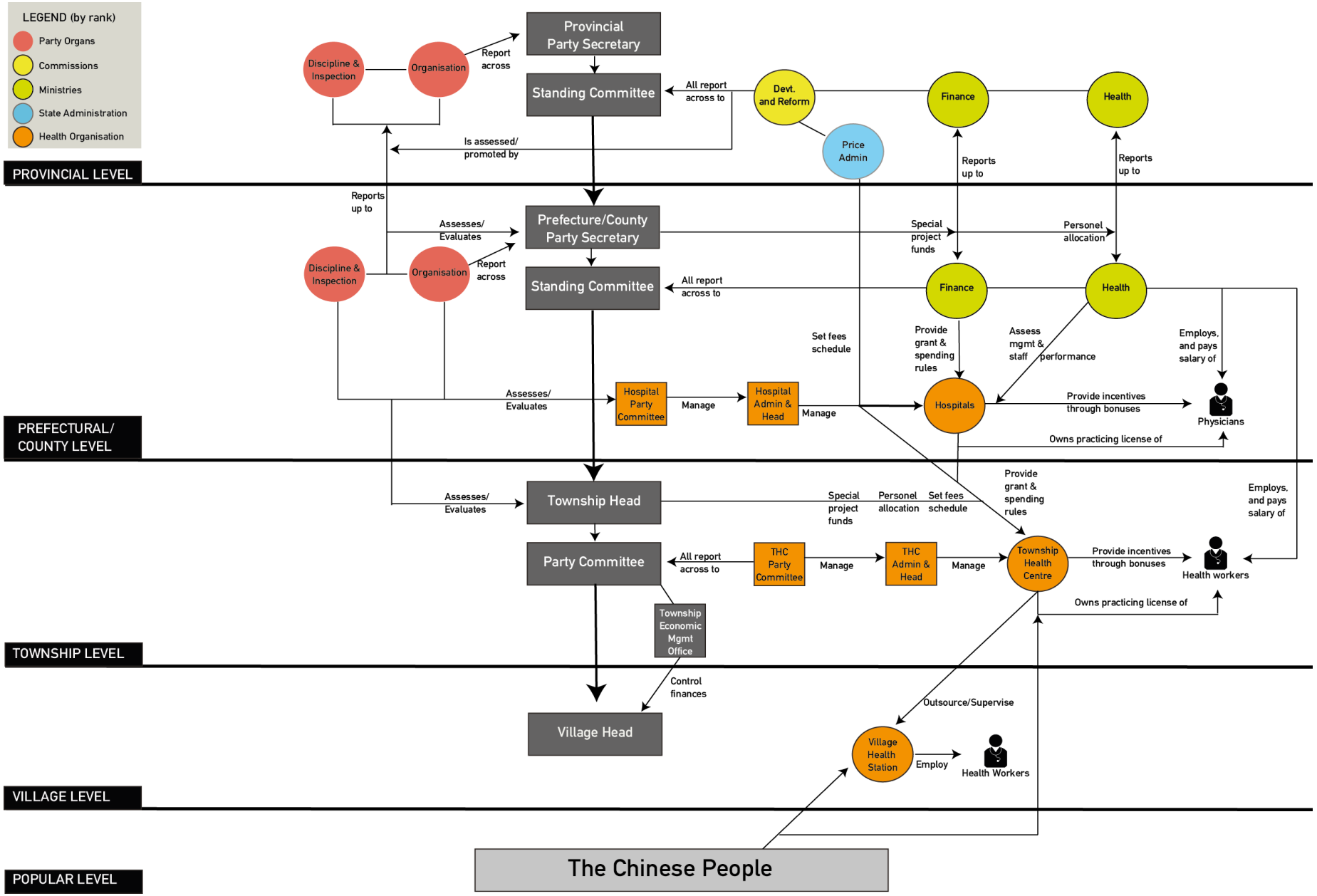
To obviate this institutional dilemma, the local level attempted to put in place its own incentives. The Party Standing Committee signed contracts with hospital and clinic

[661] A Wagstaff, W Yip, M Lindelow, and WC Hsiao (2009), 'China's health system and its reform: a review of recent studies.' Health Economics, vol. 18, pp. S7–S23.
[662] 'A typical 'evaluation' reads as follows: attendance days increased from 270 to 305 days; quality of work increased; drug expenditures reduced 30%; there were volunteers for immunization campaigns; 'unnecessary' expenses reduced 28%; more surgery performed; and revenues were up 5%. The last point, 'revenues up' appears in virtually every evaluation.' Mary Young (1988) 'Impact Of The Rural Reform On Financing Rural Health Services In China', *World Bank Report,* number 31568, World Bank: Washington DC.
[663] The most extreme form is an immediate cut in current salary (up to 50%) coupled with a bonus system based on performance to make up for the loss. Alternatively, performance payments are made to supplement salary.

directors allowing them to assign bonuses to staff according to their performance.[664] The director would then receive a bonus if the centre's overall performance was judged by the Ministry of Health bureau (national-level) to be above average. The Ministry of Health — which also trained health professionals — was similarly allowed to assess the performance of physicians in facilities. As the Ministry of Health held the licensing certificate of the physician, it also had significant control over where the physician could officially practice (aligning its interests with that of the local government). This potpourri of institutional changes shows the confusing environment that faced health care providers throughout the reform period. Figure 16 below shows this institutional environment graphically.

[664] Note that there was no hard and fast rule as to which member of the Party Standing Committee signed the contracts — it was usually the Deputy Governor or equivalent responsible for health care — under the rules of collective responsibility, the Party Secretary was held accountable for failures in this contracting. See Minzner (2009), *op cit.,* and Chapter 3.

Figure 16: An institutional map of the Chinese hospital system, 1980s
Source: Author's own research and schema



How institutional changes hindered the return of the CMS

The institutional changes occurring concomitant to the collapse of the CMS then hindered later attempts to bring social health insurance back. The shift to the individual paying for service, and the lack of regulation over provision of services, both led to higher costs of treatment in the post-Mao period.[665] These higher costs of treatment would then have to be borne by the state should it try and reintroduce social health insurance. So the more treatment costs rose, the more difficult it would be to bring back collective or cooperative health financing mechanisms.

There were a number of structural problems embedded in this conundrum. The first was that a more complicated institutional environment put pressure on local governments to manage complex insurance systems, and this made it much harder for local governments to establish risk pools that would allow for the establishment of any form of cooperative insurance at the village or township level. There were institutional elements to this failure. As central and provincial contributions were one-off contributions, shortfalls in the fund or the operating had to be made up by the county or township government. And, according to Beijing regulations, [666] should the fund 'spend excessively' on

[665] Adam Wagstaff, Magnus Lindelow, Shiyong Wang, Shuo Zhang (2009) *Reforming China's rural health system*. Washington, DC : World Bank Group. Available online: http://documents.worldbank.org/curated/en/2009/01/10715427/reforming-chinas-rural-health-system

[666] Case study is of Tongzhou district of Beijing. Zhuanxing Institute(2012) *新农合作医疗：问题与展望*, 传知行社会经济研究所:Beijing (*NCMS: Problems and Prospects*, Zhuangxing Institute Press: Beijing), p. 15.

reimbursements for health treatment then the local government would have to pay (case studies show that this reimbursement would account for 80 per cent of the shortfall).[667] Regulations were introduced to have 10 per cent of the risk pool put aside in advance. But it was hard for participants to forecast what the cost of treatment will be upfront. While there is no actual data to support this claim, *a priori* reasoning suggests that such a level of actuarial capacity (and the data to run the models) was unlikely to have been present in a poor Chinese village at this time. There would also have been limited ability to actually measure and investigate any risk pool or insurance institution due to the monitoring costs.

Another problem was that, even when the centre mandated social health insurance schemes, it still argued that the schemes must be suited to local conditions and local (people's) will, and adopted only in conjunction with other measures.[668] The need to adapt SHI to 'local conditions' led to a number of coordination problems for the local governments. Local governments face many problems in adopting standardised contribution rates because of the discrepancy of economic growth across localities. Differential economic performance led to the creation of many schemes. Each scheme faced problems of size, and the technical problem of ensuring adequate risk pools while

[667] This applied with the village clinic or township health centre as the treating danwei. *Ibid.*

[668] See the 1987 Ministry of Health opinon on 7th Five Year Plan: "改革我国农村的医疗保健制度，应从各地的实际情况出发，根据经济条件和群众的意愿逐步进行，可以实行合作医疗，也可以试行其他各种办法". ('To reform our rural health system we must build institutions, set out in accordance with the reality of local conditions, and gradually progressed according to economic factors and the wishes of the masses. In that way we can put cooperative health care into practice, and also try various different types of methods'). 卫生部、国家中医管理局 (1987)"七五"时期卫生改革提要，卫办字第3号 (Ministry of Health and Traditional Medicine Administrative Office (1987) 'A summary of health reform in the period of the Seventh Five Year Plan', Health Office Decree Number 3), 14 February. See also Cao Pu (2010) '1978-2002：关于农村合作医疗存废的争论与实证性研究的兴起' ('The rise of empirical research and debate on the maintenance or abolition of rural cooperative health care') *Zhonggong Yunnan sheng weidangxiao xuebao (The Yunnan Province Study Journal of the Central Party School)*, vol. 4, available online: http://www.cssn.cn/shx/shx_shflybz/201310/t20131026_584601.shtml and Wang Shaoguang (2008) '学习机制与适应能力: 中国农村合作医疗体制变迁的启示', 中国社会科学, ('Studying the system and increasing responsiveness: the renaissance of the NCMS', *Chinese Social Science Study*'), vol. 6, p. 14.

also ensuring adequate cover to induce participants to sign up.[669] Wealthier areas got around this by using market companies to run the schemes for them,[670] but this option would have cost poorer areas money that they were unlikely to have.

Moreover, adapting SHI to 'local conditions' meant accepting whatever the local conditions were prior to reform. This meant that, again, poor areas were unlikely to be able to induce participants to join any insurance program, as potential clients observed 'bad facilities: dirty, and smelly'.[671] Other reviews of failed social health insurance trials reported that the collective economic 'expenditure was too low'.[672]

There were also problems of coordination. It was difficult to force departments to join the program without the use of 'hard administrative measures'. Local Ministry of Health hospitals or health centres could argue that they did not fall under a program, because it

[669] A trial in Hubei noted that local governments were unable to set the right collection criteria: too low and the risk pool collapses, too high and enrolment collapses and that they found compensation rate setting was difficult — too much risk pool versus too much compensation remained a problem. See 曾玉书;吴新华 and 熊福然 (1992) 谷城县23个村卫生室恢复合作医疗后的调查与思考, 中国初级卫生保健, (Ceng Yushu, Wu Xinhua and Xiong Furan (1992) 'Some thoughts on a survey of 23 village clinics in Gucheng county following the renewal of cooperative health care', *China Primary Health Care*) vol. 2, pp. 11-14.

[670] 'For example, the health sector in Jinshang county of the Shanghai municipality has worked with the county insurance company since the late 1980s to develop a rural health insurance scheme through a co-payment mechanism' Xingyuan Gu and Shenglan Tang (1995) 'Reform of the Chinese health care financing system', *Health Policy*, vol. 32, issues 1-3, p. 186

[671] 曾玉书;吴新华 and 熊福然 (1992) 谷城县23个村卫生室恢复合作医疗后的调查与思考, 中国初级卫生保健, (Ceng Yushu, Wu Xinhua and Xiong Furan (1992) 'Some thoughts on a survey of 23 village clinics in Gucheng county following the renewal of cooperative health care', *China Primary Health Care*) vol. 2, pp. 11-14.

[672] 曹普(2014) *新中国农村合作医疗史*, 福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p. 188.

was a 'government or a Party thing'.[673] Officials were criticised as being corrupt or disengaged,[674] so-called 'empty shells'.[675]

Even if officials wished to join programs and support the provision of social health insurance, they often lacked the funds to do so.[676] This could occur even in the same township area — townships could initiate the proceedings to establish SHI schemes but villages unable to afford the program could refuse to join.[677] These local officials had no incentive to take on the risk of trying to institute health insurance schemes,[678] and when they did, they attempted to limit their risk by instituting differing account types, differing fee collection schedules and differing usage principles and reimbursement rates.[679]

The lack of a responsible party for the enforcement of regulations within social health insurance schemes was also a problem. The inability to use hard administrative incentives

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[673] 'Although the process was vigorous, the effort was less than ideal' 乔益洁 (2004) 中国农村合作医疗制度的历史变迁，青海社会科学, (Qiao Lijie (2004) 'A history of changes in the Chinese rural health care system', *Qinghai Social Sciences Study),* vol. 3, p. 2.

[674] 曾玉书;吴新华 and 熊福然 (1992) 谷城县23个村卫生室恢复合作医疗后的调查与思考, 中国初级卫生保健, (Ceng Yushu, Wu Xinhua and Xiong Furan (1992) 'Some thoughts on a survey of 23 village clinics in Gucheng county following the renewal of cooperative health care', *China Primary Health Care*) vol. 2, pp. 11-14.

[675] "空壳" (*kongxu)*; 曹普(2014) *新中国农村合作医疗史*，福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p 190.

[676] One of the cruces of Duckett's argument of retreat: see Jane Duckett (2011), *op cit.* page 19

[677] Miao Baoying describes their trial in Shandong for example as being unable to penetrate to the lower levels, quoting a cadre as saying that: 上级要求举办合作医疗，我乡每人集资8元，某日某月缴到村经官员处 … 缴钱者寥寥无几' ('higher levels demanded CMS be provided, my township then raised 8 yuan per person, I went daily, monthly to the village officials, but people who would pay were rather thin on the ground'). 缪宝迎 (1992) '对合作医疗补偿方式的探讨', 中国卫生事业管理, (Miao Baoying (1992) 'An indepth study of rural health care payment experiments', *China Healthcare Administration and Management)* vol. 9, pp 15-17.

[678] Hubei health insurance trial argued that there was a circle — there was a lack of support from farmers, who blamed the offials; officials didn't want to take on the risk of being blamed for system problems so didn't want to commit to the scheme. See 曾玉书;吴新华 and 熊福然 (1992) 谷城县23个村卫生室恢复合作医疗后的调查与思考, 中国初级卫生保健, (Ceng Yushu, Wu Xinhua and Xiong Furan (1992) 'Some thoughts on a survey of 23 village clinics in Gucheng county following the renewal of cooperative health care', *China Primary Health Care*) vol. 2, pp. 11-14.

[679] Another method was to state that fund collection and usage rules were inappropriate; or that there were too many accounts; *ibid.*

meant that there were few penalties for non-compliance. Village doctors were seen to be the prime beneficiaries of any increase in funds within the health system, with a Chinese study arguing that trust in doctors was low because popular perception was that that village doctors were attempting to enrich themselves.[680] A phrase quoted on village doctors becoming private was that in the first year they would be able to buy land, in the second year they could purchase gold and in the third year they could build a multi-story mansion.[681] Given that the village doctors were also often responsible for collecting fees from peasants joining social health insurance funds, there were worries about the doctors pocketing any fees that they collected.

All these problems with social health insurance schemes probably greatly confused local farmers, who failed to support the scheme. As the next chapter will show, these problems also made it difficult for the government to reinstitute any social health insurance scheme.

Conclusion

This chapter has shown that, as with the Maoist period, shifts in responsibility for local government Party secretaries appeared necessary and sufficient conditions for the collapse of health insurance enrolment. Chapter 4 showed how, during the Mao period, Party

[680] The Shanxi province, Pingyuan county study of 1997, for example, argued that cadres take the funds from health insurance 刘克军 and 范文胜 (2002) '对两县90年代合作医疗光衰的分析', 中国卫生经济, (Li Kejun and Fan Wensheng (2002) 'An analysis of the ups and downs of cooperative health care in two counties in the 1990s', *China Health Economics),* vol. 6.

[681] '一年土，二年洋，三年盖楼房' ('in the first year they would be able to buy land, in the second year they could purchase gold and in the third year they could build a multi-story mansion'); 曹普(2014) *新中国农村合作医疗史*，福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p 188.

decrees forced the local Party secretary to induce enrolment in the CMS. But this led to a number of issues, the most important of which was that the local Party had to pay for the CMS. As the Party secretary was incentivised to find these funds by the political incentive of high enrolment being looked upon favourably from above, the cost problem did not affect enrolment. In the post-Mao period, the structure of local party-state accountability changed. The new structure exacerbated cost problems for local party-states. There were almost no fiscal incentives provided to the local leaders to overcome this cost imperative. And, as of 1983, changes in responsibility for enrolment meant that there were no political incentives provided to local leaders to maintain the schemes, as the costs of maintaining the schemes were to shift to rural citizens (and thus away from local leaders).

The change in the rural structure of production to household responsibility from collective responsibility also changed the relationship between the Chinese state and health financing. Part of this shift was due to central mandates — the state saw social health insurance as a 'leftist' good[682] and wished to prevent the 'indiscriminate transfer of resources' under it.[683] In Chinese eyes, the CMS collapsed mainly because people did not want it enough to pay for it themselves. [684] So, the state decided not to step in. Given the rising cost of care in the post-reform era, it was thought that an 'indiscriminate transfer' of

[682] 张自宽 (1993) 中国的初级卫生保健要走自己的路, 中国农村卫生事业管理, (Zhang Zikuan (1993) ' China's early health insurance had to walk its own path', *China Rural Health Care Administration and Management),* vol. 5.
[683] Editorial (1979) 关于农村合作医疗、赤脚医生的几个问题, ('Several questions on rural cooperative health care and the barefoot doctors') *People's Daily*, 7 February, which decried the 'egalitarianism and indiscriminate transfer of resources' of the CMS.
[684] 根本原因是农民"不欢迎" ('basically, the reason was that it wasn't welcome to the people'). 李德成 (2007) 中国农村传统合作医疗制度研究综述, 华东理工大学学报, (Li Decheng (2007) 'An overview of research into China's traditional rural social health insurance', *Huadong Ligong University Study Journal),* vol. 1, p. 6.

funds from the state may threaten local state finances (and, by implication, threaten central state finances). Similarly, the Party removed itself from health insurance matters.

After the decline, the Party hurriedly tried to re-establish social health insurance schemes. But the scrambled institutional environment within China's rural health governance system prevented reestablishment. The result was that different regions were allowed to develop their health systems in different ways. This disparity, when combined with the fee-for-service revenue model[685] and low base salaries for doctors, led to the development of different tiers of provider — better providers were located in wealthier areas where they could charge more for their services to supplement their meagre state income (and thus have more funds to spend on high-tech medicine or better drugs, should they choose), whereas rural doctors in poor areas were forced to subsist on lower fees and their low salaries and thus 'generally earn much less than capable, ambitious peasants, dampening their incentive to serve in rural areas'.[686] As medical technology improved, more sophisticated equipment and procedures (albeit not always the most cost-effective)[687] were used by wealthier doctors and demanded by patients who are able to pay. At the same time, resources required to provide basic health services were becoming increasingly limited.[688] And village doctors, as noted above, gained far greater freedom to raise their

[685] 'The health care system in China has now become extremely dependent on fee-for-service (FFS) revenue, mainly from drug sales. Bonus payments to physicians provide an incentive to raise service revenue as much as possible. Targeted marketing methods, previously unheard of in China, even bribes to treating physicians, are now quite commonplace.' L. Bogg, D Hongjin, W Keli, C Wenwei and V Diwan (1996). The cost of coverage: rural health insurance in China. *Health Policy and Planning*, vol. 11, no. 3, p. 241.
[686] L Shi (1993). Health care in China: a rural-urban comparison after the socioeconomic reforms. *Bulletin of the World Health Organization*, vol 71, no. 6, p. 723.
[687] Xingzhu Liu and Anne Mills (2005) 'The effect of performance-related pay of hospital doctors on hospital behavior: A case study from Shandong, China'. *BMC Human Resources for Health*, vol. 3, p. 11.
[688] Xingzhu Liu and William Hsiao (1995) 'The cost escalation of social health insurance plans in China: Its implication for public policy', *Social Science and Medicine*, vol. 41, no. 4, pp. 1095–1101.

fees, should they wish. All of these problems, as we shall see, made health system reform yet more difficult and complicated efforts to bring back social health insurance.

This chapter helps explain why the CMS collapsed, a development of current interest in the literature. The findings of this chapter set the scene for the next two chapters, which look at the return of the state to the provision of rural social health insurance. The next chapter looks at another problem, as yet unaddressed in the literature, namely why the central government was unable to renew health insurance in the period following the collapse of the CMS in spite of a number of major attempts. It strengthens the claim that central commands are necessary but not sufficient conditions for successful implementation. In this way, the following chapters will show how the centre alone cannot force implementation — rather, implementation must came from a mobilisation of the local state caused by Party decree.

Chapter 6: A failure to revive social health insurance

A presumption about authoritarian states might be that should a leader decree something to happen, then it will happen. What then of the counterfactual case where a leader decrees something to happen and it is not delivered? If the commitment of a leader to a national scheme is a necessary condition, is it also a sufficient one?

A study of rural social health insurance schemes in China in the 1990s provides interesting reflections on these questions. As shown in Chapter 4, Mao's decree alone changed local incentives enough to create China's first nationwide rural social health insurance scheme. Chapter 5 showed what happened when the centre did not force local leaders to have a social health insurance scheme. This chapter shows what happens when the centre (and the authoritarian leader) decrees that they want something to happen, but it fails to occur.

The collapse of social health insurance described in Chapter 5 did not go unnoticed in Beijing. A 1987 commission made clear that Beijing wanted a system of social health insurance in place in rural areas. A wide array of pilots and trials were launched. In 1994, the central government made a major statement about the direction of social health insurance. In 1997, Jiang Zemin issued a major Central Committee decree. Another wave of pilots and trials were launched. Senior political leaders made a number of specific efforts to encourage local leaders to adopt social health insurance schemes. Central funding for

health care increased. A number of mandates to create social health insurance trials were passed down. But enrolment, after a temporary rise, fell to even lower levels in 2000.

These attempts to introduce schemes nationwide undoubtedly had high-level central support. But this central encouragement was not sufficient to motivate local leaders to enrol citizens in insurance schemes. So, paradoxically to some of the current theories in the literature, central funding and elite interest in health insurance both increased in the 1990s, but health insurance coverage remained very low. Despite a number of attempts at reform in the 1990s, the rural health sector was in a parlous state at the end of the Jiang Zemin regime, with very few residents having health insurance and with accessing health care left almost universally 'difficult, and expensive'.[689]

The push for a state return to health

As discussed in Chapter 4, following the Maoist period, social health insurance collapsed rapidly. But the idea of social health insurance still remained popular within China. Its popularity was highlighted in a number of Chinese internal studies. A 1990 Ministry of Health study of five provinces found that 80-90 per cent of peasants supported cooperative rural health care; a study of 1500 households in Jiangsu found that 98 per cent of respondents supported cooperative health care.[690]

[689] *Kanbing nan, kanbing gui;* a very well-known popular saying. E.g. Karen Eggleston (2010) "Kan Bing Nan, Kan Bing Gui: Challenges for China's Health-Care System Thirty Years into Reform." In Jean C. Oi, Scott Rozelle, and Xueguang Zhou (Eds.). *Growing Pains: Tensions and Opportunity in China's Transformation*, Walter H. Shorenstein Asia-Pacific Research Center Books: Palo Alto CA.

[690] 蒋永兆, 鲁敏, 郁南, 葛和平 and 任有海 (1991) '江宁农村干部群众对办合作医疗意向的调查报告', *中国农村卫生事业管理*, (Jiang Yongtao, Lu Gan, Yu Nan, Ge Heping and Ren Youhai (1991) 'Nanjing rural cadres report

The central government took this popularity seriously. In 1987, the Ministry of Health created a commission (*weiyuanhui*) to examine the collapse of the CMS.[691] This commission argued that the CMS was popular,[692] that it could be adapted with some imported ideas from other schemes,[693] and that the central government should take responsibility for social health insurance.[694] The central Party went as far as to declare that their stance was to 'try anything' to encourage the return of social health insurance.[695] The central Party mouthpiece, the *People's Daily,* kept the pressure up through a steady stream of editorials throughout the early 1990s.[696]

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and study on the attitude of the masses towards cooperative health care', *China Rural Health Care and Administration*) vol. 1, pp 44-46, available online: http://mall.cnki.net/magazine/magadetail/ZNWS199101.htm.

[691] A number of articles by officials came out, including Ou Yangjing on reform in Shanxi and Gansu: 欧阳竞 (1984) '回忆陕甘宁边区的卫生工作', 中国医院管, (Ou Yangjing (1984) 'Memories of health work in Shanxi and Gansu', *China Hospital Management)* vols 1 and 2 (note: two part series); former health minister Qian Xinzhong also tried to set the record straight after the event with his 1992 memoirs: Qian Xinzhong (1992), *op cit.,* and following that, with a joint history that noted an activist role for the Ministry of Health in the 1980s: 钱信忠、张怡民 (1999) 中国卫生50年历程, 中医古籍出版社: Beijing (Qian Xinzhong and Zhang Yimin (1999) *50 Years of China Health Programs*, China Ancient Health Book Press: Beijing). Some also wanted a revision of thinking: 朱敖荣 (1988)中国农村合作医疗保障制度的研究, 中国卫生经济, (Zhu Aorong (1988) A Study of China's Rural Health Insurance System, *China Health Economics*), vol. 10, although the major push outside government came from Zhang Zikuan in 1992 and 1993 张自宽 (1992), *op cit.*; see also 张自宽 (1992) 在合作医疗问题上该澄清思想统一认识， 中国农村卫生事业管理，(Zhang Zikuan (1993) 'We should clarify our thoughts and unify our thinking on the cooperative medical problem', *China Rural Health Care Administration and Management)* vol. 6, p. 18.

[692] It was 'a Chinese creation, welcome by the masses'. Wang Hufeng (2008) *China: 30 Years of Reform and opening up (1978-2008),* Social Sciences Academic Press: Beijing, pp 31-32. Also available online: http://theory.people.com.cn/GB/49154/49156/8138804.html

[693] The expert commission recommended that SHI be 'grafted on' and the government should 'take best of the world and adopt it to China' — *ibid*.

[694] The government was advised to step in and 'restore, rebuild and solidify social health insurance' —周寿祺 (1997) 合作医疗保险概述, 中国农村卫生事业管理, (Zhou Shouqi (1997) 'An overall concept of cooperative health insurance', *China Rural Health Care Administration and Management*), vol. 10, p.33.

[695] '中央的立场是各种模式都可以尝试' ('the central government's stance was that they would try any type of model'); *ibid.* See also Cao Pu (2010) '1978-2002：关于农村合作医疗存废的争论与实证性研究的兴起' ('The rise of empirical research and debate on the maintenance or abolition of rural cooperative health care') *Zhonggong Yunnan sheng weidangxiao xuebao (The Yunnan Province Study Journal of the Central Party School)*, vol. 4, available online: http://www.cssn.cn/shx/shx_shflybz/201310/t20131026_584601.shtml.

[696] The People's Daily editorials kept up a constant push for cooperative health insurance reform throughout the early and mid 1990s, joined occasionally by government officials (e.g. 袁木 and 陈敏章 (1994) 加快农村合作医疗保健制度的改革和建设, (Yuan Mu and Chen Minzhang (1994) 'Speeding up the reform and construction of the rural medical care system'), *People's Daily,* 2 July. See also the collation by Party historian

A plethora of health insurance pilots were launched to ascertain the most suitable form of health insurance scheme. From 1985 a number of World Bank and RAND experiments ran with the assistance of the Ministry of Health.[697] In 1987, Anhui University and the Ministry of Health ran a three-province experiment.[698] In 1988, the central government launched a nationwide `rural primary health care' program, including a two-year, 16-province health insurance experiment.[699] In 1991, Sichuan province trialled a health insurance pilot that excluded the cost of drugs, and participation was reasonably high (58 per cent enrolment).[700] UNICEF and Harvard University launched an 8-year trial in 1992.[701]

The basic structure of these trials was clear. It involved the government 'supporting' individual investment in health care, and using town and village government health facilities to run health insurance trials and to manage insurance risk funds.[702] The individual would be responsible for enrolling in the insurance scheme, navigating the

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Cao Pu曹普(2014) *新中国农村合作医疗史*， 福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p.166

[697] S Cretin, N H Duan, A P Williams, Jr, X Y Gu, and Y Q Shi (1990) 'Modeling the effect of insurance on health expenditures in the People's Republic of China.' *Health Services Research,* October vol. 25(4), pp. 667–685

[698] 周寿祺 (1991) '论合作医疗保险'， 中国医院管理，(Zhou Shouqi (1991) 'Theory of cooperative medical insurance', *China Hospital Management),* vol. 11, p. 5.

[699] 中国农村医疗保健制度研究课题组 (1991) *中国农村医疗保健制度研究*，上海科学技术出版社: Shanghai (Researching China's rural health care system working group (1991) A study of China's rural health care system, Shanghai Science and Technology Press: Shanghai).

[700] 谢平 (1991) '大竹县58%的乡已实行合作医疗制度', 中国初级卫生保健, (Xie Ping (1991) '58% of villages in Dazhu county have implemented a cooperative medical scheme', *China Primary Health Care*) number 8, pp. 13-14.

[701] Yuanli Liu,(2000) 'Understanding and setting up the process for health equity', *Bulletin of the World Health Organization*, vol. 78(1), pp. 82-83.

[702] Second wave saw individual investment as key, government as support. In this wave, funds were managed by town and village government health facilities. Zhuanxing Institute(2012) *新农合作医疗：问题与展望*, 传知行社会经济研究所:Beijing, (*NCMS: Problems and Prospects*, Zhuangxing Institute Press: Beijing), p. 5

health system, and then seeking reimbursement. The government would pay for basic treatment (primary care), as well as reimbursing the individual for some inpatient and/or drug expenses, depending on the level of funds in the local government risk pool.[703] Insurance schemes would run concurrent with health reforms designed at improving rural health facilities.[704]

This array of trials reflected a widespread central interest in returning social health insurance to rural China. The interest at the centre can also be seen in a number of other ways. In 1991, there was a national health conference, organised by the central government, which agreed that health care needed to focus on rural areas in China and re-establish social health insurance.[705] In March 1991, Premier Li Peng endorsed cooperative health insurance,[706] while in July 1991 former Minister of Health Qian Xinzhong wrote an opinion piece in the *People's Daily* supporting a Hubei prefectural-level social health insurance system.[707] Aside from this push by senior individuals, a number of agencies

[703] See 杨红燕 (2009), *中国农村合作医疗制度可持续发展研究*, 中国社会科学出版社:Beijing (Yang Hongyan (2009) *A study of the sustainability and development of China's rural health care system*, China Social Sciences Press: Beijing). Note also that the risk pools could be at the township or village level, depending on the trial, but the majority were at the village level.

[704] The 'Three Constructs Program' was introduced in 1991 to improve the physical quality of township hospitals, county epidemic prevention stations, county maternal and child health stations. The Program was to be funded jointly by central, provincial, prefecture, county and townships governments. D. Kelaher and B. E Dollery (2004) 'Health Care Reform in China: An Analysis of Rural Health Care Delivery', *Politics, Administration and Change,* vol. 42, pp. 19-32.

[705] See the officially authorised report in: 艾笑 (1991) 全国卫生厅局长会议形成共识发展农村卫生事业是当务之急, (Ai Xiao (1991) 'National Ministry of Health Director-level Meeting forms a common understanding that rural health care is a vital matter of immediate urgency') *People's Daily,* January 22.

[706] Li Peng (1991) 关于国民经济和社会发展十年规划和第八个五年计划纲要的报告 ('A memo of the major points of the 10 year regulations and the 8th Five Year Plan on developing rural economy and society'), available online: http://www.reformdata.org/content/19910225/5616.html.

[707] 曹普(2014) *新中国农村合作医疗史*, 福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p.169.

released coordinated positions supporting an expansion of social health insurance.[708] The definitive central Eighth Five-Year Plan and a State Council guidance (both released in 1991) contained similar positions.[709]

But these attempts at reform failed. Local rural health insurance coverage progressed to covering around 10 per cent of the rural population nationwide by 1993.[710] Evaluations of an influential social health insurance pilot argued that China's rural SHI model was fragmented, failed to control doctors reimbursement and treatment, and lacked support from farmers who blamed corrupt and 'hollow' officials; officials claimed that they 'did not want to take on the risk of being blamed for system problems so did not want to commit to the scheme.'[711]

The Central Committee and State Council responded by releasing a raft of decrees in 1993 and 1994.[712] Central bodies also initiated a number of WHO-assisted rural health

[708] The 1990 'Policies and Goals for Universal Healthcare by 2000' document was issued in March 1990 as a joint statement of the Ministry of Health, State Planning Commission, Party Patriotic Health Campaign Committee, and five other government ministries and agencies. It stipulated 'rural health insurance coverage' as one of the measures of success of the plan. Feng Xueshan, Tang Shenglan, Gerald Bloom, Malcolm Segall, and Gu Xingyuan (1995) 'Cooperative medical schemes in contemporary rural China', *Social Science & Medicine*, 1995 vol. 41 (8) pp. 1111-1118.

[709] The State Council document 92 (1991) specified that village welfare funds were to be 'used for the *establishment and support* of cooperative health centres and schemes'. Emphasis added by the author. State Council (1991) 农民承担费用和劳务管理条例, 令92号 (Regulations on the management of rural labor and bearing the burden of fees, order no. 92).

[710] Zhou Shouqi (1997) 发展和完善农村合作医疗保险制度, 中国卫生事业管理, ('Developing and perfecting the rural health insurance system', *China Healthcare Management and Administration*) number 1, p. 22.

[711] 曾玉书;吴新华 and 熊福然 (1992) 谷城县23个村卫生室恢复合作医疗后的调查与思考, 中国初级卫生保健, (Ceng Yushu, Wu Xinhua and Xiong Furan (1992) 'Some thoughts on a survey of 23 village clinics in Gucheng county following the renewal of cooperative health care', *China Primary Health Care*) vol. 6, no.2, pp 11-14.

[712] E.g 国务院 (1992) 关于深化卫生改革的几点意见, (State Council (1992) *Some opinions regarding deepening health reform*) 23 September. This was then supported by yet more central activity in 1993 — see clause 11 on rural health care in 中共中央办公厅、国务院办公厅 (1993) 关于涉及农民负担项目审核处理意见的通知. 中办发, 10号 (General Offices of the Central Committee and State Council (1993) A notice on examining, verifying, and dealing with matters touching on the rural peasant burden, Central Notice No. 10) ; which was followed by the yet more authoritative Central Committee *jueding* on the rural economy: 中共中央 (1993) 关于建立社

insurance pilots in 14 counties across 7 provinces.[713] The aim was to have 50 per cent coverage of the countryside by the end of the Eighth Five Year Plan (that is, by the end of 1995). The decrees mandated that prevention was the 'primary focus' of all health care reform. Health insurance schemes were designed to be a combination of state, community and individual funding, with insurance funds to be used to pay for preventive services for residents.[714] The schemes were to 'operate on a voluntary basis', were to be 'adopted to the local economic situation',[715] and were to be 'economising and moderate'.[716]

Given the unequal rate of development across different parts of China schemes and trials took different forms in different areas. So while all the schemes may be titled 'cooperative insurance schemes', some failed to cover any of the cost of drugs or inpatient care; wealthier areas may have cooperative insurance that reimbursed participants for costs incurred purchasing drugs, but not inpatient care. A World Bank evaluation of the 1994 policy argued that the schemes were subject to 'wide variation and lack of clarity in

会主义市场经济体制若干问题的决定 (Central Committee (1993) Decision on some questions regarding the building of a socialist economic system), 14 November.

[713] In the provinces of Beijing, Henan, Jiangsu, Zhejiang, Jiangxi, Hubei and Ningxia. G Carrin, A Ron, Y Hui, W Hong, and Z Tuohong (1999) 'The reform of the rural cooperative medical system in the People's Republic of China: interim experience in 14 pilot counties.' *Social Science and Medicine*, no. 48, pp 961-972.

[714] Li Peng (1991) 关于国民经济和社会发展十年规划和第八个五年计划纲要的报告 ('A memo of the major points of the 10 year regulations and the 8th Five Year Plan on developing rural economy and society'), available online: http://www.reformdata.org/content/19910225/5616.html.

[715] RCMS would operate on a voluntary basis, and would have to be adapted to the local economic situation — see State Council (1994) 中国农村合作医疗制度改革 (Reform of the rural cooperative health system), February although the study itself was carried out between the State Council, Ministry of Health, Ministry of Agriculture and the World Health Organisation. See also: G Carrin, A Ron, Y Hui, W Hong, and Z Tuohong (1999) 'The reform of the rural cooperative medical system in the People's Republic of China: interim experience in 14 pilot counties.' *Social Science and Medicine*, no. 48, pp 961-972.

[716] The Ministry of Health and DRC study established 5 principles for CMS: 1) voluntary 2) assistance and services based 3) economising 4) moderate 5) aids development. 袁木 and 陈敏章 (1994) 加快农村合作医疗保健制度的改革和建设, (Yuan Mu and Chen Minzhang (1994) 'Speeding up the reform and construction of the rural medical care system'), *People's Daily,* 2 July.

priorities' and that 'government support for the proposals had little impact'.[717] Moreover, the schemes did not boost enrolment, in spite of the government's lofty goals. Indeed, by 1995, insurance coverage had still only reached 12 per cent — a long way short of the 50 per cent target.[718]

Despite this limited success (and limited enrolment), the trials continued unabated. By 1995 several provinces were experimenting with social health insurance schemes under the 1993 central guidelines. By the end of 1996, 22 provinces and more than 300 counties undertook inspections of these schemes, there had been a major conference on health,[719] and a 14 province conference on social health insurance models had been held.[720] Five central government ministries and commissions 'jointly urged local governments to support the creation of cooperative medical systems in rural areas.'[721] 183 counties in 19 provinces had health insurance trials; coverage reached nearly 18 per cent, up 6 per cent on 1995.[722] Trials included such local customisation such as paying for health insurance

[717] William Hsiao, Dean T. Jamison, William P McGreevey and Winnie Yip, (1997) *Financing health care : issues and options for China*, World Bank: Washington DC.
[718] Gerald Bloom and Gu Xingyuan (1997) 'Health sector reform: Lessons from China', *Social Science & Medicine*, Volume 45, Issue 3, pp 351–360
[719] China's first National Conference on Health in December 1996. The Conference featured speeches by Jiang Zemin and Li Peng, both discussing the importance of rural health insurance. Chinese academics and policy makers noted the 'full support' of the Party and state, including of Jiang Zemin himself, based on not only his attendance at the conference but also his speech.
[720] Chen Minzhang (1996) '提高认识 明确政策 贯彻落实 中央关于发展和完善农村合作医疗的重大决策', 中国卫生质量管理, ('Improving understanding, clarifying policy, and implementing reform: the Central Committee's important decision on building and perfecting rural cooperative health care', *China Health Quality Management),* no. 8.
[721] These included the State Planning Commission, the Ministry of Civil Affairs, the Ministry of Finance, the Ministry of Health, and the Ministry of Agriculture.
[722] Zhuanxing Institute (2012) *新农合作医疗：问题与展望*, 传知行社会经济研究所:Beijing, (*NCMS: Problems and Prospects*, Zhuangxing Institute Press: Beijing), p. 13

premiums through crops.[723] And some in the Party went as far as publicly using Jiang Zemin's idea of 'moral government'[724] (also outlined in 1996) to promote greater health insurance coverage.[725]

Finally, in 1997, the Party Central Committee and State Council released an authoritative decree on rural health care, the Health Reform and Development Decree.[726] The decree set out some 40 goals and guiding principles governing health care.[727] One of these was to specifically 'develop and improve the cooperative medical schemes (CMS), financed by different levels of government, as these schemes have an important role in guaranteeing basic medical services in rural areas'.[728] A target was attached to this goal, which was to achieve the reestablishment of rural health insurance in 70 per cent of all villages by the year 2000.[729]

[723] This was the 1996 Henan model (trialled in Anyang county and introduced by prolific bureaucrat and writer Chen Minzhang). In this model, locals provided a set amount of crops to the township level, which then created the risk pools and reimbursements.
[724] 江泽民, '在全国卫生工作会议上的讲话' (Jiang Zemin, speech at the National Health Care Forum) speech on 9.12.1996, reprinted in the *People's Daily* 10.12.1996.
[725] 曹普(2014) *新中国农村合作医疗史*, 福建人民出版社: 福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p.252-3.
[726] A 决定 *jueding*, or authoritative central decision. This forces a response from subordinate bodies; Chapter 3 discusses and shows that this is the second highest level of decree in the Chinese system. The 1997 *jueding* conceded that the Chinese health system could not meet the demands of social and economic progress, there were regional inequities in health development, inadequate investment in health, the allocation and distribution of health resources was irrational, rural and preventive services were underdeveloped, rising medical expenditure and the quality and manner in which services were delivered were not appropriate.
[727] The decrees included a 2000 drug price reform, which also failed. See for discussion: Karen Eggleston; Ling Li; Qingyue Meng; Magnus Lindelow and Adam Wagstaff (2008) 'Health Service Delivery in China : A Literature Review' *Health Economics,* no. 17, pp 149-165
[728] D. Kelaher and B.E. Dollery (2004) 'Health Care Reform in China: An Analysis of Rural Health Care Delivery', Politics, Administration and Change, vol. 42, pp. 19-32.
[729] Ministry of Health, Family Planning Commission, Ministry of Finance, Ministry of Agriculture, Ministry of Rural Affairs (1997), *Some opinions regarding the development and completion of rural cooperative health care,* 30 March 1997, available online: http://cpc.people.com.cn/GB/64184/64186/66687/4494355.html

To meet this target, the State Council issued a subsequent document 'Several Opinions Regarding the Development Improvement of Rural Co-operative Medicine' (1997). This document, while clearly outranked by the Central Committee decree, set out exactly how the central government intended to reach its target of 70 per cent coverage of villages by 2000. The planned rapid increase in coverage was to be achieved through the 'support for the development of voluntary CMS schemes tailored to local conditions to raise farmers' health status by providing access to basic health services through community risk sharing.' Activities to do this were varied, but the basic plan was that lower level governments were to provide some assistance to help poor people join schemes, were to offer some benefits for participants to aid them accessing inpatient care,[730] and were to offer some 'seed' funding for townships or villages to establish a CMS.[731]

Local states vigorously adopted pilots for this scheme. A total of 350 counties in 22 provinces formally began pilots.[732] Every Ministry of Health department head was forced to attend a Party study session for the SHI program,[733] and was to then lead their own study sessions. This occurred throughout the whole Ministry of Health system — that is, from

[730] For example, offering free hospital registration and discounted hospital fees (as in Shandong). In some provinces, attempts were made to respond to government policies requiring hospitals to offer discounts to poor people. That said, in Shandong Province, Meng Qingyue found that the discount system did "...not provide effective protection for the poor in terms of either coverage or benefits. Inadequate financial and political support for implementing such programmes appears to be the main reason.' Q Meng, Q Sun, N Hearst (2002) 'Hospital charge exemptions for the poor in Shandong, China.' *Health Policy and Planning*, no. 17, supplement, p. 62

[731] Wang Shaoguang (2008) '学习机制与适应能力: 中国农村合作医疗体制变迁的启示', 中国社会科学, ('Studying the system and increasing responsiveness: the renaissance of the NCMS', *Chinese Social Science Study'*), vol. 6, p. 14.

[732] Yuanli Liu (2004), 'Development of the rural health insurance system in China', *Health Policy and Planning,* vol. 19, no.3, p.159.

[733] At the end of these group study sessions, the entire Ministry had to report back to the Party that they had been trained in the model and 'grasp(ed) its true nature'. 叶宜德、汪时东、汪和平等 (2003)"新型农村合作医疗制度理论框架与指导原则编写研讨会"参考资料汇编，合肥科伟社会与卫生发展研究所, (Ye Xiande, Wang Shidong, Wang Heping et al (2003) 'NCMS system management framework and governing principles edited study and research theory', *Hefei Social Science and Health Development Centre*), volume 4.

central to provincial offices, from provincial to municipal offices, and from municipal to county offices.[734]

At the same time, external bodies added their support to the push to increase social health insurance enrolment. In 1998, the World Bank, the Chinese Government and UK development agency DFID ran a 10-year trial of village-run and village managed funds which covered around 1.1 million citizens and 177 villages.[735] The Asian Development Fund also launched a trial the same year.[736] Finally, in 1999 UNICEF ran a study on the 'development of CMS under market conditions'.[737]

But, in spite of all these programs, trials, studies, speeches, reports, and mandates, including considerable central government support, China's social health insurance coverage remained very low.

The failure to restore social health insurance as a failure of governance

In current literature, the failure of the state to reestablish health insurance coverage despite the many pilots discussed above was attributed to a lack of financial support, and

[734] Cao Pu (2010) '1978-2002：关于农村合作医疗存废的争论与实证性研究的兴起' ('The rise of empirical research and debate on the maintenance or abolition of rural cooperative health care') *Zhonggong Yunnan sheng weidangxiao xuebao (The Yunnan Province Study Journal of the Central Party School)*, vol. 4, available online: http://www.cssn.cn/shx/shx_shflybz/201310/t20131026_584601.shtml.
[735] *Ibid.*
[736] Yuanli Liu and Keqin Rao (2006) 'Providing Health Insurance in Rural China: From Research to Policy' *Journal of Health Politics, Policy and Law*, 2006 vol. 31 (1) pp. 71-92.
[737] Q. Meng; G Shi; H Yang; M Gonzalez-Block and E Blas(2004) *Health Policy and Systems Research in China*, World Health Organisation: Geneva

an inability to ascertain appropriate roles for government and market.[738] Feng et al argued that in poor areas, cooperative health care schemes are unlikely to succeed because of an inability to generate a sufficient level of household contributions and the low rate of reimbursement for the medical costs incurred.[739] Wagstaff, Yip and Lindelow argued that due to the limited ability of the state to collect funds, and the generally low ability to pay for health services present in most rural areas of China, many of the CMS schemes (and some of the trials) in China only provided coverage of primary health care services[740] — and thus the need for insurance coverage for catastrophic illness went largely unmet.[741]

A number of reports by foreign aid donors and bodies also recommended more funding by the government for both insurance schemes and for subsidising some of the costs of care.[742] A 1993–95 World Bank study of 30 poor counties argued that it was impossible to obtain sufficient revenue from poor households alone to establish an insurance scheme and that funding should come from multiple sources (mainly, the

[738] *Ibid.* See also 2000-2002 joint report between the World Health Organisation, Ministry of Health and UNICEF, which found that China should increase financial capacity and support, particularly central government.

[739] They maintain that there is a need for 'preferential allocations' from government to support such schemes, and that without these allocations the poor were required to meet the increased cost of health care services by 'whatever means they could'. Feng Xueshan, Tang Shenglan, Gerald Bloom, Malcolm Segall, and Gu Xingyuan (1995) 'Cooperative medical schemes in contemporary rural China', *Social Science & Medicine*, 1995 vol. 41, no.8, p.1117.

[740] See comments in Wang H, Yip W, Zhang L, Hsiao W. (2009). The impact of Rural Mutual Health Care on health status: evaluation of a social experiment in rural China. *Health Economics* 18(S2): S65–S82.

[741] Adam Wagstaff, Winnie Yip, Magnus Lindelow, and William C. Hsiao (2009) 'China's health system and its reform: a review of recent studies' *Health Economics,* Volume 18, Issue Supplement 2, pages S7–S23.

[742] WHO reports recommended more funding support from the government to provide equitable health care to rural citizens (e.g. G Carrin, A Ron, Y Hui, W Hong, and Z Tuohong (1999) 'The reform of the rural cooperative medical system in the People's Republic of China: interim experience in 14 pilot counties.' *Social Science and Medicine*, no. 48, pp 961-972). Bloom and Tang (1999) stressed the need for government subsidies and additional resources — Gerald Bloom and Shenglan Tang (1999) 'Rural health prepayment schemes in China: towards a more active role for government' *Social Science & Medicine,* Volume 48, Issue 7, pp. 951–960.

government).[743] A mid-term evaluation of a WHO-assisted rural insurance scheme found that, should illness occur, the scheme offered limited protection because of high co-payment of more than 50 per cent and the small range of insured services.[744] A UNICEF study on the 'development of CMS under market conditions' had similar conclusions, arguing that China should have diverse SHI schemes, use legislation to establish all of these schemes, and earmark public investment into special funds for insurance.[745]

These external reports also noted the question over what role the government should play, and over which part of the government was best suited to playing this role. But a push for more diverse government-funded schemes, however, remained a clear differentiation between foreign expert reports and local Chinese reports. For example, some Chinese commentators argued that the CMS and health insurance before the 1978 political reform was always a 'one size fits all' policy *yiqiedao* and that China should move more towards this sort of health insurance policy.[746] So there was a tension between these foreign criticisms arguing that China's health insurance policy needed to be more diverse, and some local Chinese writers wanting a less fragmented scheme.

The state position on this tension was clear — it wanted SHI schemes that were suited to local conditions. But adapting SHI to 'local conditions' meant accepting whatever the local conditions were prior to reform. This meant that, again, poor areas were unlikely to

[743] William Hsiao, Dean T. Jamison, William P McGreevey and Winnie Yip, (1997) *Financing health care : issues and options for China*, World Bank: Washington DC.
[744] G Carrin, A Ron, Y Hui, W Hong, and Z Tuohong (1999), *op cit.*
[745] Y Liu, R Ren, Y Chen, S Hu (2000) 'Major factors affecting the CMS operations: experience from the 10 county study.' Paper presented at the *International Seminar on Rural Health Care Financing*, held by the UNICEF and Chinese Ministry of Health in Beijing on December 11–13, 2000.
[746]袁木 and 陈敏章 (1994) 加快农村合作医疗保健制度的改革和建设, (Yuan Mu and Chen Minzhang (1994) 'Speeding up the reform and construction of the rural medical care system'), *People's Daily,* 2 July.

be able to induce participants to join any insurance program, as the participants noted that the area had 'bad facilities: dirty, and smelly'.[747] Other reviews of failed social health insurance trials noted that the collective economic 'expenditure was too low'.[748]

And making schemes suitable to local conditions, nationwide, relied on the state solving a number of coordination problems that hindered implementation of social health insurance schemes. Evaluations found that social health insurance pilots and the development of a rural socialist market economy did not fit, as there were 'organisational barriers'.[749] While elements of this governance challenge could occasionally be resolved through workarounds in individual areas — some wealthier areas, for example, even contracted private companies to run schemes for them[750] — there was no ability to resolve these problems nationwide (for example, the contracting-out option would cost poor areas money that they were unlikely to have). In other words, by not holding local Party secretaries accountable for enrolment, and by allowing schemes to be 'suitable to local conditions', the Party was unable to force enrolment nationwide as each locality could plead a lack of funds/lack of staff/lack of capacity, or any other reason that could allow

[747]叶宜德、汪时东、汪和平等 (2003)"新型农村合作医疗制度理论框架与指导原则编写研讨会"参考资料汇编，合肥科伟社会与卫生发展研究所, (Ye Xiande, Wang Shidong, Wang Heping et al (2003) 'NCMS system management framework and governing principles edited study and research theory', *Hefei Social Science and Health Development Centre*), volume 4, April.

[748] 龚向光 (1998) 贫困地区农民合作医疗支付能力研究, 中国卫生经济, (Gong Xiangguang (1998) 'A study of the ability to support cooperative health care in poor areas', *China Health Economics*).

[749] 徐杰(1997) 对我国卫生经济政策的历史回顾和思考, 中国卫生经济, (Xu Jie (1997) 'Pondering and reflecting upon the history China's health economy policies', *China Health Economics*) vols 10-11 (two part study).

[750]曹普(2014) *新中国农村合作医疗史*， 福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p.200 discusses the Jiangsu province Jiangnan municipality 2001 study (on urban residents with rural hukou), where the municipality brought in major insurance company Pacific Insurance to run the scheme for them. This will be discussed further in the next chapter on the development of the New Cooperative Medical Scheme in Henan.

them to claim that they may have tried to implement the scheme, but they just were unable to.

A similar problem affected the ability to form sufficient risk pools for a social health insurance scheme. The risk pools were almost always managed at the village or township level, with some schemes having the county contribute to the risk pool. A part of this was that most of the CMS schemes are based at the village level, and contributions are collected there. But pooling at levels below the county provided a very small risk pool, limited collection capacity across geographic jurisdictions and high levels of heterogeneity in almost every way.[751] The creation of many schemes means that each faces problems of ensuring adequate risk pools while also ensuring adequate cover to induce participants to sign up.[752] Therefore, either the risk pool needed to be moved to a higher political unit,[753] the risk pool contribution at the village level needed to be increased — a feat beyond most villages —[754] or some form of reinsurance arrangement at county and higher levels

[751] See the findings of Lily Tsai (2007) 'Solidary groups, informal accountability, and local public goods provision in rural China', *American Political Science Review*, vol. 101, no. 2, pp. 355-373 on a broader array of public goods for example.

[752] Hubei trial evaluation notes: 6) unable to set the right collection criteria: too low and the risk pool collapses, too high and enrolment collapses 7) Compensation rate setting was difficult — too much risk pool versus too much compensation. See曾玉书;吴新华 and 熊福然 (1992) 谷城县23个村卫生室恢复合作医疗后的调查与思考, 中国初级卫生保健, (Ceng Yushu, Wu Xinhua and Xiong Furan (1992) 'Some thoughts on a survey of 23 village clinics in Gucheng county following the renewal of cooperative health care', *China Primary Health Care*) vol. 2, pp. 11-14.

[753] The Shanghai Jiading Qu trial moved supervision to the municipal level for example — see 叶宜德、汪时东、汪和平等 (2003)"新型农村合作医疗制度理论框架与指导原则编写研讨会"参考资料汇编，合肥科伟社会与卫生发展研究所, (Ye Xiande, Wang Shidong, Wang Heping et al (2003) 'NCMS system management framework and governing principles edited study and research theory', *Hefei Social Science and Health Development Centre*), volume 4.

[754] Albeit not all — see Tsai (2007), *op cit.* on how lineage temples and informal social arrangements could overcome these problems at the village level. The problem is that (for any national scheme) these arrangements only worked for individual villages, and thus worked fairly rarely.

established to help overcome this problem.[755] Any of these arrangements would have meant that supervision and institutional arrangements had to be in place for villages and townships, increasing transaction and monitoring costs.

Finally, the governance arrangements of the pilot trials failed to hold local leaders accountable. Governance arrangements were usually focused on ensuring representation. For risk pools, the governance body depended at which level the risk pool was maintained. Village-based risk pools were managed by a village committee, which included a cadre, a peasant representative, and a health professional (village doctors). Township risk pools were managed by a cooperative insurance committee, usually based at the township health centre,[756] with the committee similarly containing one cadre, the director of the township health centre, and one village representative. For the few schemes that used county management, a formal committee was created and placed in the Ministry of Health office. But in none of these arrangements could the local leader (Party secretary or delegate) be held accountable by the governance body.

Governance arrangements made implementing any of these schemes most difficult. None of the people on the governance boards of the SHI scheme had the power in the local state to control any of the institutions (be they fiscal, personnel or materiel) that might force the creation, implementation or management of a social health insurance scheme. These institutions were controlled by the local Party committee. But no one from the local

[755] Yuanli Liu (2004), 'Development of the rural health insurance system in China', *Health Policy and Planning,* vol. 19, no.3, p.159.
[756] Note that the cooperative insurance office was in that period usually based at the township health centre. See Chapter 5.

Party committee was held responsible for the success or failure of the SHI schemes. And while the insurance schemes could be delegated down to being run by the citizens themselves, this ran contrary to government and Party policy.[757] So the citizens would have no method of controlling any institutions either. While it was theoretically possible[758] for some different villages to elect candidates for village leadership positions on the basis of a pro-SHI stance, it was unlikely to occur often, and it was impossible to occur nationwide.[759] For schemes to be effective, all supervision and monitoring had to come from the Party-state system; but no one in this system was held formally accountable for the success or failure of the schemes.

The lack of a responsible party for the enforcement of regulations within social health insurance schemes caused great problems for their implementation. The inability to use hard administrative incentives meant that few penalties for non-compliance could be imposed.[760] So uneven or ineffective implementation of the SHI schemes could occur even in the same township area — evaluations of pilots noted that townships could initiate a scheme but villages unable to afford the program would then refuse to join.[761] Local officials had no incentive to take on the risk of trying to institute health insurance

[757] As Chapter 5 also notes, the 1982 revisions to the constitution made local governments responsible for the provision of health services.
[758] Under the Organic Elections Law (1988) 中华人民共和国村民委员会组织法, 59号 (The Law of Village Committees of the Chinese People's Government, number 59), 1 June.
[759] As only around half of all villages implemented the Organic Elections Law — see Linda Jakobson (2004) 'Villagers' committee elections and their implications in China in Jude Howell (ed.) *Governance in China*, Rowman & Littlefield Publishers: Lanham, pp. 97-120.
[760] Chapter 5 of this thesis discusses in greater depth.
[761] See for example the feedback from the Shandong trial discussed above (缪宝迎(1992) '对合作医疗补偿方式的探讨', 中国卫生事业管理, (Miao Baoying (1992) 'An indepth study of rural health care payment experiments', *China Healthcare Administration and Management)* vol. 9, pp 15-17).

schemes,[762] and when they did, they attempted to limit their risk by instituting differing account types, differing fee collection schedules and differing usage principles and reimbursement rates.[763]

These governance challenges cannot be traced solely to the many different *types* of social health insurance schemes that were tried in this period — the many different political *levels* at which schemes were implemented also created governance challenges.

Schemes were managed at three different levels: village managed, township managed and county managed.[764] Fees were usually collected at the village level, often by doctors,[765] with the funds then transferred to the township.[766] This not only led to higher transaction costs, but also made reimbursements difficult. In theory, patients could usually be reimbursed, post-treatment, at the provider at which they were treated.[767] But reimbursing providers proved difficult. Studies showed that if you reimbursed hospitals, people do not feel that there is any benefit, and they leave the scheme.[768] As direct compensation to

[762] Hubei health insurance trials described a lack of support from farmers, who blamed the offials; officials didn't want to take on the risk of being blamed for system problems so didn't want to commit to the scheme. 曾玉书;吴新华 and 熊福然 (1992) 谷城县23个村卫生室恢复合作医疗后的调查与思考, 中国初级卫生保健, (Ceng Yushu, Wu Xinhua and Xiong Furan (1992) 'Some thoughts on a survey of 23 village clinics in Gucheng county following the renewal of cooperative health care', *China Primary Health Care*) vol. 2, pp. 11-14.
[763] Ibid.
[764] See杨红燕 (2009), *中国农村合作医疗制度可持续发展研究*, 中国社会科学出版社:Beijing (Yang Hongyan (2009) *A study of the sustainability and development of China's rural health care system*, China Social Sciences Press: Beijing), pp. 60-71.
[765] 曹普(2014) *新中国农村合作医疗史*, 福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p.185.
[766] G Carrin, A Ron, Y Hui, W Hong, and Z Tuohong (1999) 'The reform of the rural cooperative medical system in the People's Republic of China: interim experience in 14 pilot counties.' *Social Science and Medicine*, no. 48, pp. 961-972.
[767] In other words, the village collected at the village clinic; the township could collect at either the township health centre or village clinic; and the county could collect at various levels, differing by illness type.
[768] Minqi Li and Andong Zhu (2004). China's public services privatization and poverty reduction: Health care and education reform (privatization) in China and the impact on poverty. *United Nations Development*

hospitals was seen as unattractive, some local governments compensated providers directly while others required the provider to seek compensation from the local insurance pilot office.[769] All of these different requirements, run across different levels of government, were administratively burdensome. Hence, as Bloom and Gu argue, prepayment schemes had 'limited success in poor areas where they compete with other sectors for scarce funds and administrative resources.'[770]

Moreover, the problems described above assume well-meaning local state officials and cadres. But the fragmentation of schemes, and the lack of accountability, meant that any wrongdoing was difficult to detect, monitor, and/or enforce punishment. A number of reports discuss how the Chinese state was unable to prevent cadres from appropriating resources — either for other projects, as discussed above, or for personal gain. A 1997 study of Pingyuan county in Shanxi province, for example, showed that cadres appropriated funds from health insurance.[771] Lawrence suggested that many rural residents are 'wary' of CMS type schemes due to past mismanagement of finances by local officials.[772] And there were reports of 'shirking' problems, where the state could not force employees to work.[773]

Programme Policy Brief. See also曹普(2014) *新中国农村合作医疗史*， 福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p.259.

[769] 李和平 and 张里程 (2002) 山西省闻喜县农村健康保意愿分析， 卫生经济研究, (Li Heping and Zhang Licheng (2002) 'An analysis of how Wenxi county, Shanxi province demanded health care', *Health Economic Studies*), no. 5.

[770] Gerald Bloom and Gu Xingyuan (1997) 'Health sector reform: Lessons from China', *Social Science & Medicine*, Volume 45, Issue 3, p.355

[771] 刘克军 and 范文胜 (2002) '对两县90年代合作医疗光衰的分析', 中国卫生经济, (Li Kejun and Fan Wensheng (2002) 'An analysis of the ups and downs of cooperative health care in two counties in the 1990s', *China Health Economics),* vol. 6, p. 6.

[772] Susan Lawrence (2002) The Sickness Trap, *Far Eastern Economic Review,* p. 32

[773] Although the process was vigorous, the effort was less than ideal' (乔益洁 (2004) 中国农村合作医疗制度的历史变迁， 青海社会科学, (Qiao Lijie (2004) 'A history of changes in the Chinese rural health care system', *Qinghai Social Sciences Study),* vol. 3, p. 2).

Local state officials had few personal incentives to change the social health insurance system, as they have their own, general revenue-funded insurance system.[774] According to the 'Regulation of Public Service Medical Scheme' regulations of 1952,[775] all government staff, including retired employees,[776] students,[777] and dependents[778] are entitled to free medical care. Hence, in the 1980s,[779] expenses were covered by government funds or by the medical funds of state-owned enterprises. This meant that local government officials (who made decisions on health care) were themselves able to access unlimited health care. This situation is thought to continue even today:[780] as a former Vice-Minister of Health revealed in 2006, 80 per cent of the government's health care budget was used to provide health care coverage to China's 8.5m Party leading cadres, who accounted for less than 1 per cent of the population.[781] These fully-funded cadres may also act as a constant source of demand for providers, should they wish to raise revenues.

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[774] Xian Huang (2014) "Expansion of Chinese Social Health Insurance: Who Gets What, How and When?" *Journal of Contemporary China*, Vol.23, Issue 89, pp. 923-951.

[775] Gu Xingyuan and Tang Shenglan (1995) 'Reform of the Chinese health care financing system.', *Health Policy*, vol. 32 (1-3) pp. 181-191.

[776] Anecdotally, this continues to this day, although it is dependent on your former unit (*danwei*). Interview, Beijing, 2009

[777] College and university students are both covered under this: Interview, Ministry of Health, Beijing, 2007

[778] Although this was often dependent on local government fiscal capacity: 'in the mid-1980s some provincial and municipal governments decided that their employees can usually have 50 per cent of their dependents medical care expenses reimbursed from the employees welfare funds'. Gu Xingyuan and Tang Shenglan (1995) 'Reform of the Chinese health care financing system.', *Health Policy*, vol. 32 (1-3) pp. 181-191.

[779] This relationship itself changed significantly in the reforms of 1994-1996 removing the so-called 'iron rice bowl' relationship between each *danwei* and their dependents. The situation today remains heavily mixed, and somewhat dependent on the capacity of each *danwei* to afford to pay for former workers.

[780] Yanzhong Huang (2012), *op cit.* p.61 'nearly 2 million government officials were on long-term sick leave, including 400,000 who stayed in special wards, cadre guest houses, and vacation villages, costing 50bn yuan annually (Zhongguo Qingnian bao, Beijing, September 19, 2006)'

[781] Zhou Jiangong (2007) 'A Red Hue to China's Health Care', *Asia Times,* August 22, available online: http://atimes.com/atimes/China/IH23Ad01.html

At heart, this reflects the state's inability to decide its role in the health system. The central government clearly saw its role as being one of mandating health insurance rather than actually funding it. The high-level will clearly existed. But the local governments could not respond. A 1995 speech by a senior Henan Party leader argued that while '(local governments) can't have a socialist economy without cooperative medical insurance, (local governments) need "incentives".[782] He saw these incentives for local government as being governance-based incentives: 'the key is to get the risk pooling and the management right'.[783] Yet, ensuring that these incentives are aligned across different political levels, nationwide, is very difficult. Any reform needs to be able to force not only village leaders, but also township leaders, county leaders,[784] and even provincial leaders (given that they too control some institutional powers) to support the scheme.[785] The only body able to force this alignment is the central state.[786] Yet, as the unsuccessful mandates discussed in this section show, the order of the highest bodies of the central state alone is not a sufficient condition for successful implementation nationwide.

A failure of central mandate contradicts current models of social health insurance

[782] Henan Consultative Committee Vice-Chairman Shao Lingfang: 邵令方 (1995) '关于加快建立农村合作医疗保健制度的建议—在全国政协八届三次会议上的大会发言', 前进论坛, (Shao Lingfang (1995) 'Some suggestions regarding quickening the building of the cooperative rural health insurance system — remarks made at the third plenum of the national People's Consultative Conference', *Progress Forum),* p.3.
[783] *Ibid*.
[784] For example, the Chinese 1993-2000 10 county poverty projects found that if you want to have households as the primary unit, allow voluntary enrolment, and prevent adverse selection — you need to set up a scheme that has the county as the base. 龚向光 (1998) 贫困地区农民合作医疗支付能力研究, 中国卫生经济, (Gong Xiangguang (1998) 'A study of the ability to support cooperative health care in poor areas', *China Health Economics*), vol. 8.
[785] While prices for health services are set at provincial, prefecture and county level under State Price Commission guidelines, they are generally reviewed every 2-3 years.
[786] According to this argument, this was also the reason for the success of the NCMS (see Chapter 7) — because the government took charge of risk pools and the whole operation ('rigorous control'). 杨礼琼 (2008) *社会保障理论与实线*, 黑龙江人民出版社: Harbin, (Yang Liqiong (2008) *Social Insurance Theory and Practice*, Heilongjiang People's Press: Harbin) p. 247.

The 1990s period confounds political models of how SHI schemes succeed or fail. As discussed also in Chapter 5, explanations of why social health insurance collapsed in the 1980s often highlight a lack of central support. Yet other explanations argue that central support is the reason for SHI schemes *succeeding*. For example, Rao and Liu's work on the initiation of the successful NCMS scheme (to be discussed in the next chapter) argued that 'had President Jiang Zemin not taken a personal interest in the issue, the situation in China today may have been completely different'.[787] Rao and Liu's argument notes that they wrote a report on China's health system;[788] this report was read by the health minister, and taken directly to Jiang Zemin who took a personal interest in the matter. Subsequently two senior policy officers[789] came to ask detailed questions about the study, the sources of the data, and the rationale of the study's policy recommendations.[790] Rao and Liu argue that this shows that Jiang Zemin's interest and decree could, on its own, initiate and implement a social health insurance scheme. But, as the section above shows, Jiang Zemin already had periods of high interest in social health insurance in the 1990s. Indeed, there was a whole Central Committee decision (*jueding)* mandating rural health insurance in 1997.

Moreover, there is also a problem of proving what triggered elite interest. Wang, for example, makes a similar argument to Rao and Liu, except he believes that the critical

[787] They see this as actual, personal, intervention based on friendship — the 'man responsible for motivating the president into action was none other than Dr. Zhang Wenkang, China's health minister', who 'had befriended Jiang Zemin during his period as mayor of Shanghai'. Yuanli Liu and Keqin Rao (2006) 'Providing Health Insurance in Rural China: From Research to Policy' *Journal of Health Politics, Policy and Law*, vol. 31, no. 1, pp. 71-92.
[788] Yuanli Liu, Keqin Rao, Shanlian Hu (2002) *People's Republic of China Toward Establishing A Rural Health Protection System*, Asian Development Bank: Manila.
[789] 'Visitors from the Policy Research Office of the Central Committee of the Chinese Communist Party', Liu and Rao (2006) *op. cit.,* p.76
[790] *Ibid.*

change in central attitudes to health care was the widely-publicised report to then-Premier, Zhu Rongji, written by Li Changping[791] in 2000. Wang also notes the report to policy makers by influential Party think tank leader Li Jiange, who wrote a similar report stating that the government must bear the responsibility for providing rural citizens with health care;[792] Wang argued that this alerted senior political leaders and placed the issue firmly on the policy agenda.[793]

Analytically, the problem with these reports is simple. Either of these interventions described above, both of which influenced the 'highest levels', could be considered equally valid explanations explaining why senior leaders wished to act on rural health care.[794] And neither of these arguments explains why social health insurance wasn't established successfully nationwide after the 1997 decree that it should be.

Strengthening this conclusion of high-level knowledge and action prior to 2000 is the fact that information about the success or failure of different health insurance trials had already reached the highest levels in the 1990s. For example, one of the most influential social health insurance experiments in the 1990s was the 1995 experiment in Changshu

[791] Li Changping, a Party Secretary in a town in Hubei province, wrote to former Prime Minister Zhu Rongji about the precarious health situation of farmers. in 2000. His letter drew the attention of policymakers and the mass media to the health problems in the rural areas and opened a political window. Yunping Wang (2008), 'The policy process and context of the Rural New Cooperative Medical Scheme and Medical Financial Assistance in China', *Studies in HSO&P,* no. 23, pp. 127-128

[792] *Ibid.*

[793] Note that Wang's argument is partly based on the fact that Li Jiange was seen as important. Li Jiange was undoubtedly trusted by Jiang Zemin — see his use in 2002 as the leading implementer of Jiang's 2002 reform comments: 'Jiang recently named a point man for the rural health safety net: Li Jiange, a deputy director of the State Council's Economic Restructuring Office' Susan Lawrence (2002) The Sickness Trap, *Far Eastern Economic Review,* June 13, p. 32.

[794] A triggering event does not need to be totally causal, but it does need to reflect causality at the point the decision is made. See Thomas Birkland (1998) 'Focusing Events, Mobilization, and Agenda Setting', *Journal of Public Policy,* Volume 18, Issue 01, pp 53-74.

municipality, Jiangsu province. This trial had participants (individuals, not households) pay RMB30-40 per year into a common risk pool, with the local government and village Party committee providing 'subsidies'.[795] Participants were then reimbursed up to 60 per cent of subsequent outpatient and drug fees.[796] The progress of this trial was reported to the Central Committee Politburo through State Councillor Peng Peiyun; it received the approval (*pishi* 批示) of Premier-to-be Wen Jiabao; and had Premier Li Peng reporting that everyone should 'study this model carefully and think through how to develop their own scheme'.[797]

The 1990s period similarly confounds the arguments of Klotzbücher, introduced in the last chapter. Klotzbücher argues that greater decentralisation of power is the secret to social health insurance implementation. He argues that decentralising responsibility for health insurance downwards can actually be a boon for some health services, as it gives local doctors less 'decision space', and forces them to respond to the wishes of the health insurance office (which, in his model, reflects the wishes of the participants) thus making them more responsive to the needs of local citizens. He notes:

> The state is confronted with an intrinsic contradiction: the providers would like to increase their own economic outcome, but the NRCMS administration must contain costs. The only solution to this problem seems to be to reduce the former decision space of the health care providers. They are forced to respond to the needs of the rural participants of NRCMS, and at the same time their expenses are monitored by the county administration.

[795] see 林闽钢 (2001) 苏南农村合作医疗制度发展面临的挑战何选择，中国农村观察，第一期 (Lin Mingang (2001) 'The Sunan cooperative health system faces challenges and choices', *China Rural Survey,* vol. 1).
[796] *Ibid.*
[797] Cao Pu (2014), *op cit.,* p. 175, using official Central Party School project data and documentation.

The failure of the NRCMS trials of the 1990s contradict Klotzbucher's argument. There were many, and varying levels of 'decentralisation space'[798] for providers or local cadres in the 1990s and yet none of the positive outcomes that we would expect should Klotzbücher's theories hold. Should more 'decentralisation space' for leaders be the answer to health governance problems, we would have expected improvements in health insurance enrolment when decisions were delegated down from the centre. But in the 1990s, the centre made cohesive, and unambiguous decrees, and they were delegated down to the village level, reducing the 'decentralisation space' for providers and other actors in the health care sector — and these reforms did not gain traction. The problem is that local actors face competing priorities and delegation downwards can result in greater fragmentation, coordination problems and transaction costs.

This may reflect a first-principles problem with Klotzbucher's decentralisation space argument. Within the Chinese system, some conflicts between different goals and performance targets are critical.[799] As many have argued, the Chinese governance system uses competition for promotion to focus cadres' attention on economic growth and revenue generation, on which advancement and bonuses depend.[800] Subsequent studies have shown that it is very hard to elicit compliance, for example, on environmental

[798] T Bossert (1998) 'Analyzing the decentralization of health systems in developing countries: decision space, innovation and performance' *Social Science and Medicine,* vol. 47, no. 10, pp 1513-1527
[799] Susan Whiting (2006) *Power and Wealth in Rural China*, Cambridge University Press: Cambridge.
[800] Zhao Shukai at the township level: Shukai Zhao (2013) *Township Governance and Institutionalization in China.* World Scientific Publishing Company Incorporated: Singapore; Maria Edin (2003) "State Capacity and Local Agent Control in China: CCP Cadre Management From a Township Perspective," *The China Quarterly,* vol. 173, pp. 35–52; Ben Hillman, (2010) "Factions and Spoils: Examining Political Behavior Within the Local State in China" *The China Journal,* no. 64, pp. 1–20.

issues,[801] intellectual property rights,[802] education reforms,[803] and other social reforms since these often conflict with short-term economic growth and revenue generation, on which advancement and bonuses depend. The wealth of the evidence shows that the system is good at doing some things but not others. This would suggest that the conditions under which local actors are given more 'decentralisation space' matter more than the amount of 'decentralisation space' that actors are given.

And the evidence from the attempts to revive social health insurance in the 1990s indicates that providing more decentralisation space to local governments did not work. There was more decentralisation of power, but schemes were *not* being implemented. This was because the delegation of power downwards was not accompanied by a delegation of authority that would force all local governments — who were often starved of any funds and who themselves each had differing local conditions, targets, interests and goals — to mobilise and to prioritise the implementation of SHI schemes above other, competing goals and interest. This led to different rates of adoption of social health insurance mandates across different areas, as different areas decided for themselves the amount of money and attention they wished to spend on implementing health insurance schemes. The different amount of attention paid to implementing the schemes resulted in different

[801] Sarah Eaton and Genia Kostka (2014) 'Authoritarian Environmentalism Undermined? Local Leaders' Time Horizons and Environmental Policy Implementation in China', *The China Quarterly*, Vol. 218, pp 359-380

[802] Andrew Mertha (2009) 'Fragmented Authoritarianism 2.0": Political Pluralization in the Chinese Policy Process.' *The China Quarterly*, 2009 vol. 200, pp. 995- 1017

[803] Mingxing Liu, Juan Wang, Ran Tao, and Rachel Murphy (2009) 'The Political Economy of Earmarked Transfers in a State-Designated Poor County in Western China: Central Policies and Local Responses' *The China Quarterly*, 2009 vol. 200 p. 973.

areas having differing levels of funds devoted to the scheme, as acknowledged by both the then-Minister of Health[804] and the State Council. [805]

Indeed, in many ways, the greater decentralisation of public service delivery in China made successful implementation of social health insurance schemes less likely. The following section discusses.

Impact of the 1994 fiscal decentralisation on health insurance implementation

Debates regarding decentralisation are highly influential in health policy, and decentralisation has long been considered a possible method of improving health systems. There is a wide body of literature on developing countries that have initiated decentralisation health reforms,[806] although the effectiveness of decentralisation has yet to have been proven.[807] For example, there have already been a number of debates about how inequity in distribution of health insurance coverage in other countries has been increased

[804] Fund problems: Chen Minzhang (Minister at the time) argued that 'fundraising is both CMS strong point, and weak point: Chen Minzhang (1996) '提高认识 明确政策 贯彻落实 中央关于发展和完善农村合作医疗的重大决策', 中国卫生质量管理, ('Improving understanding, clarifying policy, and implementing reform: the Central Committee's important decision on building and perfecting rural cooperative health care', *China Health Quality Management),* no. 8.

[805] 1997 State Council opinion clause 28.5 for example states that local states 'need to have fiscal capacity at the different county levels to make cooperative health care work, otherwise (local governments) will need different forms of cooperative health care'. 中共中央、国务院 关于卫生改革与发展的决定 (1997). See also Ministry of Health, Family Planning Commission, Ministry of Finance, Ministry of Agriculture, Ministry of Rural Affairs (1997), *Some opinions regarding the development and completion of rural cooperative health care,* 30 March 1997, available online: http://cpc.people.com.cn/GB/64184/64186/66687/4494355.html

[806] Tanzania, Colombia, Uganda, Chile, Pakistan, Vietnam and India to begin. Bossert T. "Analyzing the Decentralization of Health Systems in Developing Countries: Decision Space, Innovation and Performance," *Social Science and Medicine,* November 1998.

[807] See Daniel Treisman (2005) *The Architecture of Government,* Cambridge University Press: Cambridge, or for a more general China-related exposition, Hongbin Cai and Daniel Treisman (2006) 'Did government decentralization cause China's economic miracle?', *World Politics*, vol. 58, no. 4, pp. 505-535.

or reduced by decentralisation.[808] Many others have written on China's decentralisation model and its impact on public services including health.[809]

But decentralisation is a broad rubric. There are a number of forms of 'decentralisation'. [810] And whichever form of decentralisation is chosen, it itself is often malleable in the way in which it is actually implemented.[811] For the purpose of analysis, the argument here will follow the convention of the World Bank and refer to decentralisation as being any behaviour that involves a transfer of 'power, authority, and responsibility for health policy, health systems management, health financing, and service delivery from central government agencies to lower-level, autonomous government or non-government agencies'.[812]

This section seeks to highlight that China's extensive system of fiscal decentralisation increased the difficulty of implementing a nationwide scheme top-down. As noted in the previous chapter, China's modern decentralisation reforms began in earnest in the early 1980s with the end of the previous political units of communes and brigades,[813] and with

[808] Anne Mills (ed) (1990) Health System Decentralization: Concepts, Issues and Country Experience, World Health Organization: Geneva.
[809] Vivienne Shue and Christine Wong (eds) (2007) Paying for Progress in China: Public Finance, Human Welfare and Changing Patterns of Inequality. Routledge: London.
[810] Including 'deconcentration' (some responsibilities are transferred from the central to sub-national units, but decisionmaking power is retained from above); 'delegation' (the central government becomes the principal and local governments the agent); and 'devolution' (local governments have the authority to make decisions on specified matters without any reference to higher levels of government). Framework taken from Richard M. Bird and Duanjie Chen (1998) "Intergovernmental Fiscal Relations in China in International Perspective," in Donald J.S. Brean, ed., *Taxation in Modern China*, Routledge: New York, pp. 151-186.
[811] J Litvack, A Junaid and R Bird (1998). *Rethinking Decentralization in Developing Countries*. World Bank: Washington, DC, p.26.
[812] World Bank (2005) *Deepening Public Service Unit Reform to Improve Service Delivery*. World Bank: Washington, DC, available online: https://openknowledge.worldbank.org/handle/10986/8648
[813] See 1982 change to the Chinese constitution, which called for People's congresses and people's governments to be 'established in townships, nationality townships and towns'

the issuance of a series of Party circulars mandating the roles and responsibilities of villages, townships and counties.[814] This decentralisation reform was pervasive and led to China's decentralising almost all social spending responsibilities. [815] Almost all responsibility for funding health care services was decentralised down to the local levels. 70 per cent of China's government expenditure was subnational — this compares to a 14 per cent average in developing countries, 26 per cent in transition countries and 32 per cent in all OECD countries in the 1990s.[816] The lion's share of this subnational spending in China occurred at the county level.

Table 4: 1999 shares of subnational expenditure by political area (%)

	Province	Prefecture	County	Township
Hebei	26	24	40	10
Gansu	33	18	36	13
Hunan	31	22	39	8
Jiangsu	26	34	40	

Source: World Bank (2002) *China: National Development and Sub-national Finance — A Review of Provincial Expenditures.* Report No. 22951-CHA, Poverty Reduction and Economic Management Unit, East Asia and Pacific Region, World Bank, Washington, DC, p. 79.

[814] Namely, the end of collectivisation, the October 1983 'Notification of Establishment of Township Government' by both the Party and State Council, and Central Party Circular no. 22 of September 1986. For more indepth coverage, see Du Runsheng (2005) *中国农村体制变革重大决策纪实*, 人民出版社: Beijing (*A record of China's important rural system reforms and decisions*, People's Press: Beijing).
[815] See Richard Bahl (1999) *Fiscal Policy in China: taxation and intergovernmental fiscal relations*, University of Michigan Press: Michigan.
[816] Christine Wong (2007), "Budget Reform in China", *OECD Journal on Budgeting*, Vol. 7, No. 1, pp 1-24.

Fiscal decentralisation changed the relationship between the central and provincial governments, and between the provincial governments and each of the respective local governments the political levels below. [817] Each province signed a contract with the central government, stipulating the amount of funds to be forwarded to the centre annually.[818] This system then continued *seriatim* down to lower political levels. Revenues generated over and above this stipulated, contracted sum could be retained in whole or in part for local government usage. Under this system, the provinces and local governments have more resources at their disposition should they successfully create more revenues. This system encouraged provincial and local governments to hoard funds. It also encouraged provinces, and higher-level governments in general, to pass any spending responsibilities down.[819]

But, in 1994, a 'tax sharing' system, which formally delineated local and central taxes, was introduced to replace the earlier contract responsibility system.[820] The new tax-sharing system aimed to strengthen the centre's financial position and sever ties between local government revenue and the revenue of local state-owned or state-operated enterprises. Specialists in China's fiscal system argue that the 1994 tax reform ensured that the centre had a much greater proportion of funds than the localities — as can be seen in the difference between 1993 and 1994 in the table below.

[817] Jia and Lin (1994) *Changing central local relations in China: reform and state capacity,* Westview Press: Boulder, CO.
[818] Christine Wong and Richard Bird (2008) 'China's Fiscal System: A Work in Progress' in L Brandt and T Rawski (editors), *China's Great Transformation: Origins, Mechanism, and Consequences of the Post-Reform Economic Boom*. New York, Cambridge University Press, 2008.
[819] Christine P. W. Wong (1991). Central–Local Relations in an Era of Fiscal Decline: The Paradox of Fiscal Decentralization in Post-Mao China. The China Quarterly, 128, pp 691-715
[820] *Ibid.*

Table 5: Government spending split between centre and local government 1990-2002

Year	Govt Rev	Central Rev	Local Rev	Central %	Local %
1990	2937.10	992.42	1944.68	33.8	66.2
1991	3149.48	938.25	2211.23	29.8	70.2
1992	3483.37	979.51	2503.86	28.1	71.9
1993	4348.95	957.51	3391.44	22.0	78.0
1994	5218.10	2906.50	2311.60	55.7	44.3
1995	6242.20	3256.62	2985.58	52.2	47.8
1996	7407.99	3661.07	3746.92	49.4	50.6
1997	8651.14	4226.92	4424.22	48.9	51.1
1998	9875.95	4892.00	4983.95	49.5	50.5
1999	11444.08	5849.21	5594.87	51.1	48.9
2000	13395.23	6989.17	6406.06	52.2	47.8
2001	16386.04	8582.74	7803.30	52.4	47.6
2002	18903.64	10388.64	8515.00	55.0	45.0

Source: Christine Wong and Richard Bird (2008) 'China's Fiscal System: A Work in Progress' in L Brandt and T Rawski (editors), *China's Great Transformation: Origins, Mechanism, and Consequences of the Post-Reform Economic Boom*. New York, Cambridge University Press, 2008.

The system theoretically enabled the central government to play a redistributive role through the usage of fiscal transfers, ensuring that adequate funds are available throughout all levels of the Chinese political system. But instead the centre retained much of the revenue, and provided incentives to local governments to raise their own revenues to fund any shortfalls in fiscal revenue. Moreover, each level delegated their responsibilities down to the level below, while still asking for fiscal transfers. So provinces and municipalities were able to delegate much of their spending responsibilities to counties and townships.[821]

[821] Wagstaff et al. report that in two rural counties in Guangxi around 85% of government spending on public health is financed by the county government. for example, in 2003 Beijing and Shanghai spent around 16 yuan per person on disease control programs, whereas Anhui and Guangxi (two poor provinces) spent

While the central government increased its revenues more than two-fold, and created a budget surplus,[822] it failed to pass subsequent funding down to lower levels to fund the programs that it was decreeing from above. Fiscal transfers between different levels were not enough to cover the costs of health care provision, and counties and townships in particular were left with a major shortfall; the table below on county level budgets in Hunan province shows an example.

Table 6: Sources of revenue for social expenditure in Hunan at county level (1999)

Unit: BN RMB

	Budget	Actual	% from budget	Personnel costs	Personnel as % of budget
Health Care	1.17	7.23	16	2.57	220
Education (Primary)	1.44	3.33	43	2.45	170
Education (Middle)	1.73	3.55	49	2.45	142
Agriculture	2.27	3.16	72	0.87	38
Urban maintenance	1.28	1.55	83	0.5	39

Source: World Bank (2002) *China: National Development and Sub-national Finance — A Review of Provincial Expenditures.* Report No. 22951-CHA, Poverty Reduction and Economic Management Unit, East Asia and Pacific Region, World Bank, Washington, DC, table 5.2, p.66.

around 3–4 yuan per person despite a much higher prevalence of TB. Adam Wagstaff, Winnie Yip, Magnus Lindelow, and William C. Hsiao (2009) 'China's health system and its reform: a review of recent studies' *Health Economics,* Volume 18, Issue Supplement 2, pages S7–S23.

[822] Christine Wong and Richard Bird (2008) 'China's Fiscal System: A Work in Progress' in L Brandt and T Rawski (editors), *China's Great Transformation: Origins, Mechanism, and Consequences of the Post-Reform Economic Boom*. New York, Cambridge University Press, 2008.

The shortfall in the budget revenue compared to expenditure means that, while cadres seek to fulfill the demands of the cadre evaluation system imposed on them from above, they lack adequate revenues to fulfil all the functions delegated down to them.[823] Moreover, should there be not enough funds to perform all activities, ones that generate revenue for the local government will look more attractive than activities that do not generate revenue. This creates what Christine Wong terms "revenue hunger"[824] particularly at the lower levels (the levels that expenditure responsibilities are delegated down to). This revenue hunger is likely to impact heavily on social health insurance schemes, which, under Chinese regulations, cost the local state a large amount of money rather than provide them with revenue.[825] As a result, performance criteria that are not related to revenue-generating activities (and social health insurance is included in this group) are, *ceteris paribus*, less likely to be implemented faithfully.[826]

Hence, as Eggleston argues, a lack of money to a lack of effective incentives for local governments to spend time, money or administrative effort on delivering public services. She notes that:

> under the current system, in which local officials get promoted based on local economic growth, local governments prefer activities that boost economic development quickly and

[823] For example, Chou and Wang argue that, on average, for every 10 million yuan increase in budget deficits, health expenditure will be decreased by 26.3 per cent, ceteris paribus. Chou, W. L. and Wang, Z. 2009, 'Regional inequality in China's health care expenditures', Health Economics, vol. 18, no. S, pp. 137–46.
[824] Christine Wong (2009) 'The New Social and Economic Order in 21st Century China: Can the Government Bring a Kinder, Gentler Mode of Development?' in E Paus, P Prime and J Western, Editors, *Global Giant: Is China Changing the Rules of the Game?* Palgrave Macmillan: London. p.28
[825] Due to regulations which ban the use of contributions to insurance from being used for administrative expenses.
[826] Shukai Zhao (2013) *Township Governance and Institutionalization in China.* World Scientific Publishing Company Incorporated: Singapore.

> neglect long-term objectives… Although there is no inherent reason why fiscal decentralization should affect public goods provision, China's current investment in public services such as education and health care is insufficient, due to the absence of an effective incentive mechanism.

One of the crucial 'incentive mechanisms' Eggleston is referring to is the ability to get promoted. But by delegating down responsibility for establishing social health insurance schemes to different actors and different levels, no single actor can be given an incentive to be promoted for successfully implementing a social health insurance scheme. This makes it hard to implement a scheme nationwide. It is likely to be even harder to implement schemes where there are budget shortages, as local government revenue-increasing options look more attractive. This makes social health insurance schemes look less attractive to implement for local governments. Indeed, this problem can be seen even within the health sector. As costs rise, then health agencies also have to choose as to which measures they prioritise. The following section will show how SHI scheme implementation was but one of many needs in the rural health system in the 1990s, and will argue that this multidimensionality also made the implementation of SHI schemes difficult.

China's indigent rural health system makes SHI implementation yet harder

This final section will look at the 'revenue hunger' problem discussed in the previous section as it pertains to introducing social health insurance schemes. It will argue that the costs of health service provision kept rising throughout in the 1990s, and that this made it more difficult to introduce a national social health insurance scheme, because local

governments are forced to foot the bill for rising health care costs, and the rising costs (and the diversion of local government attention) meant that local governments were less likely to choose to implement social health insurance schemes. If the system lacks funds, passing social welfare program responsibilities down without providing incentives to force local actors to provide the programs usually will result in social welfare programs receiving very limited public monies. So it proved with rural social health insurance.

Health facilities struggled greatly with decentralisation and rapid change.[827] China's decision in 1984 to allow health bodies to charge fees for services allowed many health organisations to cover any shortfalls in public budget by passing charges onto patients.[828] But, as Table 8 below shows, even the limited public funds were largely allocated to urban hospitals — the same hospitals that had more capacity to charge their patients more for treatment.

[827] A full consideration of this is beyond the scope of this thesis. To give an overview, Bloom and Gu summarised the health reforms designed to assist health facilities to cope with decentralisation and rapid change as being: (a) Increased reliance on out-of pocket payments by users of health services as government subsidies and its share of health expenditure fell and community co- operative medical schemes weakened; (b) Decentralisation of public sector health services to local government that had responsibility for salaries and development and maintenance of health facilities and services; (c) Increased autonomy of health services to generate revenue from fee-for-service charges and dispensing drugs to meet some salary costs, bonuses, the provision and maintenance of hospital equipment, including training for staff; (d) Increased freedom of movement of health workers and flexibility in pay has meant salaries linked to revenue earned, an outflow of superior health staff from rural to urban areas or to the growing private sector, even at the village level. Some public sector doctors work part time in private practices; and (e) Decreased political mobilisation and political control has given health workers greater freedom and reduced supervision as priority has shifted to increasing revenue flows. Farmers are also less able to participate in public health campaigns for the same reason. Gerald Bloom and Xingyuan Gu (1997) 'Health sector reform: Lessons from China', *Social Science & Medicine,* vol. 45, issue 3, p.352.

[828] See for example 张自宽 (1993) 论合作医疗, 山西人民出版社: Taiyuan (Zhang Zikuan (1993) *A Theory of Collective Health Care*, Shanxi People's Press: Taiyuan).

Table 7: Funding for health services providers 1995-2003 (%)

Year	City Hospital	County Hospital	Health Centre	Disease Control/ Prevention Institute	Maternal and Child Health Institutes	Other
1995	31.03	10.03	20.43	14.2	4.02	20.29
1996	31.8	10.27	20.46	13.63	4.01	19.83
1997	32.52	9.87	19.97	13.71	4.08	19.85
1998	32.67	9.52	19.78	14.12	4.1	19.81
1999	34.89	12.92	17.82	13.06	3.88	17.43
2000	36.1	12.62	17.08	13.32	3.98	16.9
2001	37.25	12.77	15.88	13.11	3.88	17.11
2002	38.05	11.72	15.58	14.17	3.93	16.55
2003	35.17	11.45	14.17	15.14	3.47	20.6

Source: China Health Statistical Yearbook 2005, Table 4-3-1, available online: http://tongji.cnki.net/overseas/engnavi/HomePage.aspx?id=N2012030035&name=YSIFE&floor=1

So the rural health care sector was in a poor state. By 2002, only 10 per cent of farmers who fell ill in rural areas had any form of insurance. The average rural hospital bill, in 2002, at 2,236 yuan, was nearly equal the average annual rural salary (2,622 yuan).[829] Surveys in 1995 showed that many rural residents avoided health care institutions, or sought care at higher-level or urban hospitals.[830] Rural health care providers, unable to get funds from the local government, often suffered from a shortage in revenue.[831] In order to

[829] Ministry of Health 2004 statistics; see Richard Daniel Ewing (2006) 'The need to fix rural health care in China', *Asia Times,* available online: http://www.atimes.com/atimes/China/HE12Ad01.html

[830] 'Under the three tier system resulting in patients by-passing township health facilities more frequently to go to county hospitals or to see private doctors.' Y Liu, W Hsiao, Q Li, X Liu, X. and M Ren (1995) 'Transformation of China's Rural Care Financing,' *Social Science and Medicine*, Vol. 41, No. 8, p. 1091.

[831] 'Without revenue from fees and drugs, staff may not receive their regulated wages for long periods and thus supplement their salary by, amongst other things, private medical work or working in the fields. Township hospitals/health centres, in particular, have also been affected by the limited ability of local government in poor counties to continue subsidising the salaries of health staff. This has resulted in such

raise these revenues, and keep themselves in business, providers have major incentives to raise prices, prescribe more drugs,[832] employ more high-tech machinery and over-supply medical care.[833]

Rural medical services remained very expensive; Table 8 below shows the average cost of a number of common services:

Table 8: Health treatment costs in rural as a % of total annual income[834]

Service	RMB	% annual farmer income
Simple Ambulatory Care	99.6	4%
Caesarean section	2348	95%
Appendectomy	2652	107%
Pneumonia treatment w/ inpatient care	4627	187%

Source: McKinsey & Co. (2010) *China's Health Care Reforms*, McKinsey Global Institute: Boston MA, p86.

And the costs of health care kept rising. Between 1993 and 1998 average income increased by 6.5 per cent. In the same period average outpatient expenditure increased 10.2

facilities giving priorities to staff retention and increasing salaries.' Gerald Bloom and Gu Xingyuan (1997) 'Health sector reform: Lessons from China', *Social Science & Medicine*, Volume 45, Issue 3, p. 352.

[832] 'Services and drugs revenue account for about 85% of total health facility revenue' Yuanli Liu (2004) 'Development of the rural health insurance system in China', *Health Policy and Planning*, vol. 19, no. 3 p. 160. 'In six counties surveyed, sales of drugs made up 53.1% of total health care revenue.' L Bogg, H Dong, K Wang, and V Diwan (1996), 'The cost of coverage: rural health insurance in China,' *Health policy and Planning*, vol. 11, no. 3, p. 243.

[833] Moreover, the difficult budgetary situation in poorer townships meant that hospitals attempted to keep patients as long as possible and to perform some clinical services which may have tested the limits of both treating doctor competence and the hospital facilities and equipment. Gerald Bloom, Leiya Han, and Xiang Li (2000) *How health workers earn a living in China*. Institute of Development Studies: University of Sussex.

[834] Note that this assumes 2476 yuan annual income per annum.

per cent and inpatient expenditure by 13.8 per cent.[835] Between 1978 and 2003, the annual growth rate of health expenditure in China was 12 per cent, which was higher than the 9.4 per cent growth of GDP.[836] The PRC government share of national health expenditure fell from 36 per cent to 16 per cent between 1986 and 1993.[837] In the decade 1991 to 2000, government expenditure on health care as a percentage of total health expenditure fell from nearly 20 per cent to 6.6 per cent; social health expenditure fell from 6.7 per cent to 3.3 per cent; and individual expenditure went from being 80.7 per cent to being 90.1 per cent of all expenditure on health care.[838]

Therefore, should the local government wish to implement social health insurance, they would need to divert funds from a publicly-owned health care system that was increasingly expensive (and unpopular), and put the funds into either rural social health insurance, or, possibly, administration (in order to aid, monitor and manage local governments into establishing SHI schemes that could provide financial security themselves). But rural health insurance was not a priority in central health budgets in the 1990s. There were very few extra funds devoted to rural insurance (note that 'medical insurance' was mainly a continuation of the urban social health insurance scheme; note also the lack of increase in budget to rural social health insurance or administration following the 1997 decree).

[835] Gao, J., Qian, J., Tang, S., Eriksson, B. and Blas, E. (2002), 'Health equity in transition from planned to market economy in China,' Health Policy and Planning, 17 (Suppl 1): 20-29.
[836] Gu Xin (2006) *诊断与处方：直面中国医疗体制改革*，社会科学文献出版社: Beijing (*Pathologies and cures: directly reforming the Chinese health care system,* Social Sciences Press: Beijing).
[837] *Ibid*, p. 2.
[838] *Ibid*.

Table 9: Central government health care funding by area as % of total 1990-2003

Year	Health Institutes	Medical Insurance	GIS	Food and Drug Institutes	Family Planning Institutes	Capital Invest	Health Admin	Others
1990	45.96	0	23.68	0	8.29	4.13	2.43	15.51
1991	45.94	0	24.7	0	7.9	3.56	2.53	15.37
1992	45.66	0	25.41	0	8.47	3.36	2.79	14.31
1993	43.02	0	28.06	0	8.41	4.21	2.95	13.35
1994	46.46	0	26.88	0	7.73	3.61	3.2	12.12
1995	45.68	0	28.99	0	8.24	2.98	3.38	10.73
1996	44	0	29.46	0	8.2	4.68	3.38	10.28
1997	43.42	0	30.52	0	8.45	4.36	3.26	9.99
1998	41.2	0	29.95	0	8.54	3.41	3.37	13.53
1999	42.05	0	29.84	0.47	9.11	5.41	3.57	9.55
2000	41.73	0	29.74	0.42	9.09	4.14	3.78	11.1
2001	42.63	12.08	17.37	0.97	10.22	6.04	4.12	6.57
2002	42.01	17.62	10.08	1.98	12.63	5.11	4.92	5.65
2003	41.3	22.27	6.37	2.01	12.7	5.87	4.62	4.86

Source: Zhao Yuxin (2005), *Assessing Government Health Expenditure in China*, World Bank: Washington DC, p 19.

Given all this, and perhaps unsurprisingly, no one really wanted to join a health insurance scheme. As Table 10 below shows, there is a significant difference in insurance coverage between urban and rural areas — 87% of rural residents had no insurance in 1998.

Table 10: Household enrolment in a health insurance scheme (%)

	Urban	Rural
GIS	16	1.2
LIS	22.9	0.5
Partial LIS	5.8	0.2
Private	3.3	1.4
Social Fund	1.4	0
Cooperative medical care	2.7	6.6
Others	3.7	2.8
Out of Pocket only	44.1	87.3

Source: Wang Mengkui (2005) *China Human Development Report 2005*, Development Research Centre of the State Council of the People's Republic of China: Beijing (using data from the 1998 and 2002 Health Services Surveys), pp. 60-61.

Conclusion

In the 1990s, a popular saying on health care developed: how much money you have is how much sickness you treat.[839] In the 1998 health services study, 45 per cent of households who fell into poverty reported it was due to health reasons. 90 per cent of health care spending came from the individual. Yet the amount of money spent by the central government *increased* during the 1990s. Cost inflation in treatment rose so quickly to eat away any increases in spending.

The central government undoubtedly responded; there were a plethora of different schemes and pilots launched to improve China's health financing. The government

[839] The other common phrase used was 小病不治， 大病就死 (***xiaobing buzhi, dabing jiu si,*** 'small illness is untreated, large illness means death').

appeared to recognise that it had some role in health care, rather than fully 'retreating'. This was particularly the case at the central and elite levels. A number of schemes, pilots, and trials were launched. A major central decree mandated that the entire Chinese political system pay more attention to rural social health insurance. But none of the different schemes lasted, nor were they nationally successful.

Following the 1980s, the idea developed that any 'one size fits all'[840] policies were inappropriate, and that the most important role for the state to play was that of supporting health care through the development of a system of regulation that would allow the individual to pay for health care and insurance. But, as Chapter 5 showed, this reliance on the individual proved ineffective, and the central government was caught in a difficult position. It realised it needed a SHI scheme in order to have a functioning health system, but was unable to support schemes with central funds. It tried instead to use mandates from the top to force local governments to introduce SHI schemes. Yet despite many efforts, the fragmentation of the system meant that there was no one person held accountable for introducing these schemes — and reintroduction failed, despite considerable central support. This counters the idea of elite intervention being all in the Chinese system.

A broader program of decentralisation reinforced these developments. But the local state had poor institutions, creating incentives that led to greater cost inflation. The local state was thus given large unfunded mandates, and spending money on spiralling health

[840] Or 一刀切 (*yiqiedao)* policies.

care costs would divert local state funds from other social priorities. This diversion counters the idea of needing to give local governments more 'decentralisation space' in order to have them implement social health insurance programs.

So the local state faced a considerable dilemma. The fragmented nature of China's local state institutions meant that the state could not regulate providers to lower prices. And the state was unable to pay providers enough to keep them from focusing on revenue-raising activities, nor was the state able to equalise the gaps in quality within different geographic areas. At the local level, funds were insufficient to cover costs of health care even should the state have wished to do so.

The next chapter will show how the state resolved this dilemma: the Party used political mobilisation methods similar to those of the Maoist period to force the local state to enrol people in social health insurance. The Party was able to hold the county Party secretary accountable for ensuring high enrolment, and the local state was then mobilised sufficiently to ensure that individuals were enrolled in the schemes.

Chapter 7: The recent success of the NCMS

Unsuccessful policies often look cursed from the beginning. Such policies rarely succeed. So, *ex ante,* the success of the New Cooperative Medical Scheme (NCMS) in enrolling the Chinese countryside appears baffling. The conditions of the introduction and implementation could hardly have been less felicitous.

For example, analyses of health insurance schemes emphasise that a well-functioning health system will be more successful if it covers the whole population.[841] An increase in health insurance coverage theoretically needs to be led by citizens wishing to enrol in the scheme, on the presumption of their receiving benefit. As Chapter 6 showed, health care costs rose dramatically in the decade before the introduction of the NCMS. And surveys and other evidence reveal a citizenry that was deeply discontented with health care provision.[842] Citizens in some parts of rural China reported that health care costs were enough, alone, to drive them into poverty.[843] Finally, as Chapter 6 pointed out, a very similar scheme had been launched in 1997 to similar fanfare with little buy-in.

The NCMS went in the opposite direction from the recommendation of most health insurance schemes for developing countries (and, from the many recommendations given to China by external aid agencies in the 1980s and 1990s). The NCMS was focused on

[841] Guy Carrin and Chris James (2005) "Social health insurance: Key factors affecting the transition towards universal coverage". *International Social Security Review* vol. 58, no. 1, pp. 45–64.
[842] Shenglan Tang (2008) 'Tackling the challenges to health equity in China', *The Lancet* , Volume 372 , Issue 9648 , pp. 1493 - 1501
[843] World Health Organisation and China State Council Development Research Centre (2005) *China: Health, Poverty and Economic Development*, World Health Organisation: Geneva, p. 14.

inpatient care rather than primary care; by no means provided sufficient reimbursement to cover the whole cost of treatment; and it had highly restrictive rates of reimbursement for inpatient expenses. Even if citizens could anticipate using reimbursements from the NCMS service, they still needed to pay upfront for any medical treatment.[844]

From 2002, there was a lack of central ministerial attention and money devoted to the NCMS (although there was central Party attention). The initial trials, and the national rollout, were allocated very limited amounts of money by the central Ministry of Health, which did not identify the scheme as a priority until *after* nearly the whole country was enrolled in it. Furthermore, fiscal transfers were by no means sufficient to cover the costs of the introduction of NCMS — the money had to be found at the local level. Cash-strapped local states were to implement the NCMS, ensure all peasants were voluntarily enrolled, to manage the risk pools and compensation, to promote the scheme, to create trust in the local populace regarding the scheme and finally, to do all of this while avoiding an increase in the number of fees that rural residents had to pay.

As Lawrence noted in her discussion of China's rural health care 'crisis' at the time of the introduction of the NCMS:

> (N)o one is under any illusion about the crisis easing any time soon. The biggest question is where the money for a rural insurance scheme might come from. The central government is reluctant to come up with the cash. Provincial governments

[844] Xuedan You and Yasuki Kobayashi (2009) 'The new cooperative medical scheme in China.' *Health Policy*, vol. 91, no. 1, pp. 1-9.

> say their own budgets are already stretched much too thin. Many rural residents are wary about contributing to a rural health-insurance programme because of mistrust of local officials, who often have a history of mismanaging finances. And local officials point out they are under orders to cut the number of fees levied on farmers, not increase them.[845]

Hence, the subsequent success of the NCMS was unusual. It came about because of successful Party-led mobilisation of local state officials. Implementation relied upon local county Party secretaries to allocate scarce funds and to use their powers over personnel management to ensure NCMS enrolment and risk pool viability. But, vitally, the local county Party secretaries were to be held accountable for NCMS enrolment. This made a mobilisation of the local state possible.

This accountability system came nationally in 2005, when enrolment in the NCMS was included as the only health care metric in the omnifarious Party campaign to 'build the new socialist countryside'. NCMS enrolment then boomed, covering the countryside. This most impressive feat was the byproduct of a much bigger program, one almost completely removed from the health care *xitong* and the Ministry of Health, where the Party mobilised the local state to ensure that the criteria of ensuring a 'new socialist countryside' were met. The local state, in spite of a lack of funds, responded to these criteria thoroughly, introducing the NCMS well ahead of schedule, targets and even official Ministry of Health expectations.

[845] Susan Lawrence (2002) The Sickness Trap, *Far Eastern Economic Review,* June 13, p. 32

This experience underlines the importance of understanding China's health governance, and its health insurance policy, as part of a broader system of governance. The unexpected success of the NCMS was not so much a triumph for the health care sector; it was a triumph for the Party. And the triumph showed how holding the local Party secretary accountable for high enrolment is both a necessary and sufficient condition for policy implementation.

Introduction of the NCMS

As discussed in Chapter 6, 1997 saw the launch of a major health insurance reform. But this reform failed to address the many structural issues within the Chinese health care sector. Accessing rural health care remained 'difficult, and expensive'. In 2000, the WHO ranked China 188th out of the 191 member states in terms of fairness of financial contribution to health systems, a position which caused great consternation within China.[846]

In response,[847] the central Party launched another round of rural health care reforms. The 2002 Central Committee decision and announcement mentioned a 'new rural

[846] World Health Organisation (2000) The World Health Report 2000. Health systems: improving performance, WHO: Geneva.

[847] The WHO report mentioned above notoriously triggered its own State Council report. Obviously, no strong for claim for causality can be made, but a number of well-connected and/or official Chinese health care writers all note the WHO report as the trigger. See for example, Yuanli Liu and Keqin Rao (2006) 'Providing Health Insurance in Rural China: From Research to Policy' *Journal of Health Politics, Policy and*

cooperative health insurance scheme' as one of the measures — a similar health insurance announcement was in 1997 reforms — but gave few specifics.[848] Following this, Jiang Zemin gave a speech on health care, and, as with the 1997 reform announcements, the Party ensured that relevant ministers and other Party heavyweights attended Jiang Zemin's speech.[849] The State Council organised a coordinated position on the health care reform across all the ministries, and issued a high level directive in January 2003. Each province then issued its own directive in response.[850] The central Ministry of Health followed this with further instructions in August 2003.[851] In December 2003, the new Party Secretary Hu Jintao and Premier Wen Jiabao attended a high-level meeting convened in Hubei, showing further official high level support for the NCMS program.[852]

The 2002 and 2003 rural health care reforms had almost exactly the same process, content, goals, directives and implementation system as the 1997 reforms. Both were

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Law, 2006 vol. 31 (1) pp. 71-92; Zhuanxing Institute(2012) *新农合作医疗：问题与展望*, 传知行社会经济研究所 :Beijing, (*NCMS: Problems and Prospects*, Zhuangxing Institute Press: Beijing).

[848] Central Committee and State Council (2002) 关于进一步加强农村卫生工作的决定, 中发 (2002) 13号 ('Decision on advancing and quickening rural health care activities', Decree 13 (2002).

[849] According to official reports, ministers for all of the following official bodies were represented: Family Planning, Agriculture, Finance, Health, and Education. More senior attendees included the State Councillor for agriculture, and Li Lanqing (Standing Committee member, First Vice-Premier, and head of Patriotic Health Committee). See Anonymous (2002) '中共中央 国务院关于 进一步加强农村卫生工作的决定' ('The Central Committee and State Council Decision on advancing and quickening rural health care activities'), *People's Daily*, 30 October.

[850] See for example Henan Party Committee and Province Government (2003) 中共中央国务院关于进一步加强农村卫生工作的决定》的实施意见, (Opinion on measures to implement: 'Decision on advancing and quickening rural health care activities') Directive 11 (2003), available online: http://www.hnhzyl.com/content.aspx?id=847526814780.

[851] See Ministry of Health (2003) 关于报送中共中央、国务院关于加强农村卫生工作的决定（代拟稿）的请示 (Draft instructions on implementing: 'Decision on advancing and quickening rural health care activities'), available online: http://www.reformdata.org/content/20020929/20949.html.

[852] '因地制宜，循序渐进， 积极稳妥地发展农村合作医疗试点工作' 'As the system proclaims, we will proceed step-by-step, developing proactive, stable trials of cooperative health care'; see Anonymous (2003) 吴仪在援外医疗队派遣四十周年纪念会上表示促进援外医疗工作持续健康发展, (''Wu Yi proclaims at the 40 year commemoration of China's foreign aid teams that China will contine to develop sustainable health care services and aid for foreign countries'), *People's Daily*, 6th December.

initially decreed by the same leader of China, Jiang Zemin (see Chapter 6). Both decrees had the same level of importance based on their classification.[853] And both reforms focused mainly on cost control.[854] Neither of the reforms focused specifically on health insurance.

As with the 1997 reform, the state was to play an active role in the establishment of funding of the NCMS in the 2002 reform. Unlike the 1997 reform though, the central government was more prescriptive in specifying how the NCMS would be financed. Funding for the NCMS came from a combination of voluntary individual contributions, mandatory local government contributions and matching central government contributions. As an example, early iterations of the NCMS policy (2003–05) used a theoretical model of each NCMS fund requiring a contribution of RMB10 per person, an RMB10 local government subsidy and an RMB10 central government matching subsidy.

Local governments could contribute additionally to the local NCMS fund should they choose, and have the money available. The breakdown of funding for the initial model was that the central government gave RMB10 per capita but only post-enrolment, RMB1 million of which was taken by provincial government for administrative costs. In terms of different payments, no less than RMB5 per capita of the RMB10 total local government funds were to come from either the county or municipal government.

[853] Both were Central Committee *juedings*.
[854] Clause 34, 1997 decision, for example, which pronounced that it wished to 'perfect government management of health services' ('完善政府对卫生服务价格的管理').

The nuts and bolts of enrolment in the NCMS were also slightly different from these previous schemes, although they were based on similar principles. While the individual was responsible for paying the initial fee, enrolment was at the household level rather than the individual level. Individuals or households could enrol at a village station,[855] a township tax outpost or a township health centre.[856] The risk pool itself was to be managed at the county level. Following the receipt of money from the participant, funds were transferred into a special bank account held by a state-owned bank or credit trust,[857] and the government put its matching money into the fund.[858]

Unlike previous schemes, the NCMS focused on inpatient costs. The NCMS was largely designed to be a catastrophic event insurance fund to prevent peasants from going into poverty by providing reimbursement of costs following inpatient episodes — as opposed to earlier schemes which focused more on primary care reimbursements. The bulk of reimbursement by the NCMS is for inpatient expenses, even in counties where outpatient expenses are covered.[859] The NCMS also had a stated focus on supporting the ability of citizens to afford drugs. NCMS was to be responsible for developing price ceilings, and for reimbursement against the cost of certain drugs.

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[855] Xuedan You and Yasuki Kobayashi (2009) 'The new cooperative medical scheme in China.' *Health Policy*, vol. 91, no. 1, pp. 1-9.

[856] 曹普(2014) *新中国农村合作医疗史*，福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p. 225.

[857] Funds are run by state banks (ICBC/Agricultural) or credit trusts.

[858] For poor households, the fee for their enrolment was transferred directly to the NCMS risk pool by centre and local tax bureaus from the Ministry of Civil Affairs budget after the annual poverty head count figures were received by the central Ministry of Finance.

[859] A 2006 World Bank survey noted that in the 27 counties for which data were available, the share of reimbursements accounted for by inpatient care varied from 100 per cent to 66 per cent, depending on the coverage mode. Adam Wagstaff (2007) *Extending Health Insurance to the Rural Population. An Impact Evaluation of China's New Cooperative Medical Scheme.* World Bank: Washington DC.

Similar to earlier schemes, local states were 'free to choose the benefit package and administrative arrangements of their NCMS according to local conditions, as long as they follow two policy guidelines: voluntary enrolment and coverage of catastrophic illnesses.'[860] You and Kobayashi note that there were five common benefit packages combining reimbursement for inpatient and outpatient expenses,[861] with the majority[862] of pilot counties using a combination of limited inpatient reimbursement with a household savings account which allowed funds to rollover to the following year. The coverage for inpatient care was typically shallow: deductibles were high, reimbursement ceilings were low, and coinsurance rates were high.[863]

Why high enrolment in the NCMS was so surprising

[860] You and Kobayashi, *op cit.*

[861] You and Kobayashi classify them 5 ways: (1) inpatient reimbursement and household savings accounts: expenditure on hospitalization can be reimbursed with some co- payment; the family savings accounts can be used by the participants directly to pay for outpatient expenditures; (2) inpatient reimbursement and outpatient reimbursement: outpatient fees at county and/or township levels are reimbursed at a certain proportion; (3) inpatient reimbursement and household savings account as well as reimbursement of catastrophic illnesses treated in outpatient departments: this is to pay special reimbursements for diseases which are expensive to treat, but do not necessarily involve admission to hospital, e.g. nephropathy, hepatitis, diabetes, and hypertension; (4) inpatient reimbursement and reimbursement of catastrophic illnesses treated in outpatient departments; (5) only inpatient reimbursement. Note that Chinese commentators often list more categories: early *People's Daily* pronouncements discuss 9 different types (Anonymous (2003) '政府牵头多方筹资，完善合作医疗制度', ('Government to take the lead in diversifying fund sources, perfecting cooperative medical system') People's Daily, 20 February). See also 余少祥 (2008)新农合：是大餐？还是鸡肋? "新农村合作医疗"发展研究报告 (Yu Shaoxiang (2008) 'NCMS: a sumptious banquet, or a chicken scrap? A report on a study of the development of the NCMS'), available online: http://www.iolaw.org.cn/showNews.aspx?id=22842.

[862] They cite that '65.2 per cent of pilot counties across the country prefer the design of the inpatient reimbursement+household savings account.' Phil Brown, Alan de Brauw, and Yang Du (2009) 'The New Cooperative Medical System: Does it Help Farmers with Health Shocks Maintain Living Standards?' *Labor Economics* vol. 4, no. 1, pp. 1-22.

[863] On average, there is a deductible of 200–500 yuan, a ceiling of annual 10,000 yuan per person and a coinsurance of 45–80% for inpatient care.

The minimal nature of these changes in policy form and structure from earlier social health insurance attempts meant that China's success at enrolling citizens in the NCMS is baffling. One of the reasons this success is baffling is that it contradicts much of the current literature on the uptake of health insurance and its utilisation. Uptake for many types of insurance in developing countries is low,[864] even for highly subsidised and compulsory health insurance. This can be seen in a brief review of the comparative international literature. While valid comparisons are difficult, the difference between China and other countries is striking.

A possible analogue for the introduction of Chinese health insurance is the Mexican *seguro popular* insurance scheme, also launched in 2003.[865] In spite of an extensive enrolment campaign, public funding and attempt to boost participation, treatment clusters could only enrol 44 per cent of households participating in the program, compared with 7 per cent in control communities. Similarly, a study in Nigeria showed that only around 20 per cent of eligible workers took up a voluntary health insurance program.[866] Wagstaff found in Colombia that, 10 years after the scheme's initiation, less than 50 per cent of the principal target group was enrolled.[867] In Vietnam, about 40 per cent of those who ought to

[864] See for example Michael Kremer and Rachel Glennerster (2012) 'Improving health in developing countries: evidence from randomized evaluations' in Pedro Pita Barros, Thomas G McGuire, and Mark V.Pauly, (eds) (2012) *Handbook of Health Economics*, Elsevier Publishing: Amsterdam.
[865] *Seguro Popular* is the health ministry's semi-SHI scheme that operates in parallel to the social security institute's SHI scheme, and is aimed at the informal sector. The poorest two deciles are exempt from contributions. The remainder of the population contributes according to assessed income. See G. Nigenda, (2005) *El Seguro Popular de Salud en México. Desarrollo y Retos para el Futuro.* Nota Técnica de Salud No. 2/2005. InterAmerican Development Bank: Washington DC.
[866] Rebecca L. Thornton, Laurel E. Hatt, Erica M. Field, Mursaleena Islam, Freddy Solis Diaz and Martha Azucena Gonzalez (2010) 'Social Security Health Insurance For The Informal Sector In Nicaragua: A Randomized Evaluation', *Health Economics,* vol. 19, pp 191-206
[867] Alejandro Gaviria, Carlos Medina, and Carolina Mejía (2006) 'Assessing Health Reform in Colombia: From Theory to Practice', *Economía,* Volume 7, Number 1, Fall 2006, pp. 29-72.

have received health insurance coverage (or a free health care card) by virtue of being poor had actually done so in 2004. Voluntary SHI enrolment among informal sector workers and the families of formal sector workers in the Vietnam SHI stuck at around 20 per cent of the target group.[868]

There are many reasons for this inability to enrol citizens. Mills in her discussion of low-to-middle-income countries (LMIC) notes that 'inadequate resources tend to mean that arrangements are either not fully universal (for example, a substantial proportion of Colombia's population is still not encompassed by the compulsory and subsidised insurance regimes, and falls back on a publicly funded safety net), or co-exist with still substantial levels of exposure to out-of-pocket payments.' [869] Risk pools can be insufficient,[870] particularly as countries frequently have many different insurance schemes co-existing at the same time. As the idea of health insurance is often that 'what matters is not how a particular financing scheme affects its individual members, but rather, how it influences progress towards Universal Health Coverage at a population level'.[871] So the fragmentation of schemes may lead to some schemes being highly effective—but if this

[868] Adam Wagstaff (2010) 'Social Health Insurance Reexamined' *Health Economics,* Volume 19, Issue 5, pp 503–517.
[869] Anne Mills (2012) 'Health Systems in Low- and Middle-Income Countries' in Sherry Glied and Peter C. Smith (eds) (2012) *The Oxford Handbook of Health Economics*, Oxford University Press: Oxford, available online: http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199238828.001.0001/oxfordhb-9780199238828-e-3.
[870] She argues that this can be possibly countered through merging risk pools, such as in Costa Rica, but this can also be blocked by vested interests ('entrenched interests can, however, make this politically difficult to achieve, as in Thailand where legislation permits the merging of schemes but politically it is not currently being pursued'). Unfortunately this examination is beyond the scope of this thesis, but it remains a topic of some interest.
[871] Joseph Kutzin (2013) 'Health financing for universal coverage and health system performance: concepts and implications for policy', *Bulletin of the World Health Organization,* Volume 91, Number 8, pp 545-620.

high standard is not maintained nationwide, high levels of coverage nationwide are very difficult to achieve.

As well as the experience of countries reviewed above, and similar to the problems of rural China discussed in chapters 5 and 6, studies of urban insurance in China reveal difficulty ensuring access and enrolment. In the case of the 1999 urban health insurance package (a scheme organised through employers and the state, a scheme with a far more generous package than the rural package, in areas with much higher levels of formal employment), only 24 per cent of private sector employees and 50 per cent of state-owned enterprise employees enrolled in the new urban health insurance scheme.[872]

In the case of the NCMS it appears that poorer, rural China was far more successful than wealthier urban China in enroling citizens in the NCMS. This is in spite of having lower population density, poorer health facilities, less doctors and nurses and less public funds for health care.[873] International evidence[874] suggests that that people's ability to pay and willingness to participate or contribute to a social health insurance scheme are vital for sustaining health schemes (and health system). Previous chapters have shown that this support was lacking in the Chinese attempts in the 1980s and 1990s.[875] The reasons given for the lack of support included the high cost and low quality of services in health centres, a

[872] K Dong (2009), 'Medical insurance system evolution in China', *China Economic Review*, January.
[873] See Chapter 6 for the state of the Chinese rural health service at the beginning of the NCMS.
[874] Guy Carrin and Chris James (2005). 'Social health insurance: Key factors affecting the transition towards universal coverage'. *International Social Security Review* vol. 58, no. 1, pp. 45–64; World Health Organisation (2000) *The World Health Report 2000. Health systems: improving performance.*
[875] Yuanli Liu (2004), 'Development of the rural health insurance system in China', *Health Policy and Planning,* vol. 19, no.3, p.159.

lack of trust in the management of funds and the disincentives for the young and healthy to contribute.[876]

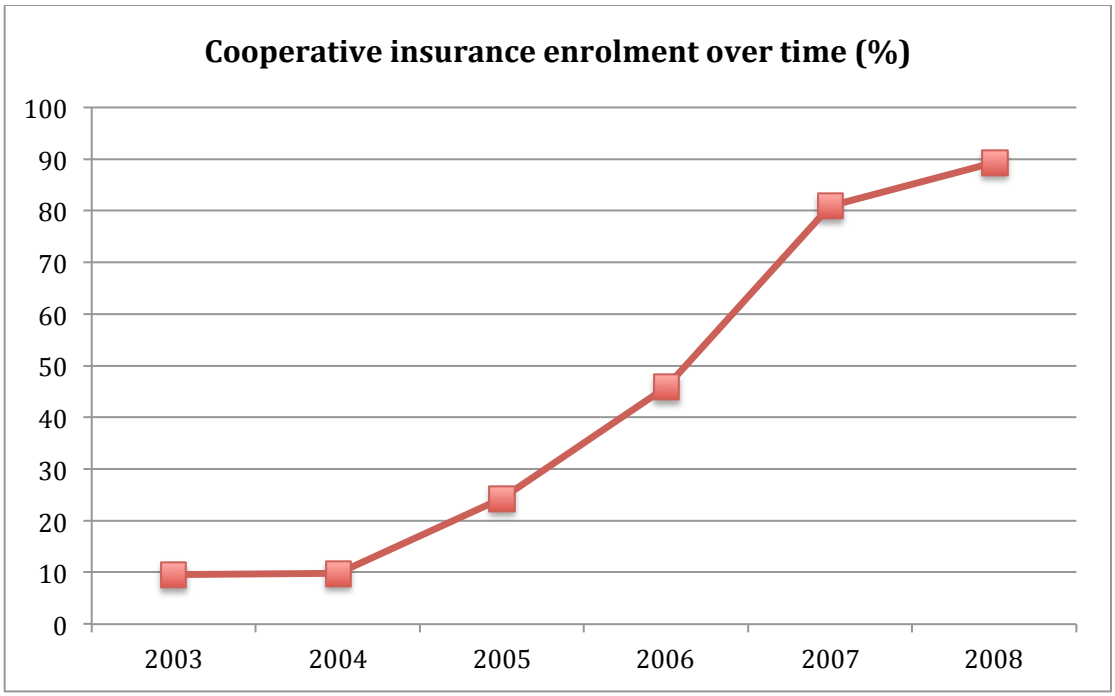
But, the implementation of NCMS appeared a success. Enrolment in the voluntary NCMS program in China was around 70 per cent in pilot counties.[877] Official reports of a Hubei trial noted, perhaps unsurprisingly, a satisfaction rate 'above 90 per cent'.[878] The State Council[879] and Premier Wen Jiabao both declared that they were 'happy with early progress'.[880] Initial concerns with the NCMS were mainly over the ability to reach enough citizens to encourage them to enrol; the next section will discuss the experience with the scheme in further detail.[881]

The successful uptake nationwide was a radical change from the first wave of SHI programs in the 1990s. Despite many flaws in the Chinese rural health care system,[882]

[876] Gerald Bloom and Tang Shenglan (1999) 'Rural health prepayment schemes in China: towards a more active role for government'. *Social Science & Medicine*, vol. 48 (7) p. 563.
[877] Wu Yi (2005) 吴仪：积极推进新型农村合作医疗制度健康发展, ('Wu Yi: Positively develop and progress the NCMS system building'), *Xinhua*, 15 September, available online: http://news.xinhuanet.com/health/2005-09/15/content_3492903.htm.
[878] Wu Yi (2005) 吴仪：积极推进新型农村合作医疗制度健康发展, ('Wu Yi: Positively develop and progress the NCMS system building') *Xinhua*, 15 September, available online: http://news.xinhuanet.com/health/2005-09/15/content_3492903.htm.
[879] See Wen Jiabao's speech to the State Council Work Meeting (no. 101, 2005); available online: http://www.sda.gov.cn/WS01/CL0056/10761.html; see also the official system response to this speech: Ministry of Health (2006) 关于加快推进新型农村合作医疗试点工作的通知 ('Notice on speeding up progress of work on NCMS trials'), directive number 13.
[880] Wen Jiabao (2005) 温家宝主持召开国务院常务会议， 研究加快建立新型农村合作医疗制度问题, ('Wen Jiabao holds a meeting of the State Council, discusses research on questions of speeding up the building of the NCMS system'), *People's Daily,* 11 August.
[881] State Council General Office (2004) 国务院办公厅转发卫生部等部门关于进一步做好新型农村合作医疗试点工作指导意见的通知, notice no. 3, contained in the State Council General Office. (2004) *List of official government notifications* (政府信息公开目绿) available online: http://www.gov.cn/xxgk/pub/govpublic/zzmlxz/200808/P020080814410885150159.pdf.
[882] The weak points of China's health system have already been covered by a number of comprehensive surveys. For a study of the specific time period in question, see for example: Gu Xin (2006) *诊断与处方：直面中国医疗体制改革*，社会科学文献出版社: Beijing (*Pathologies and cures: directly reforming the Chinese health care system,* Social Sciences Press: Beijing).

people still enrolled in the program and stayed enrolled in the program. The biggest jump came in the years between 2005 and 2007; by the end of 2007 the NCMS covered nearly the entire countryside.

Figure 17: Percentage of rural residents enrolled in cooperative insurance schemes in China 2003-2008



Source: Ministry of Health China Health Statistical Yearbook; Zhuanxing Institute(2012) 新农合作医疗：问题与展望，传知行社会经济研究所:Beijing, (*NCMS: Problems and Prospects*, Zhuangxing Institute Press: Beijing), pg. 3

The NCMS: unfunded, expensive, and surprisingly successful

This increase in enrolment was so surprising because the NCMS appeared to share a number of problems that had afflicted earlier health insurance schemes (see Chapters 5

and 6). Among these problems was that encouraging citizens to enrol put considerable pressure on the local state. Studies of earlier SHI schemes showed that state funding was essential. Party evaluations of the many studies into rural health insurance that occurred in the 1990s came to the conclusion that central and local government policy and financial support is 'completely indispensible (*wukehuo de)* for the success of any social health insurance scheme'.[883] A major problem was going to be preventing the schemes collapsing due to the state not providing adequate funds to capitalise the risk pool, or to cover the costs of administering the scheme.[884]

However, a major difference between the NCMS and the unsuccessful schemes examined in chapters 5 and 6 was that *counties* bore most of the responsibility for the management and administration of the new CMS funds,[885] and they were also held responsible for the management and administration of the new CMS risk pool mechanism. The mechanism for achieving this was through state management of the finances of the NCMS.

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[883] For example, Cao Pu (2010) '1978-2002：关于农村合作医疗存废的争论与实证性研究的兴起' ('The rise of empirical research and debate on the maintenance or abolition of rural cooperative health care') *Zhonggong Yunnan sheng weidangxiao xuebao (The Yunnan Province Study Journal of the Central Party School)*, vol. 4, available online: http://www.cssn.cn/shx/shx_shflybz/201310/t20131026_584601.shtml lists the findings of the Central Party School's four-year project into the failed post-Mao attempts to reinstitute the CMS.

[884] Or what was pithily called the 'start in spring, finish in autumn effect'; quote itself is based on the Hubei experiment, referenced extensively in last two chapters. See 叶宜德、汪时东、汪和平等 (2003)"新型农村合作医疗制度理论框架与指导原则编写研讨会"参考资料汇编，合肥科伟社会与卫生发展研究所, (Ye Xiande, Wang Shidong, Wang Heping et al (2003) 'NCMS system management framework and governing principles edited study and research theory', *Hefei Social Science and Health Development Centre*), volume 4 for an overview.

[885] Compare to the 1997 decision, which specified that individual contributions were to be the most important part of the decision: clause 11 of the 1997 decision for example argues that '筹资以个人投入为主，集体扶持，政府适当支持' ('fundraising will come from the individual first of all, with collective aid and government support') and that the major target of the cooperative program was township and village health centres (see clause 33). Compare this to the change in the 2002 decision which argued that "国家鼓励、支持农民巩固和发展农村合作医疗和其他医疗保障形式，提高农民的健康水平' ('the state will encourage and support rural people solidify and develop collective health insurance and also different insurance models in order to raise the health levels of the people').

The process itself remained highly 'top-down'. The central government—in a quest to improve social welfare and general health service provision—committed funds and issued targets to provinces. Provincial leaders were then able to set the parameters of the policy: they received transfer payments from the centre, set the subsidised drug list, and analysed hospital admissions, fiscal balances and fund payouts.[886] They were also expected to contribute to the NCMS fund as part of the 'local government' contribution.

Control over how the NCMS actually worked was left at the county level. The risk pool was maintained at the county. The central contribution was according to the county government's decisions in its annual budget on the sum of money raised and required. Central funds (including provincial funds) were only released once the county raised its own funds (through enrolling citizens) and showed evidence to the centre/province. This was achieved through the NCMS having a set account for contributions/joining fees.[887] The account itself was monitored and managed by the Ministry of Finance, which also set the annual budget and revenue targets for the fund.[888] So the county NCMS office (managed by the Ministry of Health county office) and the county NCMS accounts (managed by an office in the Ministry of Finance) were the two critical offices.

[886] Provinces could also undertake their own target setting and analysis, although they were usually unable to go below a 'floor' measurement imposed by the central government.
[887] The money is to be held with the local state-owned bank (usually the Agricultural Bank) or with credit trusts.
[888] The special account itself is supposed to have a 'strict financial management system, including special surplus/stockpile accounts; earmarked transfer accounts; separate cash and credit; daily clearance, monthly report accounts; receipts, special cards, task logging etc'.

The county head and/or delegate was held accountable for any failures in enrolment or any overspending.[889] NCMS funds can be paid in at any of the three levels of local health care provider, or any branch of the local bank and cooperative trust. The use of a specific bank account that is managed by the Ministry of Finance means that shortfalls in either revenue or enrolment can be reported instantly to the central level, making embezzlement of the risk pool difficult without local collusion.[890] The fact that funds needed to be in the account before the centre and the province paid out their contributions, with each level having to contribute money, provided an incentive for the local state to ensure that enrolment is high.[891]

There were downsides for the local state in these arrangements. One downside was that the NCMS did not seem to address problems raised in earlier trials.[892] Similar to trials in the 1990s, the new CMS fund payout was too small to make a significant dent in households' out-of-pocket spending. The NCMS was focused on inpatient costs, and participants still needed to pay for treatment up front, defeating one of the key reasons for having health insurance. The minimum level of financing per beneficiary represented only around one fifth of average per capita total health spending in rural areas.[893] Normally, this would be a possible disincentive to enrol, as the cost of care may not be lowered enough to

[889] Deputies were occasionally held accountable, but as Chapter 3 showed, deputies are members of the county standing committee, and the county Party secretary is held responsible for any mistakes of standing committee members.
[890] Not, obviously, that it was impossible.
[891] 刘华 (2007)*中国农村合作医疗制度研究,* 经济科学出版社: Beijing (Liu Hua (2007) *A Study of China's rural cooperative health system,* Economic Sciences Press: Beijing).
[892] Note that this also contradicts the theory of Wang Shaoguang, who argues that China's health insurance successes are due to the system 'learning' from earlier mistakes. Wang Shaoguang (2009) 'Adapting by Learning: The Evolution of China's Rural Health Care Financing', *Modern China,* vol. 35 no. 4, pp. 370-404
[893] Phil Brown, Alan de Brauw, and Yang Du (2009) 'Understanding Variation in the Design of the New Cooperative Medical System,' *The China Quarterly* vol. 198, pp. 304-329.

induce individuals to seek out health care services nor to prevent patients unable to afford the upfront fees from being turned away.[894] Patients in this sense could 'vote with their feet' by not enrolling, or could induce adverse selection effects by enrolling only in the years they thought they may have high sickness costs.[895]

Another problem raised in earlier trials was that of adverse selection. Similar to earlier health insurance trials, the NCMS made social health insurance enrolment totally voluntary for the individual. Voluntary schemes often faced problems of 'adverse selection'. [896] Adverse selection refers to the problem of information asymmetry in voluntary insurance contracts. The insurance buyer may know that he or she is likely to contract an illness, but the insurance provider cannot know that. As a result, the insurance scheme may end up enrolling high-risk members and face much higher costs.[897]

Studies of health insurance schemes prior to the NCMS note evidence of adverse selection. A number of studies on community health schemes have found that rural residents in China who are insured have both a higher probability of health care utilisation and higher costs per episode of care than their uninsured counterparts, controlling for

[894] For example, in one study, the median program reimbursed only 23–60 per cent of inpatient expenditures expensed at county-level hospitals, depending on the total bill. Such obligations can leave health care beyond the reach of many poor households.

[895] They are also less likely to engage in so-called 'advantageous selection' (see Liran Einav and Amy Finkelstein (2011) 'Selection in Insurance Markets: Theory and Empirics in Pictures.' *Journal of Economic Perspectives*, vol. 25, no. 1, pp. 115-38 for example).

[896] Kenneth J. Arrow (1963), 'The Welfare Economics of Medical Care', *American Economic Review*, vol. 53, pp. 941-973.

[897] Richard Zeckhauser (1970) "Medical Insurance: A Case Study of the Tradeoff between Risk Spreading and Appropriate Incentives," *Journal of Economic Theory*, vol. 2, pp. 10-26.

other factors.[898] A joint UNICEF and Ministry of Health study indicated that the elderly and the chronically ill have a higher probability of enrolling in the community financing schemes, compared with the young and healthy.[899] Wagstaff and Lindelow found that having insurance made it more likely that the recipient used health services, less likely that they used private providers, and more likely that the recipient went to a more expensive provider (often urban, or in a county capital).[900]

Given the voluntary nature of NCMS, the prospect for adverse selection is high. The government argued that it put a number of measures in place to obviate adverse selection. Participation was at the household, rather than individual level, forcing all members of a household to enrol in the NCMS in order that one member use the service. But this was true of earlier trials as well. To force the local state to encourage high enrolment, the central government mandated that it would only provide a matching contribution should 80 per cent of eligible households in a county be enrolled. But this put considerable pressure on local cadres to enrol local citizens, made the scheme far less voluntary, and put further pressure on the local state.[901] The NCMS office was also mandated to provide actuarial cost models and create varying treatment ceilings,[902] raising costs for the local

[898] Yuanli Liu (2004), 'Development of the rural health insurance system in China', *Health Policy and Planning,* vol. 19, no.3, p.159.
[899] S Hu (2000) *The 10 County Intervention Studies*. Paper presented at the International Seminar on Rural Health Care Financing, held by the UNICEF and Chinese Ministry of Health in Beijing on December 11–13, 2000. See also Liu et al, *op cit.*
[900] Magnus Lindelow and Adam Wagstaff (2005) *Health Shocks in China: Are the Poor and Uninsured Less Protected?* World Bank: Washington DC
[901] See Kobayashi and You (2009), *op cit.*
[902] 20,000 yuan in the eastern seaboard but 5000 yuan in the western areas

state, but theoretically reducing adverse selection. Finally, the NCMS had very high co-payment rates.[903]

Another possible explanation for the high enrolment rates in the NCMS (or in general) was that county leaders merely reported enrolment but did not actually enrol citizens. While this is impossible to disprove, it is illogical. High enrolment rates create obligations for local governments. These obligations were a disincentive for local leaders to 'fudge' enrolment data, in that manipulation of data creates further responsibilities and commitments for local leaders. Should local citizens be enrolled in social health insurance, they are likely to use it (and the local governments have to foot the bill). Within the NCMS scheme (2003 until the present), for example, there has been an enormous number of reimbursements to health insurance members — over half a billion by 2008. These reimbursements to citizens create obligations for the state; if citizens are listed as enrolled, they are able to access state services. Reimbursements thus cost money. This makes it unlikely that local leaders, on whose often cash-strapped budgets there were many calls, would allow false high enrolment statistics — as the citizens would use this to demand repayments for health services. Table 12 below shows the impact of this demand for repayment on the county government (who run the NCMS program); there were 76 million reimbursements for treatment in the first year alone.

[903]曹普(2014) *新中国农村合作医疗史*，福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p. 222

Table 12: An overview of the coverage of the NCMS, 2004-2008

Year	No. of counties	Enrolees (m)	Enrolment rate (%)	Total amount reimbursed (Bn RMB)	No. of reimbursements (m)	Ave. reimbursement (RMB)
2004	333	80	75.2	2.6	76	34
2005	678	179	75.7	6.2	122	51
2006	1,451	410	80.7	15.6	272	57
2007	2,451	726	86.2	34.7	453	77
2008	2,729	815	91.5	66.2	585	113
Source: China Health Statistical Yearbook various years table 12.2; Author's calculations						

The responsibility for mobilisation was delegated down to local governments by the centre. Organisation and work fees had to come from the local budget and not the risk pool. As central and provincial contributions were one-off contributions, shortfalls in the fund or the operating costs had to be made up by the county or township government. And the measurement process was more difficult than others to manipulate.[904] Hence, should local citizens not actually voluntarily sign up for the NCMS program, the local state was under enormous pressure to pay fees into the NCMS bank account to 'enrol' them.

Local governments were forced to provide an NCMS budget of RMB30 per capita, with the centre and province contributing around one-third of this baseline funding, and citizens contributing another third. Local governments were then allowed to contribute

[904] Obviously, this does not mean that it is impossible. But at least the funds have to be there should central or provincial inspectors come visit. For more on collusion and methods of avoiding such measures, see Zhou Xueguang (2012) 运动型治理机制：中国国家治理的制度逻辑再思考, 开放时代 ('Activities-based governance systems: the logic and thought of China's governance system', *Open Times),* issue 9.

extra funds should they have spare budget capacity. Thus, due to the participation of some relatively wealthy counties,[905] the overall total NCMS budget tended to be higher than the RMB30 minimum,[906] and this varied considerably with local income and coverage mode.[907] Later on, central government mandate progressively increased subsidies.[908]

Yet, even with increased subsidies, local governments still had to bear considerable cost to enrol citizens. [909] But there appeared a lack of administrative capacity to implement the program at the county level. To begin, health administration attracted a very small proportion of (already limited) public funds, as Table 13 below shows.

[905] Guangdong province kicked in an extra 9.1m yuan per annum, up to 37m yuan total by 2006. See 韩翠以 (2011) 广东省农村卫生人才培养现状及队伍发展对策研究, (Han Cuiyi (2011) 'A study of the development and counter-development of health personnel training teams in Guangdong province')Master's dissertation, Guangzhou Medical University, available online: http://cdmd.cnki.com.cn/Article/CDMD-10572-1011135584.htm

[906] In a World Bank study, 62.9 yuan on average in a sample of 189 counties from 17 provinces; Adam Wagstaff and Shengchao Yu (2007) Do health sector reforms have their intended impacts? The World Bank's Health VIII project in Gansu province, China, *Journal of Health Economics,* no. 26, pp 505-535

[907] *Ibid*.

[908] From 30 yuan originally, to 50 in 2005-6, to 300 today.

[909] See the work of Wang Yanzhong: 王延中(2008) '合作医疗30年的经验与教训', 中国卫生政策研究, (Wang Yanzhong (2008) '30 years of experimentation and training of cooperative health care', *China Health Policy Studies),* vol. 2.

Table 13: Share of funding for health services providers 2001-2003 (% of total health budget)

Year	Health Institutes	Medical Insurance	GIS	Food and Drug Institutes	Family Planning Institutes	Capital Investment	Health Administration	Others
2001	42.63	12.08	17.37	0.97	10.22	6.04	4.12	6.57
2002	42.01	17.62	10.08	1.98	12.63	5.11	4.92	5.65
2003	41.3	22.27	6.37	2.01	12.7	5.87	4.62	4.86

Source: Zhao Yuxin (2005), *Assessing Government Health Expenditure in China*, World Bank: Washington DC, p 33.

The introduction of a new scheme administered by the Ministry of Health covering the entire nation would be likely to increase these health administration costs enormously. For example, each household savings account — which around 80 per cent of pilots in the poorer Western and Central areas used[910] — only contains RMB8–10 per person annually. But managing these accounts greatly increases local government administration costs. Under the NCMS, the money for these costs would need to come from the county's general budget, as the health budget alone would not cover administration costs (as the next section will show more thoroughly). Cash-strapped counties would therefore have to forego other goals and priorities in order to implement the NCMS.

[910] Kobayashi and You (2009) *op cit.*

All of this evidence — studies showing that health insurance did not necessarily lower costs, and the fact that for peasants health insurance was not only voluntary but still required payment for treatment upfront — would normally indicate that, similar to the many trials in the 1990s, the NCMS may have suffered from problems with enrolment and with lower than expected risk pools. The NCMS program had a similar number of pilot counties as the 1997 scheme discussed in the previous chapter.[911] Yet, by the end of 2003, 69 per cent of eligible households had signed up in the NCMS pilot areas, rising to 75 per cent in 2004.[912] This enrolment was well above initial expectations.[913] Initial enrolment rates were around 70 to 80 per cent. This increased to over 90 per cent in 2007.

Problems with pilots

Provinces were told to choose four to five counties as pilots, each with around 2 million people, for initial enrolment, with the goal to expand that to 10 counties by 2004,[914] although in practice most provinces just chose 10 counties from the start. Perhaps due to the problems of funding noted above, early NCMS pilots were chosen according to the county's will, financial capacity, Ministry of Health administrative ability, and the

[911] Initially there were 304 counties, rising to 333 in 2004; compare this with the 350 counties for the 1997 scheme.
[912] At the end of 2003 coverage rate is 69% (9300/6450); whereas at the end of 2004 it was 75.2%; see for example the 2008 official white paper (Li Ruiqing (2008) 2008年医疗卫生绿皮书：我国"新农合"基本全覆盖 (2008 Health Green Paper: NCMS achieves basic universal coverage), Chinese government press release, available online: http://www.gov.cn/jrzg/2008-10/10/content_1116682.htm.
[913] For example, Guangdong province kicked in an extra 9.1m yuan per annum, aimed at a sum of up to 37m yuan total by 2006, and only wanted 60% enrolment.
[914] 曹普(2014) *新中国农村合作医疗史*，福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p. 212.

'commitment of government leading cadres (in local government) to ensuring high enrolment rates'.[915] In the early stages, a number of provinces[916] were designated as 'important' test areas; in other areas, provinces were allowed to choose the counties that implemented the NCMS. Early adopters were likely to have higher levels of income, capacity and political will,[917] although no mention was made at this earlier stage of how the NCMS would become a national program.

Table 11: NCMS pilot data 2003 by geographic region

Region	*GDP per capita*	*Per Capita rural income*	*Per capita local gov revenue*	*No of Pilot Counties*	*Participants (10,000)*	*Participation rate*
Total	2003	3284	66	282	8040	71.9
East	5162	5221	172	122	3361	69.5
Central	728	2756	35	88	2876	75.4
West	577	2179	12	72	1802	70.8

Source: Mao Zhenzhong (2005) 'Features and challenges of the rural new cooperative medical scheme', *China Health Economics*, vol. 24, no. 1, pp. 14-15.

The management costs of these pilots were significant. For example, the central Ministry of Health declared that the management cost of pilot counties paid by the finance departments of local governments in 2004 was RMB 85 million, or approximately RMB 1

[915] *Ibid,* p.223.
[916] Zhejiang, Hebei, Yunnan, Guilin were all designated as important (*zhongyao)* test areas.
[917] Lindelow M, Wagstaff A (2005) 'Health shocks in China: are the poor and uninsured less protected?' *Policy Research Working Paper*, World Bank: Washington DC; see more recently Julie Shi (2013) "Financial Protection of a Rural Health Insurance Program in China", Working Paper, Peking University School of Economics: Beijing, available online: http://econ.pku.edu.cn/upload/file/20140926/20140926161201311131.pdf

per capita.[918] And all of this money had to come out of the pre-existing funds of the pilot counties' general budget, as central government regulations forbid the use of funds from the NCMS to support management costs. In 2003, the first year of implementation of the NCMS, 91.7 per cent of the total government health appropriation for NCMS pilot implementation came from local governments.[919]

There is some evidence that these pilots were fiscally onerous for the county government; it is undoubted that early pilots were very conservative. For example, on expenditure, 10 per cent of the risk pool had to be put aside in advance, as per the regulations, but the county usually left far more money in the risk pool. Part of this may have been because of a lack of actuarial capacity — there are anecdotal reports that it was hard for participants and the county to forecast what the cost of treatment would be upfront.[920] But a greater part is probably because should the fund overspend on reimbursements, the county would have had to pay 80 per cent of the shortfall.[921]

So county governments often became more unwilling to spend even the funds in the risk pools they had raised through the NCMS. Poorer governments, concerned about budgetary shortfalls, were likely to contain costs and avoid overspending through designing very conservative plans that limited coverage and benefits.[922] The evaluation data for NCMS pilots undertaken in 2006, for example, shows that all areas only used around

[918] T Hu (2004), 'Financing and organization of China's health care', *Bulletin of the World Health Organization*, January, p.2.
[919] Kimberley Barbiaz (2012) 'China's New Cooperative Medical Scheme Improved Finances Of Township Health Centers But Not The Number Of Patients Served', *Health Affairs*, vol. 31, no. 5, pp. 1065-1074.
[920] Interviews: Gu Junshang; Ran Tao; Gu Xin; Beijing 2012.
[921] Zhuanxing Institute(2012) *新农合作医疗：问题与展望*, 传知行社会经济研究所:Beijing, (*NCMS: Problems and Prospects*, Zhuangxing Institute Press: Beijing), p.32.
[922] The author would like to thank Professor Christine Wong for this point.

three-quarters of their funds on reimbursing patients. Within this sample, the poorer areas also had much smaller average funds:

Table 12: Evaluation data for different NCMS pilots by geographic region 2005

	Fund usage as %	Ave fund per cap (RMB	State contribution %	Peasant cont %	Other %	Leftover from last year %
East	76.6	128.36	55.3	25.6	3	16.1
Centre	71.3	49.12	71.1	22.1	0.2	6.7
West	66.7	55.7	65	21	2.2	11.9
Total	73	74.7	61.5	23.7	2.1	12.8

Source: Xuedan You and Yasuki Kobayashi (2009) 'The new cooperative medical scheme in China.' *Health Policy*, vol. 91, no. 1, pp. 1-9.

Hence, it appeared likely that the NCMS would run out of money as it would be costly to the local state, and of less interest. Particularly revealing were the 2005 pilots (see Table 15 below), a period in which the poorer central and western regions ran far fewer pilots than the wealthier eastern regions.

Table 13: Number of NCMS pilots by geographic region 2004-2006

	2004 trials		2005 pilots		2006 pilots		total (end 2006)	
	Number	%	number	%	number	%	number	%
East	100	30	235	68	225	29	560	39
Centre	87	26	46	13	245	32	378	26
West	146	44	64	19	303	39	513	35

Source: Xuedan You and Yasuki Kobayashi (2009) 'The new cooperative medical scheme in China.' *Health Policy*, vol. 91, no. 1, pp. 1-9.

The structure of the NCMS as it stood in 2005 may have failed to offer the local state in the poorer central and western areas significant enough incentives to want to create a scheme (and to submit to the rules of the scheme after it had been initiated).

Henan as a case study

The case study of Henan province that follows adds provincial level data to the analysis. Henan is a relatively poor area by global development standards, and an average rural province by Chinese standards. Its GDP per capita is slightly below the Chinese national average.[923] Henan is an agricultural province, being China's third largest province in terms of total grain output, and is largely rural and heavily populated.[924]

More significantly in the context of this argument, the Henan provincial government has very little taxation income and low fiscal spending per capita, and hence also spends relatively little public funds on health care. Table 16 below provides a comparison of different provinces' rural population, fiscal capacity, and per capita spending on health care. It shows that Henan is the province with the largest rural population, the province with the lowest level of total fiscal funds available to spend per head (referred to below as

[923] About US$1,670, compared to the national average of US$1,740; National Bureau of Statistics (NBS) 2006, *China Statistical Yearbook 2006*, China Statistics Press, Beijing.
[924] 王丙乾(2009) 中国财政60年回顾与思考，中国财政经济出版社: Beijing, (Wang Bingqian (2009) *Reflections and thoughts on 60 years of China's fiscal governance,* China Fiscal and Economic Studies Press: Beijing), book 2, p. 704.

'fiscal capacity' per capita), and the province with the third-lowest level of public health care spending per capita.

Table 14: Comparison of spending across different provinces per capita 2004 (RMB)

Provincial level body	Revenue per capita	Transfers per capita	Total fiscal capacity	Health spend per capita
Henan	441	522	963	34.7
Anhui	426	560	986	33.9
Sichuan	442	634	1,076	38.7
Guangxi	487	632	1,119	44.4
Guizhou	382	741	1,123	50.1
Jiangxi	481	688	1,169	40.3
Hunan	479	702	1,181	28.1
Hubei	515	688	1,203	43.5
Hebei	599	634	1,233	51
Shandong	902	455	1,357	49.1
Chongqing	644	782	1,426	38.5
Gansu	397	1,095	1,492	52.1
Fujian	951	559	1,510	65.9
Yunnan	596	932	1,528	80.2
Sha'anxi	580	968	1,548	48.3
Hainan	697	955	1,652	66.4
Shanxi	768	895	1,663	66.4
Jiangsu	1,318	590	1,908	82.8
Jilin	613	1,334	1,947	62.8
Heilongjiang	757	1,226	1,983	61.8
Xinjiang	795	1,491	2,286	98.5
Guangdong	1,709	668	2,377	87.6
Ningxia	629	1,779	2,408	74.2
Liaoning	1,257	1,160	2,417	59.3
Zhejiang	1,708	776	2,484	111.8
Inner Mongolia	826	1,680	2,506	73.7
Qinghai	501	2,433	2,934	118.9
Tianjin	2,402	1,515	3,917	171
Tibet	365	5,065	5,430	204.1
Beijing	4,983	1,371	6,354	363.8
Shanghai	6,349	2,261	8,610	258.4

Source: Mao Zhenzhong (2006) *Health System of China Overview of Challenges and Reforms*. United Nations Health Partners Group in China working paper, Beijing

As we would expect in a province with very low public funds per capita,[925] Henan has a particularly low number of doctors per capita. Even for the most basic level of health care provider, the village doctor (who is often private and would be expected to be less affected by shortages of public funds), Henan has very low numbers by national standards.[926] Henan is also undersupplied with higher-level health care providers. The number of doctors in Henan hospitals is half of the nationally recommended number per thousand.[927] Finally, an analysis of the quality of the medical personnel in Henan province showed that it is very low, even by national standards. A 2006 study of doctors' educational levels carried out in conjunction with the Henan provincial Ministry of Health showed that 14 per cent of doctors in Henan had no formal schooling, and only 59 per cent went to any form of medical school.[928]

Henanese rural citizens see fewer doctors, and visit the hospital less, than other Chinese citizens.[929] Similarly, the China Health and Nutrition Survey showed that Henan rural citizens are 6 per cent less likely to seek treatment compared to farmers from other central

[925] Per capita public spending on health for rural residents by region ranged from 32.36 yuan in Guizhou to 266.52 yuan in Zhejiang; see Zengzhong Mao (2006). *Health System of China Overview of Challenges and Reforms.* United Nations Health Partners Group in China working paper, Beijing.
[926] 顾颜胜 (2011) 河南省卫生人力资源状况调查研究报告, (Gu Yansheng (2011) 'A report on an investigation into Henan's health care human resources') PhD Dissertation, Zhengzhou University, pp21-22 available online: http://cdmd.cnki.com.cn/Article/CDMD-10459-1011215733.htm. Note that Mr Gu was on loan from the Ministry of Health, and was given access to their data.
[927] Zhang, Z. (2005). 'Henan sheng xinxing Nongcun Hezuo Shidian Ceng Jizhao Diaocha Yanjiu (The investigation report of the base-line survey of the Experimental Counties of the New CMS in Henan)'. *Chinese Health Economics,* vol. 24, no.5, pp. 51-55.
[928] 顾颜胜 (2011) 河南省卫生人力资源状况调查研究报告, (Gu Yansheng (2011) 'A report on an investigation into Henan's health care human resources') PhD Dissertation, Zhengzhou University, pp21-22 available online: http://cdmd.cnki.com.cn/Article/CDMD-10459-1011215733.htm.
[929] 朱仙波 (2005) '事业单位财务制度改革分析', 河南职工医学院学报, (Zhu Xianbo (2005) 'An investigation into public service units fiscal system', Henan Workers Medical University Journal) number 4, pp 243-245.

provinces.[930] Studies of the reasons behind the apparent aversion to seeking medical treatment in Henan concentrate on an inability to afford health services. A 2005 study of responses to treatment of fungal illness in Henan by the Zhengzhou Medical Sciences University showed that following the onset of illness, the proportion of individuals who did not visit any form of medical facility due to economic factors was 45 per cent. When referred to a hospital, the proportion of non-hospitalisation due to low income was 87 per cent.[931] Another local Henan study argued that a lack of income was 'the major factor influencing the utility of being in hospital' and as a deterrent to the use of health services.[932]

So, in many ways Henan epitomises the structural problems of Chinese rural health care. It has low levels of funding. Funding shortages are then passed down to lower levels of government and affect the amount of government support given to facilities. Facilities are driven to raise fees, and yet the high price of medical care appears as a deterrent for farmers who wish to use medical facilities.

Yet, in spite of the apparently poor state of health care in Henan, people from the province joined the voluntary new CMS policy at a high rate.

[930] Wei Yang (2013) 'China's new cooperative medical scheme and equity in access to health care: evidence from a longitudinal household survey', *International Journal for Equity in Health*, vol 12, number 20.
[931] 曹鸿玮 (2006) '2005年郑州大学附属医院深部真菌感染病例分析', 郑州大学, (Cao Hongwei (2006) '2005 Zhengzhou auxilary hospital analysis of the spread of fungal infections', Zhengzhou University,) report available online: http://cdmd.cnki.com.cn/Article/CDMD-10459-2006143286.htm.
[932] 徐宛玲 (2013) '乡镇和社区卫生服务机构医生健康与压力现状调查', 现代预防医学, ('Xu Wanling (2013) 'An investigative study of physician health and stress in township, villages, and communities', *Modern Prevention Studies*), vol. 14.

Table 15: Enrolment in the New Cooperative Medical Scheme in Henan province, 2004-2008

	2004	2005	2006	2007	2008
Participants (10,000 people)	n/r	1118	3238	6102	7280
Up-take rate (%)	73.7	73.2	80.96	86.95	91.82

Source: Henan Government (2012) '2005-2011年河南省新农合发展情况' [2005-2011 report on the conditions and development of Henan province NCMS], Zhengzhou. [933]

What explains high NCMS enrolment in Henan?

The following section looks at a number of NCMS trials in Henan in an attempt to explain this high rate of enrolment in the NCMS.[934] Following the Central Committee's NCMS implementation decree in 2003,[935] the Henan government launched 18 NCMS pilot trials in the province. Three of these were then evaluated by the government.[936] The following section draws heavily on the documentation of those evaluations, and interviews

[933] Henan Government (2012) 2005-2011年河南省新农合发展情况 ('2005-2011 Henan NCMS situation'); Henan 2004 data from 李超 (2011) 河南省新型农村合作医疗不同阶段实施效果评价, (Li Chao (2011) *An evaluation of the effectiveness of different measures to implement NCMS in Henan),* Masters dissertation, Zhengzhou University, available online: http://cdmd.cnki.com.cn/Article/CDMD-10459-1011215864.htm.

[934] The following section uses budget data gathered from fieldwork in Henan province and Beijing, and data made available through Henan government websites or government contacts. While the provenance and veracity of these data were partially verified through interview, the responses were more of the 'yes, that looks right' variety, and I received no formal written verification of the data's veracity. As such, although many of these data are provided through official government yearbooks and data, the documents provided during fieldwork still need to be read carefully and each one is marked as such. Given the doubts on Chinese data, the aim of this section is to show that fiscal transfers and budget remissions in a major agricultural province did not appear to influence the enrolment the NCMS in the first few years of operation, rather than to prove some form of causation or causative relationship.

[935] Central Committee and State Council (2002) 关于进一步加强农村卫生工作的决定, 中发 (2002) 13号 ('Decision on advancing and quickening rural health care activities', Decree 13 (2002).

[936] 济源市、辉县市、卢氏县 (Jiyuan county, Hui county-level city, Lushi county); data taken from Henan government provincial investigation team (2004) 河南新型农村合作医疗试点工作成效显著 (2004 Henan government report on the effectiveness and operations of the NCMS pilots), available online: http://www.ha.stats.gov.cn/cms/cms/infopub/infopre.jsp?pubtype=D&pubpath=hntj&infoid=1224120933615598&templetid=1214216645885114&channelcode=A0620010101&userId=10002.

conducted during a lengthy period of fieldwork in 2008 and 2009 (and a number of follow-up visits) in Zhengzhou and Beijing.

These evaluations noted that, overall, despite some problems that should not be ignored, the NCMS was running 'efficiently' (defined by the state itself as meaning that 'enrolment rates were above 60 per cent, and the risk pool fundraising had been going more or less smoothly').[937] The crucial interest of the evaluations of the pilot counties was in the ability of the county to raise enough funds to create a risk pool.[938] Put simply, the major concern of higher-level governments (such as the central and provincial government) was that local NCMS schemes did not go broke.[939]

But, in spite of their clear concern over the maintenance of the risk pool, higher levels of government usually provided very little money to the counties to help with risk pool creation and maintenance. And county fee-raising became more problematic with the standardisation of taxes introduced under the *feigaishui* policy in 2004.[940] More typically, counties had to raise their own revenues through fundraising, fee levying or taxation.[941] In Henan, as Table 16 below shows, counties often bore the brunt of health care expenditures (and social service spending more generally).

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[937] *Ibid*, section 1, para 1, line 1: 农民参加率均超过60%，资金筹集基本顺利 ('Enrolment averaged over 60%, and fundraising was basically smooth').
[938] See Gu Xin (2006) '公共财政体系与农村新型合作 医疗筹资水平研究一促进公共服务横 向均等化的制度思考', 财经研究, ('The public finance system and the NCMS: pondering over a system of public equalisation to advance the equality of fundraising levels', *Fiscal Study*) vol. 32, no. 11, pp 37-47.
[939] *Ibid*, see also Zengzhong Mao (2006). *Health System of China Overview of Challenges and Reforms.* United Nations Health Partners Group in China working paper, Beijing.
[940] Raymond Yep 2004 'Can "Tax-for-Fee" Reform Reduce Rural Tension in China? The Process, Progress and Limitations', *China Quarterly,* vol. 177, pp. 42-70.
[941] M Liu, J Wang, R Tao, and R Murphy (2009), 'The political economy of earmarked transfers in a state-designated poor county in western China: central policies and local responses', *China Quarterly*, no. 200, pp. 973–94.

Table 16: Share of health care spending by level of government (as %), 2004

	National	Henan
Province	24	13
Municipality	34	30
County	42	52
Township	5	5

Source: Christine Wong and Achim Fock (2008) *China: Public Services for Building the New Socialist Countryside*, World Bank, available online: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2008/01/16/000020953_2 0080116091210/Rendered/PDF/402210CN.pdf

The Henan provincial government's 2004 assessment of its implementation of the NCMS shows that the majority of funds for the NCMS risk pool came solely from local sources (see Table 17 below).[942]

[942] Henan government provincial investigation team (2004) 河南新型农村合作医疗试点工作成效显著 (2004 Henan government report on the effectiveness and operations of the NCMS pilots), available online: http://www.ha.stats.gov.cn/cms/cms/infopub/infopre.jsp?pubtype=D&pubpath=hntj&infoid=122412093361 5598&templetid=1214216645885114&channelcode=A0620010101&userId=10002.

Table 17: Sources of NCMS finance 2004 by pilot county for Henan province

County	*Total rural population*[943] *('000)*	*Enrolled population ('000)*	*NCMS enrolment (%)*	*Higher-level state funding (m RMB)*	*Tax revenue (m RMB)*	*self-borrowed (m RMB)*
Hui	670	412	61.5	0	41.2	0
Jiyuan	445	334	75	12.5	0	89.5
Lüshi	304	257	84.6	42	25.7	0

Source: Henan Government (2006) *Henan NCMS evaluation documents* (河南新型农村合作医疗试点工作成效显著).

Table 17 above shows that each of these counties had relatively high enrolment almost instantaneously; even Hui county, with the lowest enrolment rate, still exceeded 60 per cent enrolment, a rate far higher than the international comparisons examined previously in the chapter. But each county had vastly different funding arrangements. Hui county used a 'tax' system, which was essentially public funding from the county at the RMB10 fee per enrolled person, without the provision of public funds from above for the NCMS program. In the case of Hui, this most likely reflects the contractual nature of its relationship with a commercial health insurance provider which Hui county paid to assist with implementation of the NCMS. Jiyuan, a city-level county,[944] received monies from higher level governments, but almost all of its risk pool funding came from borrowing. Lüshi county was the only county that appeared to have a somewhat 'normal' distribution

[943] *nonggongye*, or rural hukou work permit holders; whether or not they actually lived in the county was unable to be determined from the data provided.
[944] Chinese administrative classifications can occasionally be highly fluid; counties can act as municipalities, or cities for example. To mitigate this problem, the thesis uses the administrative rank of the area as the definition of the area (in other words, county-rank administrations are counties).

of funds — using both the funds from rural enrollees and from higher level governments to fund the NCMS pilot.

To put these 2004 data in context, they have also been matched with the Henan provincial budget for the following year (that is, the 2005 budget).[945] Table 18 below gives the data for these trial counties in per capita RMB terms. These data highlight that the wealthiest county — Jiyuan — is not the county with the highest enrolment rate. Perhaps unsurprisingly, Jiyuan, as the wealthiest of the counties, spent the most on the NCMS, as well as spending more on health care, social insurance, and receiving the highest amount of assistance funds. But it did not have the highest enrolment rates. Moreover, Hui county, which paid a private insurance company to enrol and manage participationin the NCMS on behalf of the county, has the lowest enrolment rate.

Table 18: Per capita budget/NCMS expenditure by pilot county for Henan province

	Pop (1000)	*Overall Expenditure (RMB)*	*Total Health (RMB)*	*Social Insurance (RMB)*	*All Assistance (RMB)*	*2004 NCMS enrol of eligible (%)*
Hui[946]	412	453	49	22	182	61.5
Jiyuan	334	1861	68	100	399	75
Lvshi	257	330	61	20	249	84.6

Source: Henan Government (2004) *Henan NCMS evaluation documents* (河南新型农村合作医疗试点工作成效显著)

[945] Data set provided to DPhil candidate during fieldwork, and matched with online materials from Henan provincial government. Available for replication purposes on request, with the condition of the source of original provision remaining anonymous.

[946] As part of Xinxiang city's trial program, Hui county outsourced parts of its program to the private sector for its pilot program (*zhongguo renshou*中国人寿); thus a private insurance firm was responsible for all reimbursements. Later sections discuss how this affected enrolment.

More significantly, as Table 18 above reveals, there do not appear to be the funds in the overall health budget for each county to allow the NCMS to function. The average recurrent expenditure on health per capita in Henan was RMB19 for 2003;[947] and this included health care spending in the better-funded urban areas. And, as Table 19 below shows, Henan did not spend significantly extra money on health care in 2004, nor 2005. Nor is there evidence of a large increase in funding for administration.

Table 19: Henan budget data for 2003-2008 (all units 100m RMB)

	Revenue	Expenditure	Culture, Science, Health, Education	Admin	Social Security
2003	338.05	716.60	188.27	83.10	53.69
2004	428.78	879.96	220.81	97.43	62.88
2005	537.65	1116.04	270.22	120.96	67.97
2006	679.17	1440.09	362.82	271.08	209.65
2007	862.08	1870.61	523.51	355.71	281.22
2008	1008.90	2281.61	661.40	406.59	330.23

Source: Henan Government (2009) Henan Statistical Yearbook (Henan tongji nianjin 2009), Table 17.11

According to NCMS regulations, the mandatory amount of funding per enrollee was RMB 30; only Jiyuan county managed to allocate this amount (just). And, given that legally the funds for NCMS risk pool were unable to be used for administration, none of the

[947] A Fock and C Wong (2008), *Financing rural development for a harmonious society in China*, World Bank Policy Research Working Papers, no. 4693 (January), The World Bank: Washington, DC.

counties had any sort of budget for enrolling, managing, or building any of the NCMS infrastructure.[948] It is difficult to imagine how an organisation could enrol 412,000 people in the scheme in a geographically dispersed rural county in eight months without paying a cent.

An analysis of the political records of the Henan Ministry of Health tells a similar tale. Henan Ministry of Health documents record very little interest in implementing the NCMS, or even very little interest in claiming credit for implementing the NCMS. According to a 2007 assessment of Henan Ministry of Health's implementation of its centrally assigned tasks, the provincial branch fulfilled its tasks 'smoothly and successfully',[949] with 'more than 90% of its goals achieved'.[950] But none of the ministry's tasks included running or implementing the NCMS. Indeed, the only NCMS-related activity (for which the centre transferred money) was the training of 3,000 inspectors who could go and inspect the NCMS offices of different counties and townships; the major programs funded were, as per 2002 central Ministry of Health priorities, disease control and prevention stations, a medical emergency response system, and AIDS prevention programmes (a particular problem in Henan, where there was a major breakout of HIV infections due to the reuse of single use needles for blood transfusions).[951]

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[948] A similar conclusion was reached in Zhao Yuxin (2005), *Assessing Government Health Expenditure in China*, World Bank: Washington DC, p 19. Note that this was using official data provided to the World Bank by the Ministry of Health (as the partner in the study).

[949] 文明琴 (2007) 中央补助地方公共卫生专题资金项目在河南省的实施情况绩效评价， 河南省邓州市第一人民医院: Zhengzhou (Qin Wenming (2007) An appraisal of the effectiveness of measures to transfer central subsidies for local public health into special funds and projects in Henan province, Henan Zhengzhou City Number One People's Hospital: Zhengzhou).

[950] *Ibid,* para one

[951] See the overview in Henan Government (2009) 新中国60年河南卫生事业健康发展 ('New China 60 years of health care development activities in Henan'), available online: http://www.ha.stats.gov.cn/hntj/zwgk/ztxx/xzglsn/A0610072oindex_1.htm

The conclusion that there was a lack of state funding (be it from the Ministry of Health, or from the central/local government) is inevitable. This is because NCMS rules state clearly that funds raised from household participation in the NCMS were unable to be used for any form of NCMS administration or implementation.[952] And, to ensure that the localities fulfilled these promises as outlined in central reports, the central government Ministry of Finance also passed a decree mandating that all counties follow central transfer regulations for all health care funds.[953] So, even should there have been major, unannounced transfers from the centre that did not show up on the provincial budget, counties would have been unable to use the transfers for any administration or other fees.

Under China's budgetary system, the 'expenses for performing health administration and supervision function of health administration and supervision agencies at each level are appropriated by the fiscal department at the same level.'[954] While it is possible that the centre may transfer monies to the individual counties to run the NCMS without going through provinces or municipalities, it would contradict central regulations. It would also contradict Henan budgetary law; as Henan is one of seven provinces following direct

[952] State Council General Office (2003) 国务院办公厅转发卫生部等部门关于建立新型农村合作医疗制度意见的通知, 国办发3号, (('State Council General Office notice to Ministry of Health and other ministries regarding the opinion on building the NCMS system', Decree no. 3) clause 3.1 available online: http://www.gov.cn/zwgk/2005-08/12/content_21850.htm.

[953] See Ministry of Finance and Ministry of Health (2004)中央补助地方卫生事业专项资金管理暂行办法的通知, 财社［2004］24号 ('Notice on provisional measures regarding central transfers for health care work into special funds', 2004 Minstry of Finance Decree no. 24). A provincial version can also be seen at the Henan Ministry of Finance: http://www.hncz.gov.cn/sitegroup/root/html/ff8080812cf3df51012d0172ec1701dc/20101226181563278.htm.

[954] Zhao Yuxin (2005), *Assessing Government Health Expenditure in China*, World Bank: Washington DC, p 4.

'province-county' budget line reporting and management.[955] Under this system, all county-level inflows and outflows must be reported directly to the province (rather than the municipality), and hence any transfers from the centre would be monitored and reported by the province in their budget statements.

If the money for implementation did not come from the state, or come from state funding for other health care programs, then the money must have been provided by other parts of the local state budget. But there is a total absence of any form of budget line regarding some form of earmarked transfers for the NCMS program, as well as an absence of any form of budget line that would allow the province to contribute to the building of risk pools, and there were no monies specifically allocated to be transferred down to the counties in order to aid with the rollout and implementation of the NCMS (as opposed to other centrally mandated programs such as the 'tax for fee' reform *feigaishui,* for example).[956]

The funding responsibility for the NCMS implementation was for a large sum of money. Exact costs are unavailable, but earlier attempts to introduce risk pools (for much smaller programs with far less coverage), required approximately RMB300,000 in salary cost per county just to undertake fund management, not to mention the costs of institution

[955] Wen Wang, Xinye Zheng and Zhirong Zhao (2011) 'Fiscal Reform and Public Education Spending: A Quasi-natural Experiment of Fiscal Decentralization in China' *Publius,* vol. 42, no. 2, p. 334
[956] Henan tongji nianjin 2009, table 17.11. This was matched with an Excel copy of the Henan budget, provided to DPhil candidate during fieldwork, available on request.

and enrolment.[957] A review of Henan contracting experiences estimated that a municipality would employ over 500 people managing the NCMS, at the cost of around RMB10m.[958]

In essence, each county in Henan was motivated to find around RMB10m to spend on a program that the provincial Ministry of Health was not pushing, that was not funded by higher-level authorities, and that local governments were not allowed to impose fees on citizens to run. So, while it is impossible to rule out completely, it is most unlikely that Henan local governments received any funds to implement the NCMS. Yet, even from the start, these local governments were able to enrol hundreds of thousands of local citizens. While local governments were allowed to contract out some services to insurance companies,[959] they were held responsible for the provision of services, for the creation of risk pools and for the maintenance of funds. And even in areas where local governments contracted out services, the county enrolled citizens far more efficiently,[960] and, official reviews argue, implemented the NCMS program far more effectively than their private sector counterparts.[961]

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[957] '2001年之前，全市农村大病医疗统筹的年度人力成本为320万元' (prior to 2001, average personnel funds per annum for major disease funds were 320,000 yuan). (Note: in the municipality involved there were 9 counties of average size). See the China Insurance Regulatory Commission's 2005 report on the NCMS: CIRC (2005) 关于保险业参与新型农村合作医疗情况的函, 保监厅函152号 (Documents on social insurance enrolment and the NCMS situation, Regulation office document number 152).

[958] Moreover, the government sector is often an expensive provider of public services in parts of China — the same review estimated that the private provider would be able to provide the same service for around 3m yuan.

[959] CIRC (2005) 关于保险业参与新型农村合作医疗情况的函, 保监厅函152号 (Documents on social insurance enrolment and the NCMS situation, Regulation office document number 152), section 2, paragraph 2.

[960] *Ibid*.

[961] A Henan review of this contracting model concluded that in sample counties (up to end 2004, reviewed 2005), government financial support was insufficient, and that the government was unable to control drug prices enough in order to make contract models work; thus the review recommended that the government funded model was the only one that could be used. Moreover, in the limited data we have available, the private sector contracted out model enrolled a *lower* percentage of eligible citizens than the full state provision model (Hui County enrolment and management was done through the private sector as part of a trial program).

This is only one case study at the provincial level. That said, this 'magic pudding'[962] funding and enrolment effect can also be seen in the work of Sun Xiaoyun in Shandong province,[963] and in the work of Gu Xin in Chongqing provincial level city.[964] Gu noted that as any transfer for the NCMS would be a matching transfer, and would not account for how geographically dispersed a region is (and thus how difficult it is to administer), local governments with a high proportion of rural citizens and with less fiscal capacity would bear heavier levels of financial responsibility for the NCMS. Gu saw this as only being able to be fixed through greater levels of transfers from central and provincial governments. His research in Chongqing (also undertaken using provincial budgetary data) showed that even in very poor counties, very little fiscal support came from central or local governments.[965]

Gu's research findings complement the argument that Henan has very limited health budget to spend on the NCMS, and is likely to be disadvantaged heavily in implementing the NCMS. The experience of Henan appears to validate the claims made throughout the thesis — that while the health provision system appears to have structural flaws, and local government appears to lack funds, local citizens still enrol very strongly in some health

[962] The pudding is a magic one when, no matter how much you eat it, always reforms into a whole pudding again — see Norman Lindsay (1917) 'magic pudding', entry in the *Oxford English Dictionary*, available online: http://www.oxforddictionaries.com/definition/english/magic-pudding.
[963] Xiaoyun Sun (2007), Community Health Financing in Rural China: The New Cooperative Medical Scheme and Its Impact on Health Care Provision and Financial Protection, PhD dissertation, Australian National University.
[964] Gu Xin (2006) '公共财政体系与农村新型合作 医疗筹资水平研究一促进公共服务横 向均等化的制度思考', 财经研究, ('The public finance system and the NCMS: pondering over a system of public equalisation to advance the equality of fundraising levels', *Fiscal Study*) vol. 32, no. 11, pp 37-47.
[965] *Ibid*.

insurance schemes and not others. Current theories of health systems and health insurance up-take rates do not offer a logical explanation for this phenomenon.

The question, though, remains: where did the money and the motivation for this efficient implementation of NCMS come from?

As a government program, and given the many laws and regulations highlighted above, the money clearly came from the counties themselves using general budget funds. For local governments, there was the possibility of using medical assistance funds and emergency medical funds to pay for NCMS. They could also borrow money, as the case study above shows. Or local governments could appropriate funds from other budget lines. But the conclusion that county leaders needed to find their own funds (and rob other programs) to pay for the NCMS appears inescapable.

The NCMS: different governance system, different results

The NCMS appeared to suffer from a number of governance problems. Morover, there appeared a lack of central government commitment to supporting the NCMS, even in the central Ministry of Health. While there were major health policy promises made from 2003 to 2005; none of these promises related to the NCMS. To wit, from 2002 to 2005,

according to the Premier's National People's Congress report,[966] the major projects for central and local governments were to:

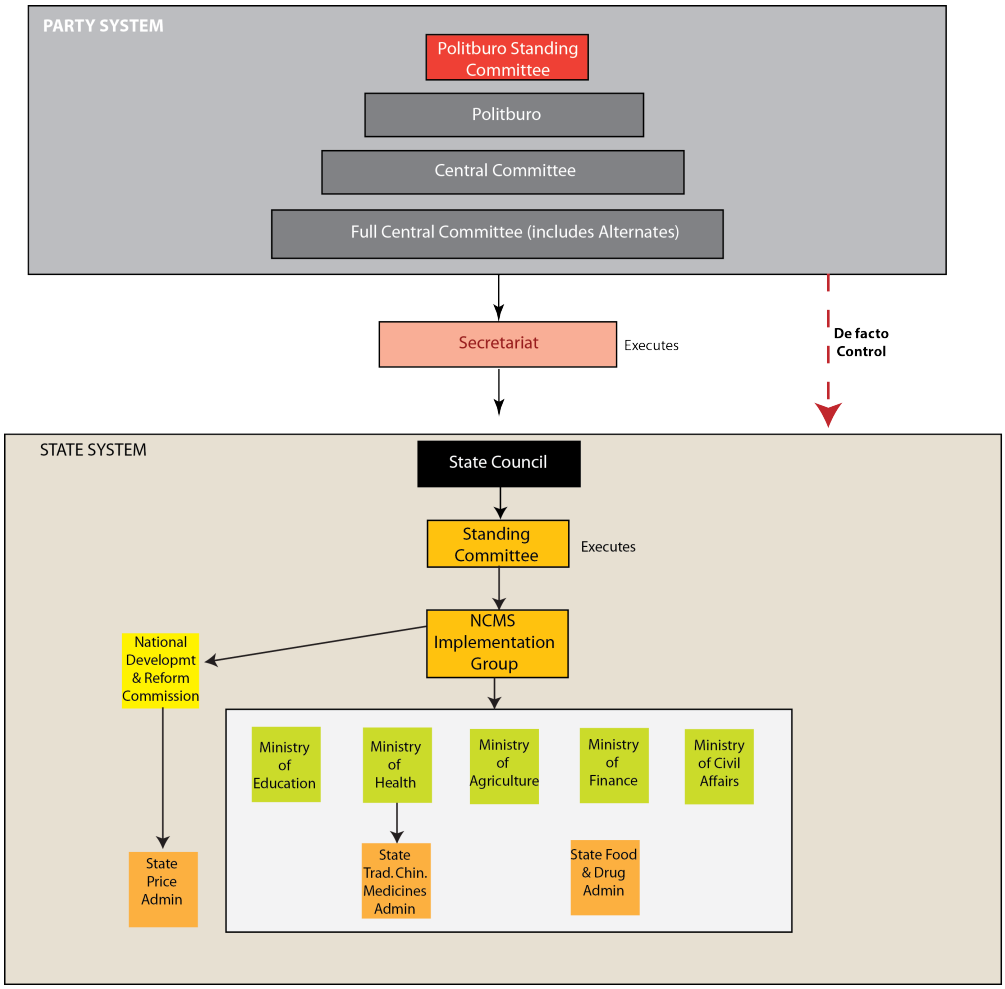
1) establish a disease prevention and control system following the 2003 SARS crisis[967] (RMB10.5b);
2) establish an emergency response system for health care (RMB16.4b); and
3) support health clinics in towns and townships (see above) in the central and western regions (RMB3b).[968]

There were not only very few funds allocated for the NCMS, but it was also considered a second-order issue for the central government. NCMS enrolment was seen as largely a result of improvements to the health sector at large. The 2005 National People's Congress report for example, noted that the central government would be committing RMB20b (including the RMB3b noted above) to 'upgrading medical equipment' and 'renovating hospital buildings in towns and townships and in some counties' and that this may also help the NCMS coverage.[969] The Henan government 'Health Care Strategic Plan' for example made clear that the strategy for the Henan NCMS was to build further facilities to encourage local residents to more actively and voluntarily wish to join the NCMS.[970]

[966] Hongman Wang (2005) *Healthcare System in Rural China — Challenges and Opportunities*. Presentation given at the Centre for Strategic and Independent Studies, Washington DC 2005. Available online: https://csis.org/files/attachments/060501WHM%20Presentation.pdf.
[967] See Tony Saitch (2006) 'Is SARS China's Chernobyl?' in Arthur Kleinman, James L. Watson (eds.) *SARS in China: Prelude to Pandemic?* Stanford University Press: Stanford.
[968] Wen Jiabao (2005) 温家宝主持召开国务院常务会议，研究加快建立新型农村合作医疗制度问题, ('Wen Jiabao holds a meeting of the State Council, discusses research on questions of speeding up the building of the NCMS system'), *People's Daily,* 11 August.
[969] Hongman Wang (2005), *op cit.*
[970] Henan strategic plan document provided to DPhil candidate during fieldwork; a copy is available on request and will be lodged in the Bodleian Library.

From the perspective of the state, the NCMS was also highly fragmented. An examination of the central institutional structure of the NCMS implementation team shows the many interests that had to be coordinated. To mediate these different interests, the Party formed a central coordination unit in the State Council under a member of the State Council Standing Committee (Wu Yi).[971] Figure 18 below describes.

Figure 18: Central NCMS implementation structures



Source: Author's research and schema

[971] The Small Group was then added to in 2005 — see Wu Yi (2005) 吴仪：积极推进新型农村合作医疗制度健康发展, ('Wu Yi: Positively develop and progress the NCMS system building'), *Xinhua*, 15 September, available online: http://news.xinhuanet.com/health/2005-09/15/content_3492903.htm.

Each of the actors was to play a specific role in the NCMS as follows:

National Development and Reform Commission (NDRC): The NDRC decides resource allocation and approves developmental projects. It was to ensure that NCMS targets were also included in economic and other plans, to promote development, and to ensure drug supervision.

Ministry of Education: Responsible for medical education, and for training in the NCMS.

Ministry of Health: Formulates individual health policies, manages the New Cooperative Medical Scheme in conjunction with local governments and controls state health facilities through negotiations with managers.

Ministry of Agriculture: Promotes the NCMS and monitors how much of the county's risk pool had been used (should the local NCMS use the Agricultural Bank to establish its special account — see below).

Ministry of Finance: Monitors budgets, expenditures and project costs. It was also tasked with auditing risk pools, including counting the number of participants in the scheme and the amount contained in the NCMS account and reporting back to Beijing Ministry of Finance. This was used to calculate the amount of central government contribution transferred to the provincial government by the centre, including extra contributions for the western and central region.

Ministry of Civil Affairs: Controls relations with NGOs, including NGO health providers. Also manages the Medical Assistance Scheme, the major focus of the 2002 reforms. Poverty Alleviation offices of the Ministry were responsible for the specialist poverty funds, which were rebated back to the county Ministry of Finance should a participant enrol.[972]

State Price Administration: Mandates the prices of health treatment (including drug prices). And reports to the NDRC.

[972] 曹普(2014) *新中国农村合作医疗史*，福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p.211

State Traditional Chinese Medicine Administration: Responsible for all policies regarding Traditional Chinese Medicine (including drug prices). Reports to the Ministry of Health.

State Food and Drug Administration: Administers laws, policies and regulations on pharmaceuticals. At this time, also reported to NDRC.

Given these different interests, it would appear that the NCMS program would be difficult to implement effectively. It is unclear where the responsibility for executing many of the elements of the scheme lies, there are a number of different responsibilities at different political levels, and there are a number of principal-agent problems of measurement, verification and enforcement on any of these metrics. There is also a problem — as discussed in Chapter 6— with the possibility of conflicts between central agencies making any policy change unsustainable.

Despite being the official ministry in charge of the NCMS at the central level, the Ministry of Health itself did not appear to make NCMS implementation a priority target. According to the 2007 health assessment targets,[973] Ministry of Health county offices only had to carry out occasional 'sample measurements' of NCMS enrolment, compensation rate and risk pool usage, and these measurements were passed up to the Ministry of Health office the level above. The targets were only three of some 215 measurements, and none of the NCMS targets were listed as 'priority' targets for the Ministry of Health.[974] Only the county government had the incentive — in the sense of being measured, held accountable

[973] 国家卫生统计指标体系（2007版) (National Health Statistics, Targets and Structures (2007 edition); provided to DPhil candidate during fieldwork, and matched with online materials from Ministry of Health national government. Available for replication purposes on request, with the condition that the source of original provision remains anonymous.
[974] *Ibid.*

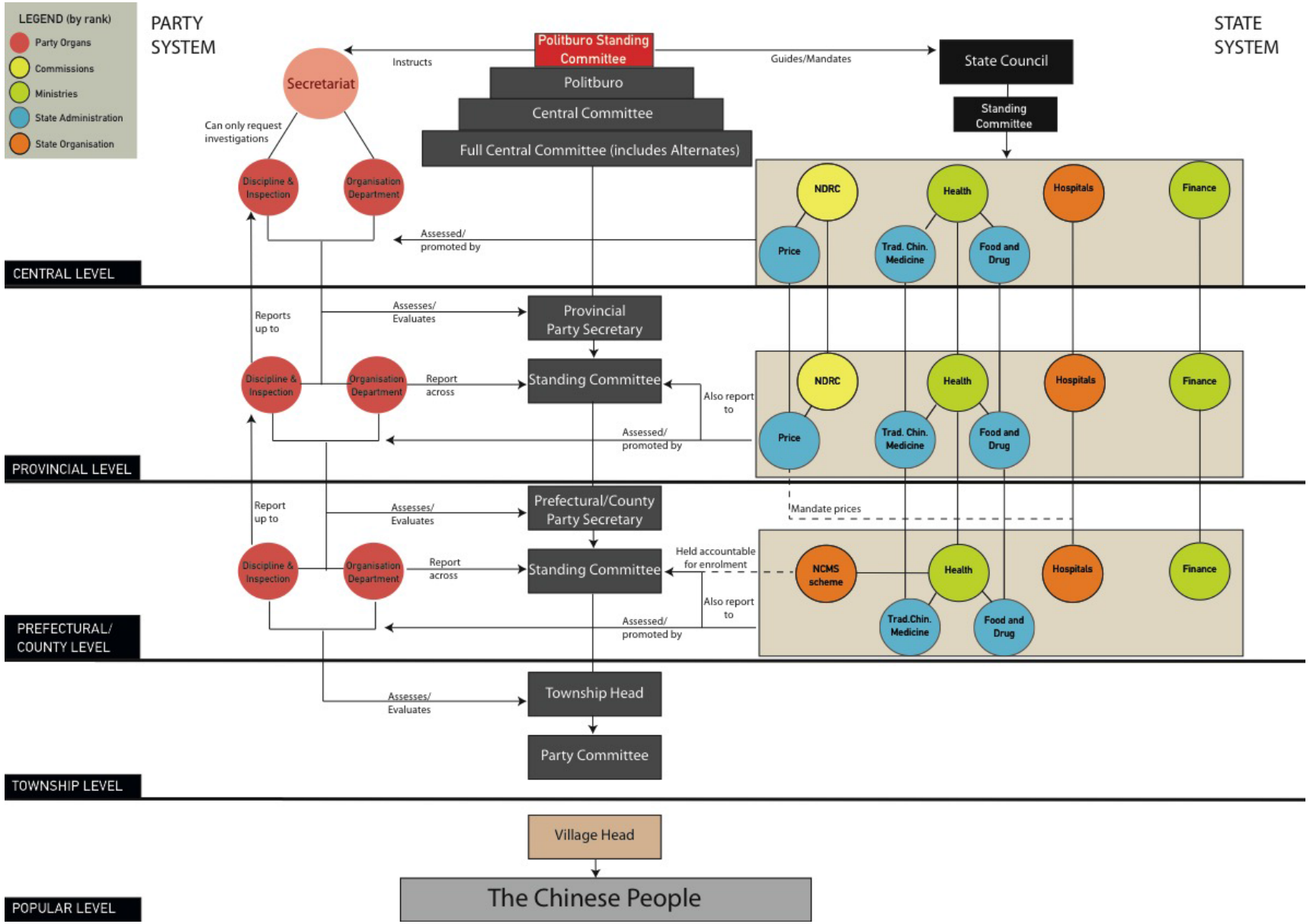
and possibly promoted — to make enrolment high, whereas those incentives did not appear present within the Ministry of Health.

As the county leadership was held responsible for any of these problems in the NCMS, there was a powerful incentive to mobilise the county political system to ensure that all the money was accounted for, and that the local state was meeting its enrolment goals. This incentive forces the local state to use pre-existing 'mobilisation' structures. The local leader (and only the local leader) could attach responsibility for 'mobilising farmers to enrol' to the Family Planning office. This meant that NCMS enrolment targets could be met along with family planning targets. As one body of literature shows comprehensively, the local state faced intense pressure to meet family planning targets.[975]

The shift of the institutional settings associated with the NCMS to the county level was different from previous SHI schemes, where the administration and risk pool (and accounts) had been kept at lower political levels.[976] Previous SHI risk pools had been based at the village or equivalent political level. In the NCMS, the county was responsible for coordinating all the different interests, and assuring 'patient input'. None of the previous SHI schemes had the same political imperatives driving enrolment as did the NCMS. As Figure 19 below shows, the NCMS was attached closely to the county standing committee.

[975] Zhao Shukai (2012) '地方政府公司化: 体制优势还是劣势?' 文化纵横, ('Local government corporatisation: system superiority or vulnerability?', *Cultural Review*), vol. 2.
[976] See Chapters 4 and 5, and also Yuanli Liu (2004), 'Development of the rural health insurance system in China', *Health Policy and Planning,* vol. 19, no.3, p.159.

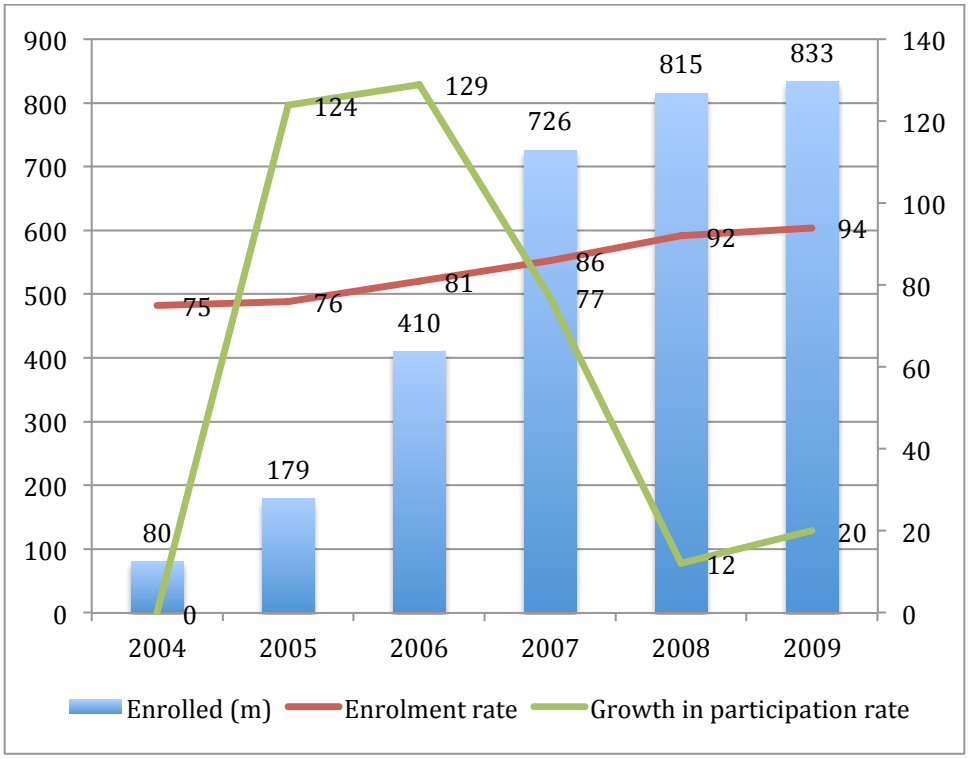
Figure 19: China's New Cooperative Medical Scheme pre-2005



The NCMS as a Party program, rather than a health care program

The NCMS was aided significantly in becoming a national policy, however, by its key metrics becoming a critical part of a completely different system unveiled formally in 2005. Rural health insurance reforms began to be prosecuted under the banner of other Party reforms — specifically the move to 'build a new socialist countryside' (*jianshe xinxing shehuizhuyi nongcun*). As noted earlier, NCMS reforms were first described in a 2002 Central Committee decree, and a (less authoritative, but still important) State Council circular subsequently put an implementation structure put in place. But the NCMS scheme was still in the national pilot stage in 2005, when county secretary's success in ensuring high NCMS enrolment was included in the building a new socialist countryside program. As this was run by the Party, and held Party secretaries at the relevant levels directly responsible, it was an even more important program — thus NCMS enrolment received a huge boost (see Figure 20 below).

Figure 20: NCMS enrolment growth, 2004-2009

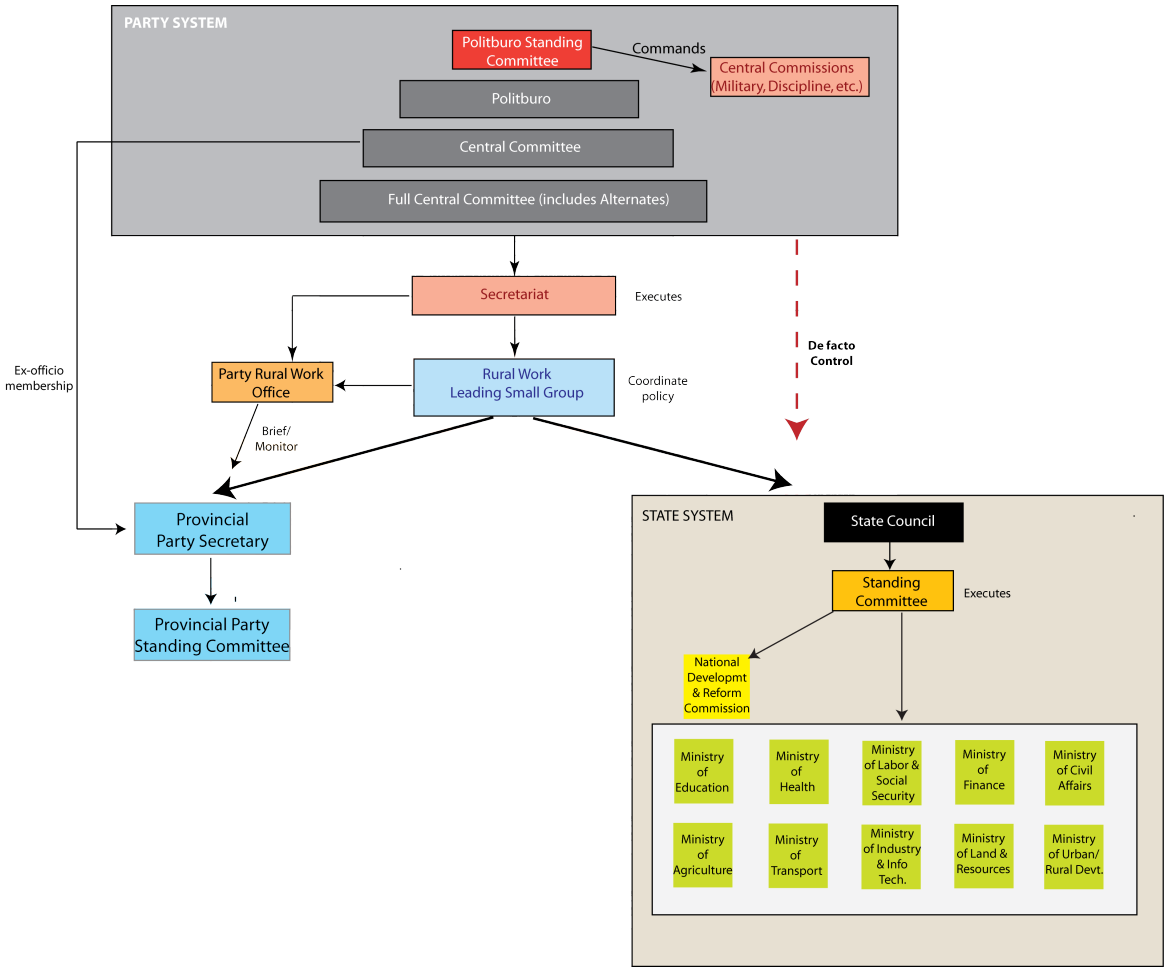


source: China Health Statistical Yearbook (2012), available online: http://tongji.cnki.net/overseas/engnavi/HomePage.aspx?id=N2012030035&name=YSIFE&floor=1

The NCMS was absorbed into the package of reforms unveiled as President Hu Jintao's 'new socialist countryside' announcement in 2005.[977] The building the new socialist countryside program solved the problems of coordination and control that had previously plagued health governance through political structures. Figure 21 below shows the political organisation and accountability methods used for the central structures of the program to Build the New Socialist Countryside (implemented in 2005).

[977] The policy was announced in late 2005 at the Party Plenum and then approved as a policy at the National People's Congress in March 2006.

Figure 21: China's building a new socialist countryside central governance structure



Source: Author's own analysis and schema

As Figure 21 above shows, the Party took control of the implementation of the building the new socialist countryside, and it became a national program of considerable importance. Moreover, the Party took control of building the new socialist countryside at all political levels. Following the initiation of the new socialist countryside program, a special Leading Small Group (LSG) for the implementation of the policy was instigated.

The whole system became far more coordinated. There was also greater control over the local level.

The goals of the new socialist countryside program were 'to reduce the rural-urban income gap, stimulate agricultural production, and improve rural public goods provision.'[978] Hence, as Ahlers and Schubert argue, the new socialist countryside program 'did not necessarily refer to the formulation and implementation of specific projects. It meant much more the comprehensive development of a new rural society, including education, public sanitation, social welfare and measures to increase the rural income, that is, a complex setting which had to be negotiated between the relevant departments.'[979] Thus, it became a sort of umbrella policy, under which a wide array of other policies were framed.[980] More importantly, this umbrella policy became the highest Party priority.[981]

What is more significant is that the creation of the umbrella policy created a disciplining and coordination mechanism for the policies of the new socialist countryside at the central level. As Figure 22 below shows, this acted to elevate the new cooperative medical scheme (NCMS) policy so that it was overseen and implemented by more senior members of the Party than any other policy.

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[978] Kristen Looney (2012) 'The Rural Developmental State: Modernization Campaigns and Peasant Politics in China, Taiwan and South Korea', unpublished PhD dissertation, Harvard University.
[979] See A L Ahlers and G Schubert (2009) 'Building a New Socialist Countryside"—Only a Political Slogan?' *Journal of Current Chinese Affairs*, vol. 38, no. 4, p. 41.
[980] See Gunter Schubert and Anna L Ahlers (2012) 'County and Township Cadres as a Strategic Group: "Building a New Socialist Countryside" in Three Provinces.' *The China Journal*, vol. 67, no. 1, pp. 67-86.
[981] See the introduction of the NDRC's overview on the new socialist country side: 李剑阁 (ed.) (2009) 中国新农村建设调查, 上海远东出版社:Shanghai (Li Jiange (ed.) (2009) *A survey of China's building the new countryside,* Shanghai Yunhai Press: Shanghai).

As Figure 22 also shows, the Ministry of Health was unlikely to have been a major force pushing high enrolment in the NCMS due to its marginalized position in the structure of the 'building a new socialist countryside' system. And, as the figure also shows, following the initiation of the new socialist countryside program, a special LSG for the implementation of the policy was created to ensure that there would not be communication or coordination problems at the central level. More importantly, the creation of this 'umbrella' group (the LSG) to oversee the 'building a new socialist countryside' program also created a disciplining and coordination mechanism for policies at the local government level. This, I argue, was key to explaining why the NCMS system had such great success in enrolling local citizens.

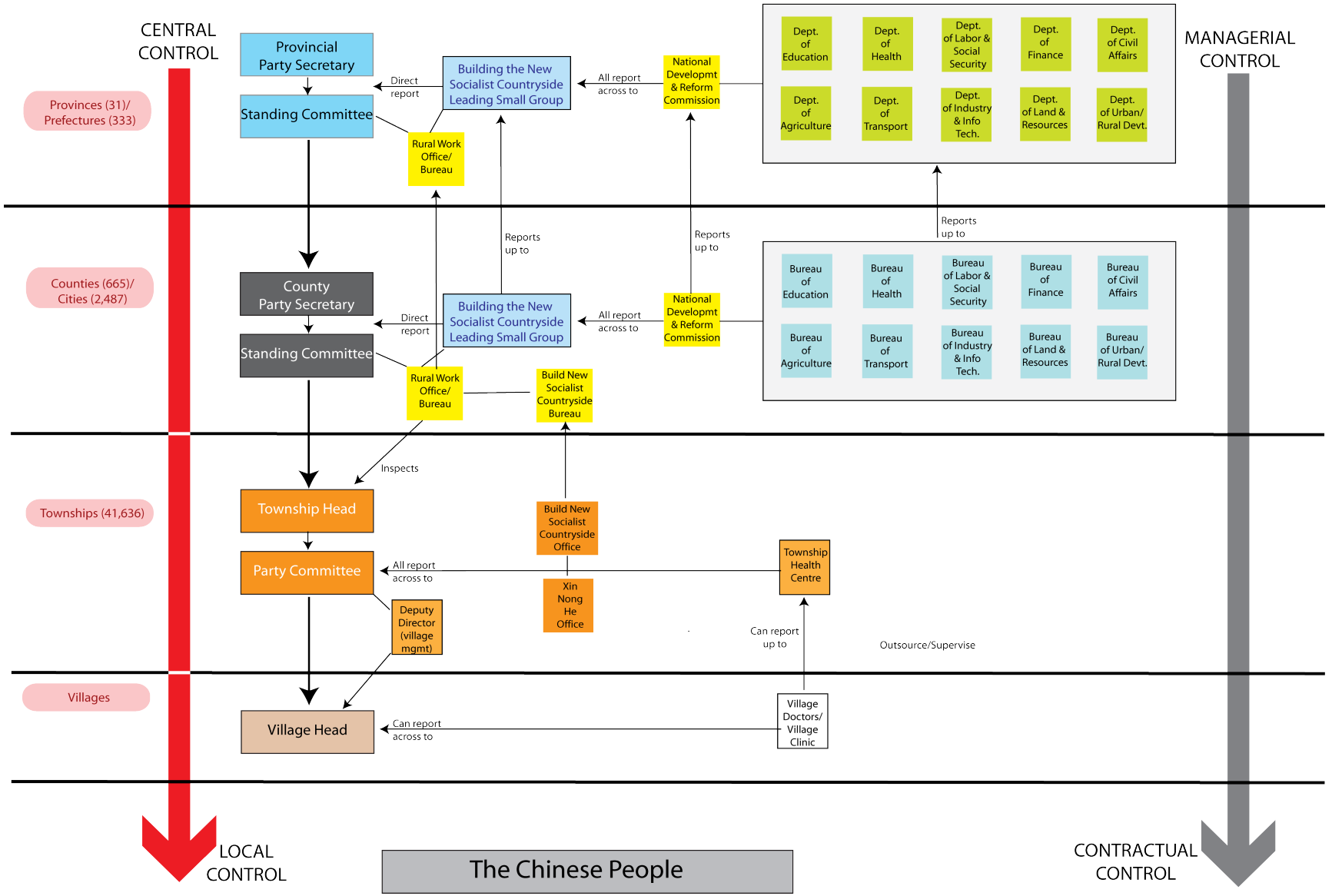
Finally, as Figure 22 below shows, if we change the locus of analysis from the central level to the local government level, we can see that the building the new socialist countryside policy LSG structure is replicated throughout lower levels of local government and that the structure reports through the Party system and not the government system. This meant that the building the new socialist countryside policy was directly overseen and implemented by the county Party secretary (or delegate), and s/he was held directly accountable for the success and failure of the measures in the building the new socialist countryside policy.[982] S/he was held directly accountable for ensuring a high enrolment rate in the NCMS social health insurance scheme — and not held accountable for any of the other NCMS metrics. They were also allowed to borrow money to ensure that the new

[982] 李剑阁 (ed.) (2009) 中国新农村建设调查, 上海远东出版社: Shanghai (Li Jiange (ed.) (2009) *A survey of China's building the new countryside,* Shanghai Yunhai Press: Shanghai); Kristen Looney (2012) 'The Rural Developmental State: Modernization Campaigns and Peasant Politics in China, Taiwan and South Korea', unpublished PhD dissertation, Harvard University.

socialist countryside was put in place.[983] Enrolment rates were the only health care metric assessed in the building the new socialist countryside policy.[984] More importantly, as Figure 22 below shows, all political units down to the county level were forced to creat a special leading small group on building the new socialist countryside, and the standing committee and Party secretary held responsible for any failures of building the new socialist countryside measures. Note how this structure reduces the number of coordination problems, and holds the county Party secretary ultimately responsible for the success of the building the new socialist countryside program.

[983] 'Counties can use loans to create building new socialist countryside mutual fund (accessible by NCMS risk pool) (i.e. accessing mortgage funds), although local credit cooperatives may be better'. Interview, 2008.
[984] 李剑阁 (ed.) (2009) 中国新农村建设调查, 上海远东出版社: Shanghai (Li Jiange (ed.) (2009) *A survey of China's building the new countryside,* Shanghai Yunhai Press: Shanghai). A complete list of all 49 national indicators can be found in Kristen Looney (2012) 'The Rural Developmental State: Modernization Campaigns and Peasant Politics in China, Taiwan and South Korea', unpublished PhD dissertation, Harvard University, pp. 344-345. For Henan evidence, see 杨屹(2009) 对河南新农村建设进程的量化分析 ('An analysis of the indicators of Henan province's process of Building the New Countryside'), available online: http://www.ha.stats.gov.cn/hntj/tjfw/tjfx/qsfx/ztfx/webinfo/2009/12/1259834805638825.htm, in which all 49 indicators published in Looney are also used by the Henan provincial government.

Figure 22: China's building a new socialist countryside local and village governance structure pre-2008



Source: Schema based on author's research

Cleverly, local governments and the Ministry of Health quickly realised the situation and focused their attentions on using the building the new socialist countryside reforms to ensure that any shortfalls in NCMS risk pools or enrolment could also be blamed on their boss — the local Party secretary — rather than on themselves. The Ministry of Health/NDRC/Ministry of Finance/Ministry of Agriculture Circular 13 of 2006 mandated that local NCMS leading small groups concentrate on improving the NCMS implementation as part of 'building the new socialist countryside'.[985] This was a reversal of previous mandates in 2005 circulars, which noted that Ministry of Health staff should concentrate on improving the NCMS solely as a way of improving local health care.[986]

Further to this idea of the NCMS being disconnected from any other goals is the lack of popular input from citizens into the management of the NCMS. While the scheme was nominally voluntary, participants and people being 'mobilised', (and paying for part of the scheme) had little say in the running of the fund. This was as opposed to the 1997 reforms which, as discussed in Chapter 6, actually offered some local participation. The NCMS leading small group at the county level was, nominally, meant to contain a 'participant',

[985] See Clause 12: '医疗组织领导各地要把建立新型农村合作医疗制度作为维护农民健康权益、提高农民综合素质、切实解决"三农"问题、建设社会主义新农村的一项重要措施'. (''Leadership groups of health care organisations in various locales must take building the NCMS system as upholding the rights and protections of peasants, of improving the overall quality of citizens, of practically solving the "three rural problems", and as an important measure in building the new socialist countryside'). 卫生部; 发展改革委员会; 民政部; 财政部; 农业部; 食品药品监督管理局; 中医药管理局(2006)关于加快推进新型农村合作医疗试点工作的通知, 卫农卫发13号 (Ministry of Health, NDRC, Ministry of Civil Affairs, Ministry of Finance, Ministry of Agriculture, Office of Food and Drug Safety, Office of Traditional Medicine (2006) Notice regarding quickening and advancing NCMS pilots, Health Decree no. 13).

[986] Meanwhile, mandates from the centre on other areas of NCMS work appeared to have been ignored. The oft-ignored direction to build better NCMS reporting systems in Health Decree 108 of 2005 for example went largely unnoticed, even though it was issued by exactly the same body as the *tongzhi* cited in the previous footnote.

but there is little evidence of genuine participation in the running of the scheme. Rather, the scheme appeared to run in a top-down fashion. NCMS management offices continued to be run by the Provincial level government, and local government officials continued to be held responsible for the performance of the NCMS risk pools.[987] Senior Party officials then took it upon themselves to urge better implementation of the NCMS program.

Indeed, in Henan, the provincial Party Secretary himself, Xu Guangchen, was roused to visit Henan's model NCMS program (Xinyang county, which allowed all Henan citizens to use NCMS funds to access their hospitals) and propagandise through both Party and Party media channels the need to 'vigorously ensure NCMS enrolment'.[988] There were no NCMS announcements at the provincial Party level before this exhortation — an exhortation that came four years after the NCMS had first been implemented, and at a time when the average enrolment rate was already over 90 per cent. Just in case anyone missed the message, four months later a major central delegation and national study tour was led by

[987] Henan Ministry of Health (2008) 河南省卫生厅关于进一步落实责任加强新型农村合作医疗管理与监督工作的通知, 9号, (Henan Ministry of Health Bureau notice regarding advances in implementing the responsibility to strengthen governance and regulation of the NCMS, notice number 9), available online: http://www.hnhzyl.com/content.aspx?id=031587114859. Note the indication was that the provincial Party committee first took the lead: 省委、省政府高度重视新农合工作...各级卫生行政部门要充分认识建立新农合制度的重大意义，切实加强领导，明确责任，精心组织，扎实推进，不断提高农民的健康保障水平. (Provincial Party Standing Committee and Government value NCMS work ... Ministry of Health Administrative Offices at every level should be fully aware of the great importance of building the NCMS system, should strengthen their leadership, clarify their responsibilities, meticulously organise, solidly advance and ceaselessly raise the level of rural social health insurance). Note also the order of Party first then State Council: 建立新农合制度，是党中央、国务院着眼于实现全面建设小康社会目标 ('building the NCMS system is viewed by the Central Committee and the State Council as buiding a moderately well-off society').

[988] 连惠燕 (2007) 徐光春批示河南全省推广新型农村合作医疗制度, 河南商报, (Lian Huiyan (2007) 'Xu Guangchun recommends Henan province advances and broadens its NCMS system', *Henan Trade News),* 7 March, available online: http://news.sina.com.cn/c/2007-03-07/030212447682.shtml.

Xu's deputy and a number of Provincial Standing Committee members to the same program.[989]

This led to the somewhat comical situation of the Ministry of Health, the body nominally responsible for the successes of the NCMS, seeing enrolment rates far above its own benchmarks as local Party secretaries scrambled to make sure that they maximised NCMS enrolments to score better points for their efforts to 'build the new socialist countryside'. The 2006 NCMS circular noted that the focus was on spreading the NCMS to more 'pilot counties', and that there was a rough target of around 80 per cent enrolment.[990] The 80 per cent enrolment rate was then used by the central Ministry of Health as their metric to reimburse provincial governments for any NCMS expenditure. The targets in the building the new socialist countryside program were 100 per cent enrolment. Unsurprisingly, the 80 per cent enrolment target was met with room to spare.[991]

This does not mean that there was no benefit to citizens, however. The NCMS did create some form of enforceable claim for local participants. Under the NCMS rules and obligations, county leaders had to report to the people the rate of enrolment in NCMS and

[989] National People's Congress (2007) 全国人大代表在河南固始视察新型农村合作医疗制度建设情况 (National NPC delegates study the current situation and how to initiate and consolidate the building of the NCMS system), report of visit from 4-5 July 2007, available online: http://www.npc.gov.cn/npc/xinwen/dbgz/dbhd/2007-07/09/content_368691.htm.

[990] Based on a joint declaration of the ministries represented in the small group (see previously in this chapter). 卫生部; 发展改革委员会; 民政部; 财政部; 农业部; 食品药品监督管理局; 中医药管理局(2006)关于加快推进新型农村合作医疗试点工作的通知, 卫农卫发13号 (Ministry of Health, NDRC, Ministry of Civil Affairs, Ministry of Finance, Ministry of Agriculture, Office of Food and Drug Safety, Office of Traditional Medicine (2006) Notice regarding quickening and advancing NCMS pilots, Health Decree no. 13) available online: http://news.xinhuanet.com/politics/2006-01/19/content_4071514.htm.

[991] Comparison can be seen at the Henan registry of government achievements for 2007: Henan Provincial NCMS committee (2007) 2007年河南新农合大事记 (2007 record of Henan NCMS achievements), available online: http://sh.dahe.cn/zhuanti/xinnonghe/dashiji/445273.html

expenditure on the NCMS. Thus, whether local participants had genuinely enrolled or not, or whether they liked the structure of the NCMS or not, they could often claim a post-treatment for part of their health care costs.[992] This was a significant improvement on previous, uninsured existence. Moreover, poor participants' participation fees were covered by government assistance,[993] and they were also covered under the far-better funding 'medical emergency' program. This made it far more likely that the indigent could access some form of insurance coverage. The following section will examine the impact that ensuring high enrolment had on the system as a whole, and examine what occurs when health care becomes a major priority at the central level.

Introduction of a serious health reform package in 2009

Widespread enrolment of citizens in the NCMS program was almost complete by 2007. Yet, in spite of the success of the NCMS, dissatisfaction with the health outcomes delivered by China's rural health system continued. Government thinktanks,[994] and the then-health minister voiced public dissatisfaction.[995] In 2006, the central government decided to enact a

[992] This conveyance of information also gave citizens the chance to game the NCMS system. As a very tentative example, while there has been nothing formal written on the topic, the author was relayed during fieldwork a number of anecdotal reports of local participants 'borrowing' the card of someone who had formally enrolled and claiming health care costs.

[993] Paid for by the Ministry of Civil Affairs under a separate program, although this was included in the NCMS program on a county-by-county basis (and was given as the reason why the Ministry of Civil Affairs was given an *ex officio* seat on the NCMS Implementation Leading Small Group at all political levels down to county).

[994] Ge Yanfang, Deputy Head of the State Council's Development and Reform Commission criticised China's health system as being too commercialised, arguing that the system had gone too far in the direction of marketisation. 葛延风 (2005) 对中国医疗卫生体制改革的评价与建议对中国医疗卫生体制改革的评价与建议，中国发展评论, (Ge Yanfang (2005) 'An appraisal of China's medical system reform and some evaluations and suggestions for how to refrom the system', *China Development Forum),* vol. 1.

[995] In August 2005, then-Minister of Health Gao Qiang wrote that some hospitals were abandoning principles for profits — 'the operational mechanism of public medical institutions in China is inclined toward

major health care system reform,[996] with the final reform released in April 2009.[997] The report aimed to provide affordable basic health care for everyone.[998] The NDRC stated that it would 'effectively solve the problem of difficult and costly access to health care services to quell people's 'strong reactions'.[999]

The reforms had three major promises: firstly, a major increase in the public subsidy for health insurance,[1000] including a major increase in state contributions to the NCMS.[1001] Secondly, the introduction of a number of supply-side reforms, including a re-emphasis on

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marketization with weakened public welfare.' Richard McGregor (2005) 'Price controls blamed for China's ailments', *Financial Times,* August 22.

[996] In 2006, China formed a Health Care System Reform Coordinating Small Group under the dual leadership of the National Development and Reform Commission and the Ministry of Health. Its role was to report on areas where China's health care system could be reformed.

[997] The draft report for comment was released in March 2007, and the final report in September 2007. In February 2008, the group completed its report. In October 2008, the public was invited to comment on the report for a one-month period. Over 30 000 comments were received. In January 2009, the State Council endorsed the report, but it was not until April 2009 that the revised report was made official.

[998] The most recent bout of reform was intended to be a seminal reform. It was anointed by the State Council and Li Keqiang himself led the project (see the details at Li Keqiang (2009) 李克强:要把医改任务落到实处让人民群众得实惠突出重点狠抓落实确保医药卫生体制改革重点目标任务的实现, (Li Keqing: We must take NCMS tasks and provide substantial benefits to the people, including a ruthless adherence to the fixed drug list), available online: http://shs.ndrc.gov.cn/ygzc/200907/t20090724_359222.html. The full details of the reform can be found at http://shs.ndrc.gov.cn/ygzc/; note that this also includes a set of opinions (*yijian*) prepared to guide the reforms.

[999] 'Health care undertakings are developing unevenly between urban and rural areas and among different regions; resource allocation is unreasonable; the work of public health as well as rural and community health care is comparatively weak; the medical insurance system is incomplete; pharmaceutical production and circulation is not well regulated; the hospital managerial system and operational mechanism are imperfect; government investment in health is insufficient; medical costs are soaring individual burden is too heavy, and therefore, the people's reaction is very strong'. National Development and Reform Commission (2009) *Opinions of the CPC central committee and the state council on deepening the health care system reform*. National Development and Reform Commission: Beijing.

[1000] Spread among the urban and rural insurance schemes. For NCMS, government contributions to the scheme were raised to 120 yuan *per annum*. Urban social health insurance schemes were also given targets for much greater coverage of the population, and caps on reimbursement post-treatment were raised.

[1001] In rural areas, county governments are mandated to reimburse a higher amount of NCMS funds. This is the so-called '85–93 rule', whereby county governments are mandated to reimburse no less than 85 per cent of the NCMS fund from the year but to not reimburse more than 93 per cent. A longer discussion of this is contained in Ryan Manuel (2009) 'China's health system and the next 20 years of reform' in Ross Garnaut, Ligang Song and Jane Golley (eds.) *China: The Next 20 Years of Reform and Development*, ANU Press, pp. 317-341.

outpatient care[1002] and an upgrading of local health facilities.[1003] Finally, there were a number of 'governance reforms',[1004] aiming at separating 'government administration and business operations'.[1005] This included a promise to shift away from public ownership, with the reform promising that '(e)fforts will be made' to transfer ownership of public hospitals to non-public institutions. [1006]

The most significant reform was an enormous increase in public funds for health care. As Table 22 below shows, this increase in funds was directed at increasing spending on both health insurance, and on direct government subsidies, [1007] moving some of the burden of funding health services off of the individual. The difference between the 2005 and 2010 data in Table 22 is striking because of the dramatic increase in government spending, and reduction in individual out-of-pocket spending.

[1002] Greater focus will be put on outpatient expenses and the reimbursement range will be increased. The scope and proportion of reimbursement for outpatient expenses will be expanded.
[1003] Substantial government funds were promised ($US 125 billion over 3 years, all claimed to be additional) for new hospital construction, for renovations to health care provision centres, for establishing a new essential drug list and for initiating further trials of public hospital finance reform. These funds were in part to rehabilitate and equip lower-level facilities, and in part to increase supply-side subsidies to health facilities.
[1004] It promises to 'rationally determine the payment criteria for drugs, healthcare services and medical materials'; to check that the 'salary level of healthcare workers is in line with the average salary level of staff of local public institutions'; and finally, to ensure that drugs are 'sold at zero price margin'.
[1005] Although the wording itself on this was a bit of a damp squib: it promised to ''encourage' local governments to 'actively explore effective formats of separating government agencies and public institutions'
[1006] It is not completely clear what form this will take. The government for example encouraged 'qualified' physicians to run clinics or establish their own clinics or practices, but did not specify what it meant by 'qualified'.
[1007] For example, 63 billion yuan went to strengthening grassroots clinics; for the NCMS, the focus was on township health centres, with the reimbursement rate lifted to 70%.

Table 22: % of total health care spending by payee 1980-2010

Year	Healthcare spending (% GDP)	Government (%)	Social security insurance (%)	Out-of-pocket payments (%)
1980	3.2	36.2	42.6	21.2
1985	3.1	38.6	33.0	28.5
1990	4.0	25.1	39.2	35.7
1995	3.5	18.0	35.6	46.4
2000	4.6	15.5	25.6	59.0
2005	4.7	17.9	29.9	52.2
2010	5.0	28.6	35.9	35.5

Source: Chinese Statistical Yearbook 2011, table 5.1, p. 468

The government's 2009 reforms were aimed at preventing cost inflation worsening. The government pledged to lower the cost of 'basic health care'[1008] to encourage non-profit organisations to deliver more health services, to increase competition, and to stop drug revenue from being the 'major compensation source' financing grassroots healthcare institutions.

These were significant structural reforms that, if successful, could lower costs. But many of these reforms were promised before. For example, it appears that the government believed it could lower costs through a mooted 'negotiation mechanism between medical insurance handling institutions and providers of healthcare services'.[1009] However, this is

[1008] It planned to do this by setting the 'service charges of grassroots healthcare institutions according to the costs after deduction of government subsidy'

[1009] The envisaged compensation mechanism is through SHI reimbursement, although providers will be forced to sign a 'designated insurance contract'. Crucially, local governments will regulate the criteria for these measures. There is no mention of which level of government will pay the providers themselves, but it is presumed from the choice of regulatory body that it will be local governments at the county and township levels.

something that it has been promising since at least 2002.[1010] Adam Wagstaff, who has spent many years working on China's health system reform with the World Bank, argued that the solution may be to split purchaser and provider.[1011] But this reform option had been mooted since the 1984 World Bank report on health care in China.[1012]

And, in spite of these reforms, the cost of providing health services remains a problem. Over the past decade the country's total health expenditure has grown almost fivefold, to an estimated 2.4 trillion yuan (US$385 billion) in 2011. Foreign experts expect expenditure to reach $1 trillion by 2020, roughly 7 per cent of GDP.[1013] No matter how good the health insurance coverage, and no matter how grand previous increases in public funds, should costs keep rising then the health-care system will have trouble footing the bill. For example, recent preliminary estimates by the Chinese Academy of Social Sciences in Beijing are suggesting that many local state-run health-insurance funds across China will begin to run deficits in 2017.[1014]

Should the problem of cost inflation not be quelled, there are fears that the major increase in money for demand-side reforms (such as the NCMS) may then trigger supply-

[1010] See 2002 Central Committee decree on health care, Clause 18: '要建立有效的农民合作医疗管理体制和社会监督机制.' ('We must build an effective NCMS system, with the people managing the system and society supervising and disciplining the relevant organs'). Central Committee (2002), *op cit.*
[1011] 'The purchaser-provider split approach, at least on paper, has much to commend it compared to an integrated system. It holds the promise of a purchaser developing a strong information system covering costs, quality and health needs, which can be used to steer resources to where they are needed most and will have the biggest impact.' Adam Wagstaff (2010), 'Social health insurance reexamined', *Health Economics*, vol. 19, p. 516.
[1012] Dean Jamison (1984) *China: The Health Sector,* World Bank: Washington DC.
[1013] Frank LeDeu (2012) Health care in China: Entering 'uncharted waters', McKinsey: Boston, MA.
[1014] The Economist (2013) 'Feeling your pain', Apr 27 edition, pp 41-43

side revenue raising that will make problems of cost inflation yet worse.[1015] Providers in China are often paid using fee-for-service methods and face a fee schedule that strongly encourages shifting to the use of drugs and high-tech care on which the margins are higher.[1016] There are examples of this leading to greater spending by insured patients compared to uninsured patients.[1017] For example, Wagstaff and Lindelow show that the new CMS insurance scheme may have increased out-of-pocket spending or the risk of catastrophic spending through patients being treated at higher level providers who have higher costs. Other studies note correlations between basic health insurance and hospital costs,[1018] suggesting possible increases in quantity of care provided or in substitution of higher-cost services for lower-cost services. This is similar to earlier studies of health insurance trials in rural China.[1019] Whichever way, utilisation may increase, and risk pools would be burdened by increased costs.

Moreover, in spite of being state-funded, the NCMS schemes have not acted as a purchaser. Rather, the individual was to choose the provider, pay for treatment, and then apply to the NCMS office post-treatment for reimbursement. The NCMS instead used rules and regulations to attempt to change the individuals behaviour by offering different

[1015] Adam Wagstaff, Magnus Lindelow, Shiyong Wang, and Shuo Zhang (2009) *Reforming China's Rural Health System*, The World Bank:Washington DC.
[1016] Liu Xingzhu and Anne Mills (1999) 'Evaluating payment mechanisms: how can we measure unnecessary care?' *Health Policy and Planning,* vol. 14, no. 4, pp. 409–413
[1017] Pan et al. for examine the effect of insurance on the hospital costs of 10 medium-size urban hospitals in Guangdong province, and find that spending on insured patients is around 10% higher than that on uninsured patients. X. Pan, H. Dib, M. Zhu, Y. Zhang and Y. Fan (2009) 'Absence of Appropriate Hospitalization Cost Control for Patients with Medical Insurance: A Comparative Analysis Study.' *Health Economics* vol. 18, no. 10.
[1018] See for example the studies in A Wagstaff, W Yip, M Lindelow, and WC Hsiao (2009) China's health system and its reform: a review of recent studies, *Health Economics*, vol. 18, pp. S7-S23; or for an experiment using panel data, A Wagstaff and M Lindelow (2008) 'Can insurance increase financial risk? The curious case of health insurance in China,' *Journal of Health Economics* vol. 27, no. 4, pp. 990–1005.
[1019] See L Bogg, H Dong, K Wang, W Cai and D Vinod (1996) 'The cost of coverage: rural health insurance in China.' *Health Policy and Planning* vol. 11, no.3, pp 238–252 .

repayment rates according to the provider and type of service accessed,[1020] arguing that this 'market competition' could help control costs.[1021] But, as the following section will argue (following a review of recent governance changes), the political organisation of local government in China makes major structural reform in the health sector — such as changing ownership, or splitting the government's purchaser and provider roles — most difficult.

A more powerful health sector still cannot force local governments to implement

Following the introduction of the NCMS, the central government's health care reforms also altered the relative power of different ministries. Ministry of Health was the main beneficiary of these changes.

A weak central Ministry of Health has been a constant assumption throughout the thesis. For example, there were a number of disputes between central ministries over how much rural social health insurance needed to be a national scheme in the 1990s, all of which needed to be referred to higher coordination bodies for arbitration — and all of which led to the Ministry of Health's interests not being supported. After the 1991 health care reform attempts, for example, the Ministry of Health reportedly attempted to coordinate support for a unified rural social health insurance scheme, but the Ministry of Agriculture instead suggested to the State Council that health services be minimised in

[1020] Anonymous (2003) '政府牵头多方筹资， 完善合作医疗制度', ('Government to take the lead in diversifying fund sources, perfecting cooperative medical system'), *People's Daily,* 20 February.
[1021] See 孙淑云 (2007) *乡镇卫生院改革的政策法律研究*, 中国法制出版社: Beijing (Sun Shuyun (2007) *A study of township and village hospital reform, policies, and laws,* China Legal Press: Beijing).

order to 'reduce the peasant burden'.[1022] The 1994 reforms dutifully noted that the need to 'reduce the peasant burden' meant that the decrees were 'voluntary' and were to be implemented 'subject to local conditions'.[1023]

Similarly, following the major decision on health care reform in 1997 discussed in Chapter 6, the Ministries of Agriculture, Supervision, Finance and Family Planning — but not the Ministry of Health — all argued in 1999 that social health insurance should not be introduced nationwide so as to reduce the collection of unnecessary fees and reduce the burden on peasants. Instead, they argued, the Party should improve the quality of rural care, as higher peasant income meant that any insurance given to rural citizens would just allow them to go to the city.[1024] While causality cannot be proven, it is undoubted that following this discussion, in 2001 the central government focused its efforts, and an enormous sum of public money on a new *urban* health insurance scheme.

Perceptions of the Ministry of Health being a weak ministry continued into the late 2000s. For example, in 2008, in spite of the Ministry of Health being the nominal head of the group writing the report that led to the 2009 reforms, there were still complaints that Health was 'too weak' a ministry to push any sort of health care reform. Influential blogger and commentator (and deputy director of the Guangdong Health Bureau) Liao Xinbo said that 'medical reform is extremely difficult because it involves at least 16 (central

[1022] For example, between 1990-1992 the Ministry of Health tried very hard to get support but Ministry of Agriculture suggested to state council that health services be minimised in order to 'reduce the peasant burden'郭清 (2008)人人享有卫生保健—庄严承诺30年, 健康报, (Guo Qing (2008) 30 years of a sincere promise of health care for everyone, *Health Times*), 18 December.
[1023] see State Council (1994) 中国农村合作医疗制度改革 ('Reform of China's rural cooperative health system'), February.
[1024]曹普(2014) *新中国农村合作医疗史*， 福建人民出版社：福州, (Cao Pu (2014) *A History of New China's Rural Cooperative Medical System,* Fujian People's Press: Fuzhou), p.199

government) departments … Among these, the Ministry of Health does not have a strong voice.'[1025]

This problem of a lack of authority for the Ministry of Health in the central government made it difficult for it to introduce any sort of reform. Yanzhong Huang, for example, argued with reference to the 2009 reforms that the central Ministry of Health had made a number of proposals to increase its control over the health care sector — and, in theory anyway, to try and control costs — by centralising the purchase of high-value medical devices for public hospitals and separating expenditures and revenues so that all hospital revenues would go directly to the Ministry of Health instead of the hospital, and the ministry would then allocate funds back to the public hospitals based on performance management.[1026] This proposal was then blocked by other ministries.[1027]

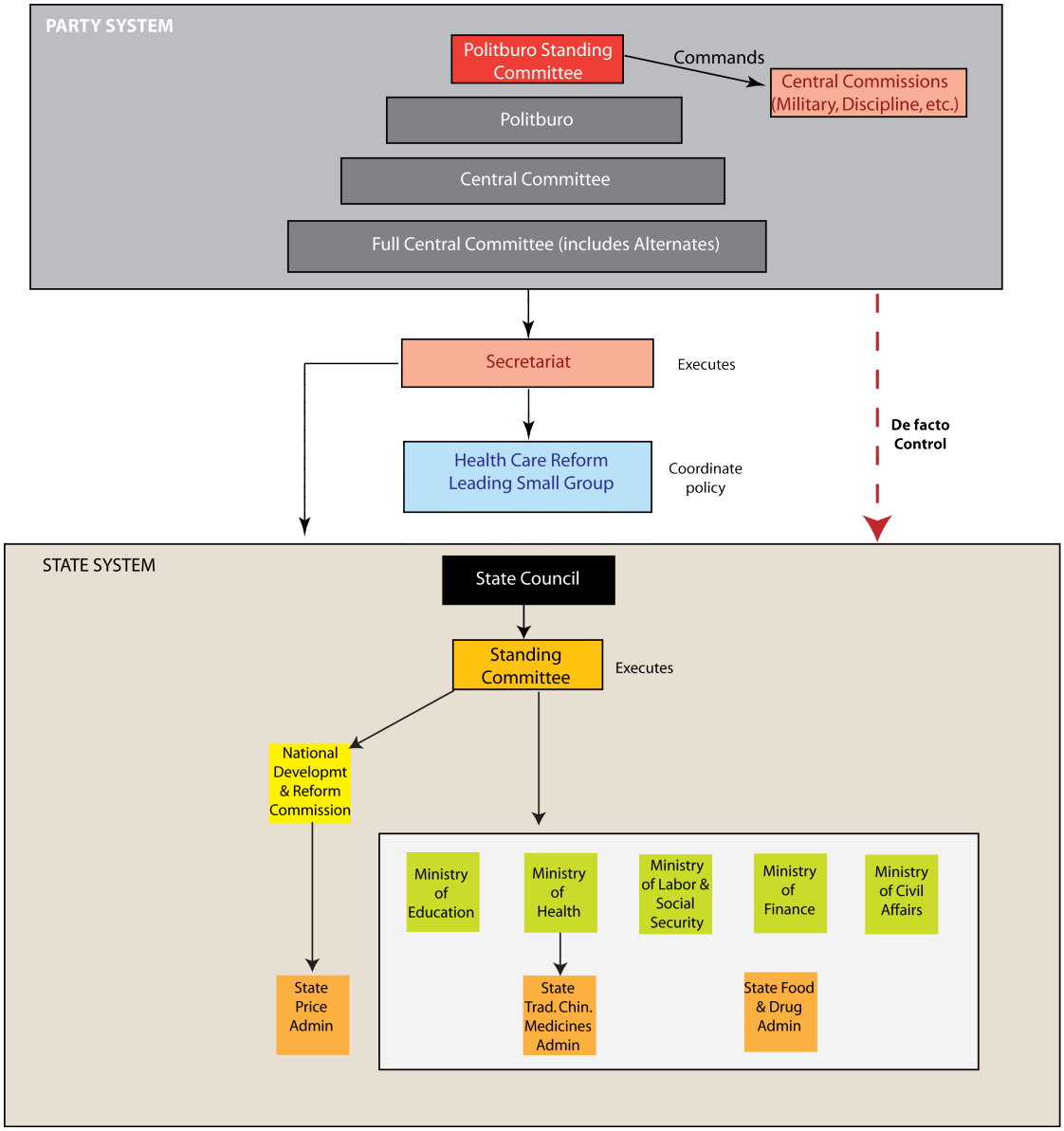
However, the Ministry of Health's fortunes soon changed, beginning in the major 2009 health care reforms discussed in the previous section. The 2009 health care reforms provide an example of how the system can use Leading Small Groups (LSGs) to solve coordination problems at the centre, and how some ministries can be the beneficiaries of LSG favour (see Chapter 3). The 2009 health care reform, which promised some RMB850b to be spent on health care over the period 2009 to 2011 was developed by a LSG which contained all of the actors listed in Figure 23 below. The LSG formed a consensus position on what they wished health care reform to look like before taking the position to the State Council and

[1025] Wang Jing (2014) 'Silencing a Health Reformer's Strong, Lonely Voice', *Caixin Magazine,* 7 October, also available online: http://english.caixin.com/2014-07-10/100702079.html
[1026] Yanzhong Huang (2012) *Governing Health in Contemporary China*, Routledge: Basingstoke, p. 65.
[1027] Huang's assessment of this was that Li Keqiang 'didn't want to choose sides so as not to hinder his promotion to Premier', *ibid,* p.73.

the Party Central Committee and gaining approval from both bodies. The final opinion on the direction of reform was promulgated jointly in the names of the State Council and the Party Central Committee.

Moreover, the LSG (the Health Care System Reform Leading Small Group) was headed by Li Keqiang, a heavy hitter who was ranked seventh in the Party at the time, and (correctly) was assumed to be anointed as the next Premier (or Prime Minister) of China. Suddenly, the central health care bureaucracy looked far more efficient (see Figure 22 below), as the LSG (which was initiated by the Party Central Committee and the State Council, and thus was of a particularly high rank) could coordinate a joint position on health care. The interests of the health care sector, as a whole, appeared more influential at the central level than at any time in the post-Mao period.

Figure 23: China's central health care governance structure post-2009



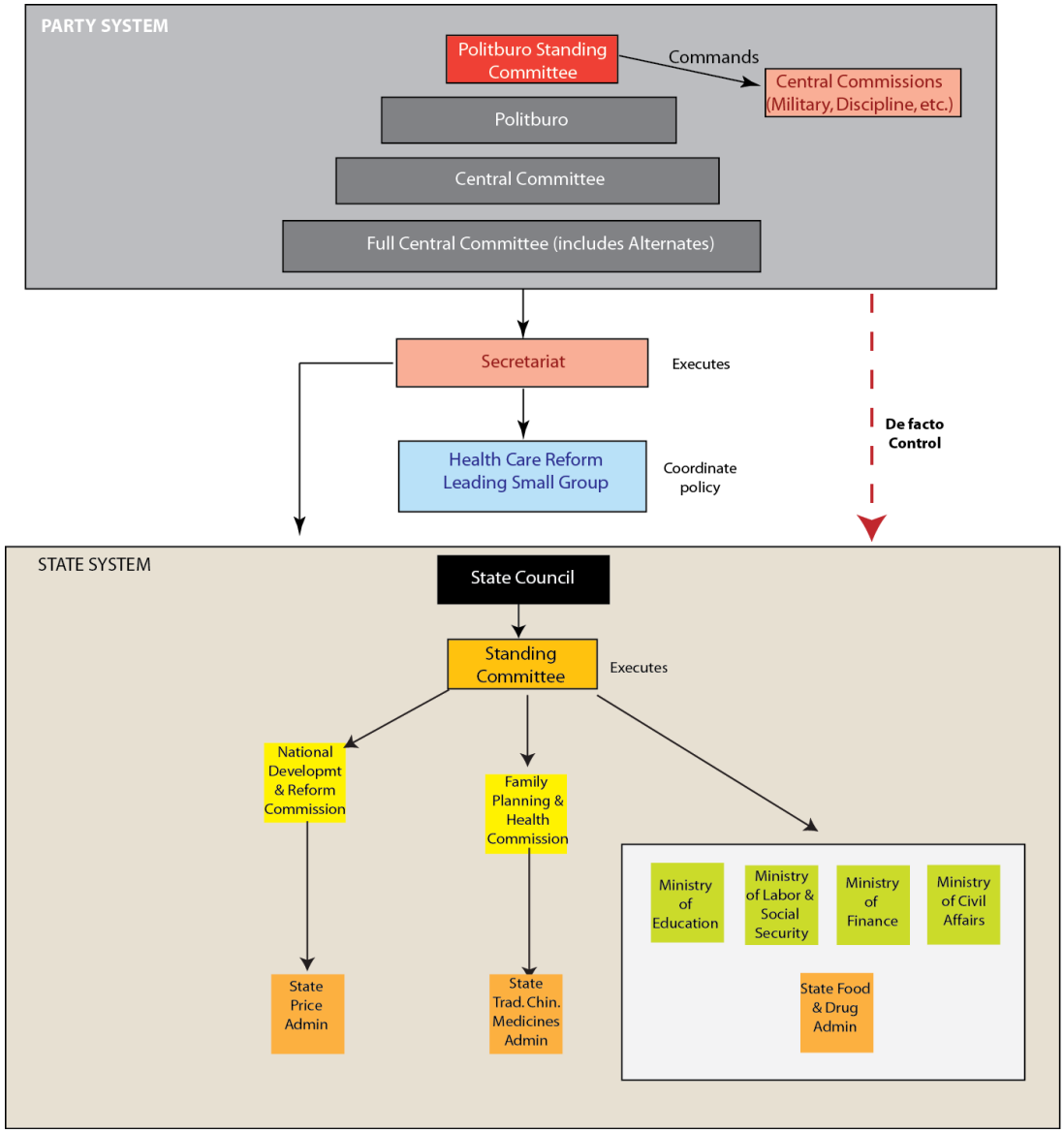
Source: Author's own analysis and schema

And, in 2013, a reform at central levels upgraded the rank of the Ministry of Health from being a *bu* (ministry) into a joint *weiyuanhui* (commission) with Family Planning. Being made a commission means that the health sector outranks any ministry in a conflict of interests. Theoretically, this could help the Ministry of Health win more internal battles in coordination bodies such as the Leading Small Group of Health Reform, as it would give

them a more powerful voice. It will could also aid the status of the ministry throughout the system when compared to other interests, as well as giving the ministry extra clout in internal fights over resources. Finally, the reform joined the health ministry with family planning, an area whose targets have long been implemented thoroughly by local governments.[1028] Note how in Figure 24 below, the Ministry of Health (formally coded as a ministry, and thus represented in green) is now upgraded to a commission (represented in yellow). Should any conflict of authority occur, the Family Planning and Health Commission would thus outrank any ministry. But it is still junior to the State Council, the Party bodies, and the most senior *zhengguoji* executive and coordination bodies (see Chapter 3).

[1028] Due both to family planning's status as a *guoce* or national priority policy (see Susan Greenhalgh (2008) *Just One Child: Science and Policy in Deng's China*, Berkeley: University of California Press) and to its ability to be easily monitored and checked up on (e.g. Zhao Shukai (2012) '地方政府公司化: 体制优势还是劣势?' 文化纵横, ('Local government corporatisation: system superiority or vulnerability?', *Cultural Review*), vol. 2.

Figure 24: China's central health care governance structure post-2013



Source: Author's own analysis and schema

These governance changes clearly make health care a much stronger policy sector (*xitong*) within the central system. This higher central rank, and the creation of a leading small group for health care reform that solves problems of coordination, should theoretically greatly improve the prospects for health care reform. It also makes the leading

small group the arbiter of conflicts of interests, making it harder for other ministries to block health initiatives (as described by Huang above).[1029]

The then-ministry, now-commission has not hesitated to use its higher status to push for more reform at the centre. Recent reforms coordinated by the commission and taken to the State Council include reforms of providing village doctors with more incentives to remain in villages and increase their skills;[1030] the creation of a committee to coordinate drug price negotiations (and thus lower costs);[1031] and the broadening of a 2012 pilot designed to force county hospitals to rely less on drug sales to raise revenues.[1032]

But, in spite of this burgeoning central clout, governance problems at the local level remain. A comparison of Figure 24 above with Figure 25 below shows that upgrading the Ministry of Health to a commission centrally makes little difference to a health ministry's

[1029] 'Among the major participants in the Small Group, National Development and Reform Commission (NDRC) is the neutral body to ensure that agencies are not merely interested in protecting their own interests but in establishing a functioning medical system; the Ministry of Health, with overlapping jurisdiction with most other parties involved, will have clear interests in expanding their jurisdiction and providing supervision of an enlarged public health sector; the Ministry of Human Resource and Social Security will be responsible for public insurance schemes and will seek to contain health care costs; the Ministry of Finance will restrict total state funding due to limited budgets.' Litao Zhao and Yanjie Huang (2010) 'China's blueprint for health care reform.' *East Asian Policy* vol. 2, no. 1, p. 53.

[1030] State Council, China's cabinet, has 'said it wants to have one doctor for every 1,000 people living in rural areas by the end of 2020. It also said it wants all village doctors to have a diploma from a vocational medical school or college.' Zhou Tian (2015) 'Cabinet Offers Dwindling Number of Rural Doctors Some Incentives', *Caixin*, 25 March, available online: english.caixin.com/m/2015-03-25/100794639.html

[1031] 'The proposal was contained in a document that the National Health and Family Planning Commission drafted to guide a trial program for drug price talks between health care administrations and pharmaceutical companies. The State Council, the cabinet, is considering the plan after several central government ministries discussed the matter, sources close to the commission said.' Zhou Tian (2015) 'Health Officials Propose Committee to Lead Drug Price Talks', *Caixin*, 24 March, available online: english.caixin.com/m/2015-03-24/100794303.html

[1032] 'As part of a reform of the country's medical care system, the State Council chose some 300 county-level hospitals for a pilot in June 2012… The National Health and Family Planning Commission has said it will choose 2,000 county hospitals this year to be part of (the) reform'. Zhou Tian and Liu Jiaying (2015) 'Health Ministry to Pick 2,000 County Hospitals for Drug-Pricing Reform', *Caixin*, 05 January, available online: english.caixin.com/m/2015-01-05/100771106.html

relations with the local Party committee at the local governance level. The local governance challenges remain identical. The new Commission still needs to report horizontally to the local Party committee. The Party committee still controls the institutions which govern the Commission's behaviour. As Figure 25 below shows, the change in status to becoming a Commission does give the health sector some further clout — but this is not enough to override the Standing Committee of the political level the Commission is contained in.

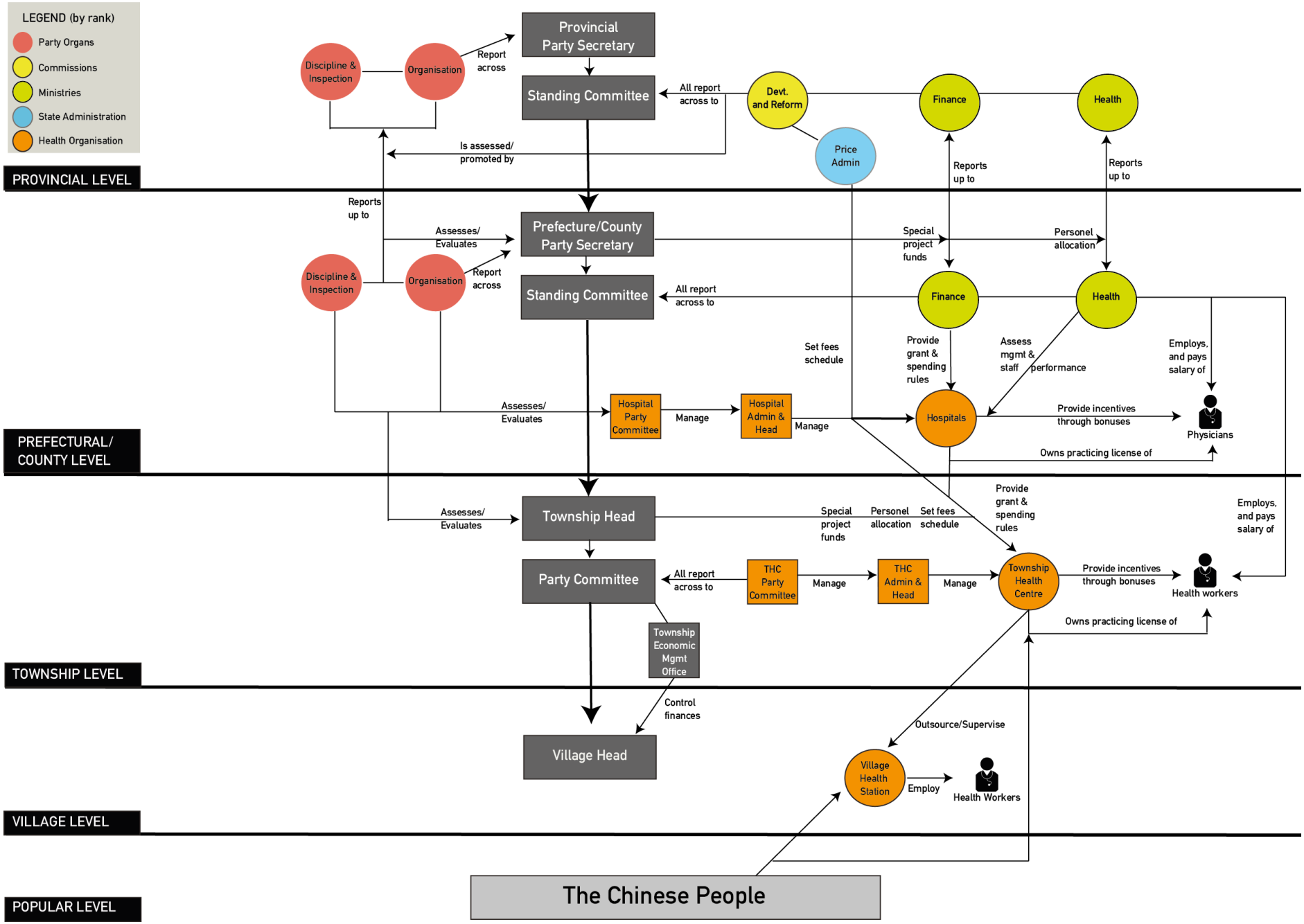
Similarly, the shift in rank does not change any of the accountability problems that the health sector faces at local government level. Many functions of the health system are overseen by departments, organisations or ministries other than the Ministry of Health. For example, none of the local government, local Ministry of Health, or local service providers are able to set the prices charged for health services. They, and drug prices, are set through provincial-level mechanisms.[1033] The local Party committee (headed by the Party secretary) sets the quota for the number of official staff in the hospital, and can approve some capital expenditure for the hospital.[1034] The local government can also determine whether or not hospital staff can be hired or fired.[1035] Finally, the local government insurance fund can refuse to pay for treatment that is considered 'excessive'.[1036] Any of these parties, should they receive word that they may be blamed for a failure in the health system, can blame the other party. And they do. Indeed, traditionally, the Ministry of Health has not been averse to taking this approach themselves — for

[1033] To be precise, through the provincial level NDRC.
[1034] Carl Minzner (2009) 'Riots and Cover-Ups: Counterproductive Control of Local Agents in China' *University of Pennsylvania Journal of International Law*, pp. 53-125.
[1035] Although this depends on the classification of the service staff (see previous chapter).
[1036] Similar to how local governments can be held responsible for repaying any debt incurred by the state by a risk pool overspending, hospitals can be held financially liable for up to 40% of the excess should they be accused of 'overspending'. Economist (2013) 'Health-care reform: Feeling your pain', *Economist,* April 27.

example, in 2010 it blamed cost increases in the health sector on rising drug prices, which it argues is not its responsibility.[1037] And indeed even a brief sketch, based on a governance perspective, of the current situation in the broader health sector shows that the prospect of actual structural reform looks difficult. As Figure 25 below shows clearly, there are many interests, actors, and lines of accountability in the rural health care sector — and almost all of them clash.

[1037] 'Liao's comments stirred another hornet's nest in 2010 at a time when the health ministry was under pressure for allegedly causing drug prices to skyrocket. While other health officials across the country refused to join the debate, Liao stepped forward to defend the ministry. He said the National Development and Reform Commission and local government agencies that oversee commodities pricing, not health officials, were to blame.' Wang Jing (2014) 'Silencing a Health Reformer's Strong, Lonely Voice', *Caixin Magazine,* 7 October, also available online: http://english.caixin.com/2014-07-10/100702079.html

Figure 25: An institutional map of the Chinese rural health system post-2013
Source: Author's own research and schema



An increase in the clout of the Ministry of Health appears unlikely to alter these conflicts. Rather, as shown throughout this thesis, the rank of the person in the local state held accountable for the policy being implemented, and the methods used by the central state to force the local state to implement the policy makes a difference in the ability of the state to provide health services. Ultimately, local governance problems can only be controlled and quelled — and the local state mobilised —by local Party secretaries. So health care reforms should target county Party secretaries, and should ensure that reforms are aligned with broader Party programs; from a governance perspective, it is this alignment — rather than a stronger ministry or a well-funded central reform package— that appears more likely to affect implementation.

Conclusion

Analyses of health insurance schemes often emphasise that a well-functioning health system is more likely to be successful in creating a health insurance scheme that covers the whole population. And this coverage is, in theory, to be led by citizens wishing to enrol in the scheme, on the presumption of their receiving considerable benefit.

The success of the NCMS in ensuring nationwide coverage is thus rather a mystery. Health care costs rose dramatically in the previous decade before the introduction of the NCMS in particular. Surveys and other evidence seemed to indicate a citizenry that was deeply discontent with health care provision. Even should citizens anticipate using the health insurance service, citizens still needed to pay upfront for any medical treatment.

Finally, a very similar scheme (from the perspective of the consumer) had been launched in 1997 to similar fanfare with little success.

The NCMS also went in the opposite direction from the recommendation of most health insurance schemes for developing countries (and, from the many recommendations given to China by external aid agencies in the 1980s and 1990s). The NCMS was focused on inpatient care rather than primary care; it forced patients to still pay for services upfront; and it had highly restrictive rates of reimbursement for patients inpatient expenses.

But the NCMS was successful. By 2008, it had enrolled nearly 800 million people, and paid out nearly half a billion claims. China had covered its whole countryside with a social health insurance scheme, again.

The NCMS was successful because the counties were successfully mobilised by the centre holding county Party secretaries responsible for ensuring a high enrolment rate. The central state did not provide transfers to cover the costs of NCMS introduction — the money was to be found at the local level. The local state also had to ensure that all peasants were voluntarily enrolled, to manage the risk pools and compensation, to promote the scheme, to create trust in the local populace regarding the scheme and finally, to not increase the number of fees that rural residents had to pay. This represented a significant disincentive for the local state. This disincentive had to be overcome by another, greater incentive — and this came from a shift in the measurement criteria for local Party heads.

The successful introduction of the NCMS represented the successful mobilisation of local state officials. The NCMS benefited from the responsibility for some of the elements of the NCMS program shifting from lower levels of the local state to higher levels of the local state. This changed the respective NCMS management responsibilities for the county, township and village. The shift of risk pools to the county level, and the shift of responsibility for enrolment to the county Party leadership, moved elements of NCMS implementation out of the health *xitong*. Implementation relied upon local Party county secretaries choosing to allocate scarce funds and to use their powers over personnel management to ensure NCMS enrolment and risk pool viability.

So the biggest NCMS decision came in 2005, when enrolment in the NCMS was included as the only health care metric in the omnifarious Party campaign to 'build the new socialist countryside'. NCMS enrolment then boomed, covering the countryside. This most impressive feat was largely the byproduct of incorporation of NCMS into a much bigger program, one almost completely removed from the health care *xitong*, where the Party mobilised the local state to ensure that the criteria of ensuring a 'new socialist countryside' were met. The county, in spite of a lack of funds, responded to these incentives, introducing the NCMS well ahead of all schedules, targets and even official Ministry of Health expectations.

This high enrolment, however, did not presage much change within the broader system of health governance. While the addition of NCMS enrolment figures to the building the

new socialist countryside program held the local Party secretary accountable for this small part of health care, other major reforms that were launched by the central government did not hold the local Party secretary accountable. Rather, a major 2009 funding reform, and a major 2013 governance reform, led to deep changes in how health care was funded and how the central governance bodies functioned. The Ministry of Health was the major beneficiary. But these shifts did not change the nature of health care governance at the local levels; and thus the permanence or efficacy of these reforms remains, at present, indeterminate.

Chapter 8: Concluding remarks

Social health insurance schemes have been very difficult to introduce in most countries. State capacity — or the ability of the state to design, coordinate and implement policies — is vital to any success. China has introduced a number of rural SHI schemes. All of these schemes have had voluntary enrolment. Yet some of the schemes have had very high enrolment rates while others have collapsed due to inadequate enrolment. This thesis has sought to illuminate why.

By introducing a number of techniques of institutional analysis, and process tracing and mapping, I have shown that state capacity to enrol citizens is related to the nature of political incentives. These political incentives are created by government and Party structures, and by the measures used by the state to assess and reward performance. They vary consistently, and systematically, in the Chinese state and affect the capacity of the state implement SHI schemes. I have argued that this variation in political incentives has had a decisive influence on implementation of health schemes.

Comparing China's SHI schemes, the state was successful at encouraging high enrolment nationwide in two different periods — the period 1968 to 1976, and more recently, with the NCMS in the period from 2003 to now. These successes came during different central governance environments. The 1968 to 1976 success was based on fiat from above and a unique influx of free medical care; the success of the NCMS, however, cannot be attributed solely to intervention from above, and occurred during a period of

higher-quality, but far more expensive health care. But, in both cases, the critical mechanism was a decree from above which held the local Party leader responsible for high SHI enrolment. The local Party leader then mobilised and coordinated local state actors to ensure that high enrolment was obtained. Holding the local Party secretary accountable for high enrolment was both a necessary and sufficient condition for successful implementation.

I argue that a comparison of political structures in SHI schemes in rural China shows that a) policies need a major central decree to be implemented, but this is a necessary condition yet not a sufficient one; b) policies need a coordinating body decreed as a priority by central Party structures; and c) one senior county-level policy maker (preferably the Party secretary) needs to be held responsible for the success or failure of the policy.

There are two reasons why this topic is important. The first is a question of policy importance. The social health insurance schemes in question affect many millions of people within China (over 800m for the second iteration of the scheme). The schemes have also been promoted, in the past, as global models. Showing the factors unique to China that have led to the success of the schemes may influence policy decisions in other countries looking to China as a model.[1038] High enrolment in a social health insurance scheme does not necessarily translate into better financial protection, nor always lead to better health outcomes. But it usually does not hurt. And it can be a base for broader health system reform (as well as providing significant benefits of its own).

[1038] With the possible exception of Vietnam — see Edmund Malesky, Regina Abrami, and Yu Zheng (2011) 'Institutions and Inequality in Single-Party Regimes: A Comparative Analysis of Vietnam and China.' *Comparative Politics*, vol. 43, no. 4, pp. 409-427.

The second reason is the topic's relevance to academia. There is a well-established and vibrant health economics discipline that examines how economic techniques can be used for the analysis of health policy; there is far less use of political science techniques to answer similar questions. This thesis attempts to contribute to this sub-discipline through using political science methods to answer a question of interest to implementation of health policy.

The thesis also makes a contribution to the development of methodologies that allow us to better analyse China. It shows that formal institutional analysis and graphical techniques can be combined to map the Chinese system, and that the Chinese political system is highly suitable to this form of structural analysis. While individual policy decisions are highly heterogeneous, China's political system means that changes in political structure must be adopted across the whole country both horizontally (that is in relation to other actors at the same level) and vertically (that is in relation to other actors at the political levels above or below). When compared with local case studies, or the analysis of central politics, a system of description that can describe relationships and institutions across multiple political levels (such as the one outlined in the thesis) allows a more accurate analysis of national policy implementation.

There are, as with all studies of China, many limitations to this research. A number of these limitations, and the methodological workarounds employed to try and minimise them, were outlined in Chapter 2. Others emerged during data collection. For example, no

information exists on the structural reasons for the fall in social health insurance enrolment in the Northwest in the 1980s; and for reasons of space and an absence of data, the thesis is unable to provide a comprehensive explanation. The study also does not adequately explore cross-provincial variation, which reduces some of the explanatory power of the dependent variable. Finally, while there were many attempts made to verify the provenance and veracity of the data used in the thesis, I received no formal written verification.

There are a number of unresolved subjects that are possible areas of future research. These include, *inter alia,* the question of whether this framework would work should implementation be shifted to yet higher levels (municipality or provincial levels) and whether this framework is able to be used to examine reforms on the supply-side. I have offered some early, tentative attempts at addressing these questions in the final chapter, but there is clearly much work still left to be done. The governance model outlined in the thesis needs to be broadened, and different sectors analysed in health care more systematically.

For example, the thesis has argued that the success of social health insurance reforms is more a byproduct of political systems than of health systems. Future reform within the health care sector will involve similar questions, and will be affected deeply by political factors. In theory, for example, the privatisation of hospitals can act as a form of competition that will introduce market conditions into health provision. But hospital privatisation would require the consent of the Chinese political system — and the political system is still a Communist Party-led, top-down system. Hence, hospital privatisation

would need to occur through a central mandate to local government that included political incentives that would force them to implement the mandate. And external parties will be unable to promote, understand or evaluate potential policy changes without a thorough understanding of the Chinese political system .

Should topics in the health system prove amenable to the approach outlined in the thesis, another area of possible future research pertains to a number of broader puzzles within study of Chinese politics and policymaking. Given that studies of Chinese governance 'ha(ve) begun to open the black box of how the local state actually works'[1039] there may also be extensions of the model to other public goods and public services — education for example. Changes to education and pension systems during the period of the 'Building the New Socialist Countryside' policy (2005-2008) appear highly relevant to Chapter 7 of this thesis.

Underpinning this analysis is the idea that social health insurance schemes may form suitable case studies for how the Chinese state is able to implement public goods, and for which public good programs are most likely to be implemented. Social health insurance schemes have had periods of high up-take and low up-take; the centre has introduced and discontinued schemes; and the centre has used different policy mechanisms to attempt to implement the insurance schemes. Furthermore, health insurance provides an excellent case study on the role of governance as social health insurance enrolment creates obligations for the local state that can be monitored and measured simply from above, but

[1039] Graeme Smith (2013) Measurement, promotions and patterns of behavior in Chinese local government, *Journal of Peasant Studies,* vol. 40, no. 6, p. 1027.

implementing social health insurance schemes offers local cadres few personal revenue-raising or rent-seeking opportunities.[1040]

The fact that the most effective mobilisation of the local state has occurred through processes that are neither fully top-down, nor bottom-up; through processes that are Party-led and local state implemented; and through processes in which the actors are not focussed on health outcomes and are rather focussed on a single metric that happens to be in the health care area are, I argue, all of great interest to other analyses of public goods provision in China and may prove a fruitful area of future research. Moreover, in the long term, both insurance scheme survival and broader reform prospects revolve around ensuring adequate transfer of financial risk away from individuals, without bankrupting the scheme (or the state). This is clearly a question of great interest to other policy areas in China.

Finally, the idea of experimentation, or what Perry and Heilmann term 'adaptive governance', may be able to be analysed through an overt political organisation lens. There are a number of questions that remain unclear — briefly, which experiments are adopted, how these experiments are chosen and formulated, and how ideas that previously were treated as heretical are then rolled out nationwide as exemplary — and an account of how the Chinese state was intended to adopt experiments based on a similar use of formal documentation and political organisation may shed some light on these questions.[1041]

[1040] This obviates one of the more difficult analytical questions in working on China, the problem of state agents acting in their own self-interest rather than acting as state agents.
[1041] See Sebastian Heilmann and Elizabeth Perry (2011) *The Political Foundations of Adaptive Governance in China*, Harvard University Press: Cambridge, MA, pp 1-33; also the debate between Graeme Smith (2010)

But these, and other questions, will have to await another research project.

'The Hollow State: Rural Governance in China', *The China Quarterly,* vol. 203 pp. 601-618 and Ethan Michelson (2012) 'Public Goods and State-Society Relations: An Impact Study of China's Rural Stimulus' in Dali L. Yang (ed.) *The Global Recession and China's Political Economy*, Palgrave Macmillan: New York, pp.131-57 on how 'hollow' the state is.

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