

AUTHORITARIAN GOVERNANCE, DECENTRALIZATION, AND STATE LEGITIMACY:
HEALTHCARE REFORM IN RURAL CHINA

By

Kerry Ratigan

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The dissertation is approved by the following members of the Final Oral Committee:

Melanie Manion, Professor, Department of Political Science and Robert M. LaFollette
School of Public Affairs

Christina Ewig, Associate Professor, Departments of Gender & Women's Studies and
Political Science

Edward Friedman, Professor Emeritus, Department of Political Science

David Weimer, Professor, Robert M. LaFollette School of Public Affairs

Rikhil Bhavnani, Assistant Professor, Department of Political Science

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To my grandfather,
Ray “Lefty” Ratigan
1926-2013

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ABSTRACT

Motivated by the puzzle of state-led social policy expansion under an authoritarian regime, I examine China's rural health reform at the national level and implementation at the local level through three major questions: (1) Without the pressures of elections, why and how does an authoritarian state expand its role in healthcare? (2) In an authoritarian context, what are the causes and consequences of subnational variation in health policy implementation? (3) Why has inadequate healthcare not generated greater political instability in rural China? Through analysis of original survey data and fieldwork, I further our understanding of the sources of subnational social policy variation and the relationship between social policy and state legitimacy in an authoritarian context.

At the national level, I demonstrate that a confluence of domestic and international factors, including changes in policymaking and international discourse regarding social policy, coupled with leadership change and a catalyzing event, precipitated health reform in China. At the subnational level, I show that provincial variation can be attributed two factors. First, because of distinct economic development strategies, Chinese provinces vary systematically in social policy priorities, producing subnational welfare regimes. Second, divergent center-province relations associated with provincial wealth generate different approaches to health policy implementation. Because poorer provinces rely on progressive central government transfers for healthcare, provincial leaders demonstrate compliance with national policy by setting provincial standards for implementation, thereby ensuring that local implementation is ostensibly consistent with central government goals. By contrast, since wealthier provinces are not reliant on central

subsidies, they tend to further decentralize implementation and funding for health to lower levels of government.

Despite the central government's progressive health subsidies, healthcare continues to lag behind in poorer areas. Although protest abounds in China, persistent problems in rural healthcare have not threatened political stability. I demonstrate that, although social welfare is linked to state legitimacy, villagers' expectations for healthcare are minimal. Consequently, although healthcare services cannot meet basic needs, they are sufficient to appease villagers. By examining health policy in rural China, my research advances our understanding of the relationship between social policy, decentralization, and state legitimacy in China and beyond.

Introduction

China has become “the sick man of Asia.”¹ Along with its economic transition, China is experiencing a concurrent disease transition: risk behaviors of chronic non-communicable diseases have become more prevalent, leading to increases in cardiovascular disease, hypertension, and diabetes. Meanwhile, half of the country continues to live in rural areas where liver, lung, and stomach cancer has risen dramatically due to environmental contaminants. Because of unprecedented industrial pollution, China is estimated to have hundreds of “cancer villages.”² Population health concerns range from the effects of exposure to historical levels of air pollution to public health incidents such as food and water contaminants as well as infectious diseases.³ China is among the countries with the most suicides per capita in the world, yet mental

¹ This phrase has its origins in late 19th and early 20th centuries when China was plagued by internal conflict and had succumbed to a number of treaties with foreign powers. The expression had been designed to mirror the phrase “sick man of Europe,” referring to the divisions that were destabilizing the Ottoman Empire at the time. It has also been used recently by Huang (2011) in his insightful account of China’s health reforms.

² Estimates on the number of villages with a cancer cluster range from about 100 to over 400, such as Lee Liu, “Made in China: Cancer Villages,” *Environment Magazine*, March/April 2010, <http://www.environmentmagazine.org/Archives/Back%20Issues/March-April%202010/made-in-china-full.html>, accessed May 27, 2013. In February 2013, the Ministry of Environmental Protection acknowledged the existence of “cancer villages” (*aizheng cun* 癌症村) after a Google map of the phenomenon had widely circulated the internet. See “环保部:个别地区因环境污染出现癌症村 [Ministry of Environmental Protection: Due to Pollution, Cancer Villages Appear in Several Localities],” *Xinhua*, February 21, 2013, http://news.xinhuanet.com/politics/2013-02/21/c_114745086.htm, accessed May 27, 2013; “China acknowledges ‘cancer villages,’” *BBC News*, February 22, 2013, <http://www.bbc.co.uk/news/world-asia-china-21545868>, accessed May 27, 2013. Also, see David McKenzie, “In China, ‘cancer villages’ a reality of life,” *CNN*, May 29, 2013, <http://edition.cnn.com/2013/05/28/world/asia/china-cancer-villages-mckenzie/index.html>, accessed May 29, 2013.

³ See, for example, Louisa Lim, “Beijing’s ‘Airpocalypse’ Spurs Pollution Controls, Public Pressure,” National Public Radio, January 14, 2013, <http://www.npr.org/2013/01/14/169305324/beijings-air-quality-reaches-hazardous-levels>, accessed May 27, 2013; Jonathan Kaiman, “Chinese struggle through ‘airpocalypse’ smog,” *The Guardian*, February 16, 2013, <http://www.guardian.co.uk/world/2013/feb/16/chinese-struggle-through-airpocalypse-smog>, accessed May 27, 2013. Regarding pig carcasses in the Huangpu River, see Nicola Davison, “Rivers of blood: the dead pigs rotting in China’s water supply,” *The Guardian*, March 29, 2013, <http://www.guardian.co.uk/world/2013/mar/29/dead-pigs-china-water-supply>, accessed May 27, 2013. Regarding contagious diseases, outbreaks of severe acute respiratory syndrome (SARS) and bird flu have attracted global attention. For example, see Ben Hirschler, “Drug resistance in new China bird flu raises concern,” *Reuters*, May 28,

health is still considered taboo.⁴ By some metrics, China could be considered the sickest country in the world.

This onslaught of challenges to population health has exposed significant weaknesses in the country's health systems, including rising costs and poor quality. In response, the central government has initiated nationwide healthcare reform, stepping up the role for both the state and the market since 2003. The reform has myriad goals including: expanding insurance coverage; regulating the cost of essential medicines; improving infrastructure, equipment, and human resources of community health systems; reforming oversight and management of hospitals; and improving public health systems. The adoption and implementation of health reform in China has had significant social and political ramifications. And, the politics of the health reform, including how local government and state–society relations impact health policy implementation, provide insight into both health policy effectiveness as well as the process of policy making and implementation in China.

In this dissertation, I examine the development of China's healthcare reform at the national level and health policy implementation in rural China at the local level through three major questions: (1) Without the pressures of elections or independent civil society, how and why does an authoritarian state expand its role in healthcare? (2) In an authoritarian context, what are the causes and consequences of subnational variation in health policy implementation? (3) Why has inadequate healthcare not generated greater political instability in rural China?

2013, <http://www.reuters.com/article/2013/05/28/us-birdflu-tamiflu-idUSBRE94R0FJ20130528>, accessed May 30, 2013.

⁴ "287,000 commit suicide in China each year," *Xinhua English News*, September 8, 2011, http://news.xinhuanet.com/english2010/china/2011-09/08/c_131117301.htm, accessed March 26, 2012.

This dissertation is motivated by the puzzle of state-led expansion of healthcare provision under an authoritarian regime. At the national level, what are the factors that motivate an authoritarian state to overhaul the health sector and dramatically increase state funding for healthcare? I explain this shift in national health policy in China by examining the confluence of international and domestic factors, coupled with a leadership change and a catalyst to precipitate policy change. Shortly after the Hu-Wen administration assumed power, the public health crisis caused by the outbreak of severe acute respiratory syndrome (SARS) in 2003 provided a catalyst for healthcare to be placed at the top of the policy agenda. Thus, a confluence of international and domestic factors led to healthcare policy reform in China. The healthcare reform process reflects some of the changes that have occurred in policymaking in China from the 1990s to the early 2000s.

At the local level, however, implementation of new health policies has been piecemeal and uneven. Some regions have been more successful in implementing health reform than others, resulting in a “postcode lottery” where access to affordable, quality healthcare depends on the arbitrary criterion of residence.⁵ China’s system of residency permits or *hukou* (户口) further exacerbates the consequences of uneven healthcare provision at the local level by severely limiting villagers’ geographic mobility.⁶ The dissertation seeks to characterize and explain this subnational variation in health policy implementation by examining both top-down and bottom-up pressures on the agents of policy implementation.

⁵ This term has been coined by the British and gained currency to express the geographically uneven distribution of resources for social policy such as healthcare and education. See, for example, Kate Devlin, “Healthcare postcode lottery means patients losing out on cancer treatments,” *The Telegraph*, September 8, 2008, <http://www.telegraph.co.uk/health/2700686/Healthcare-postcode-lottery-means-patients-losing-out-on-cancer-treatments.html>, accessed May 27, 2013; Patrick Butler, “Q&A: Postcode lottery,” *The Guardian*, November 9, 2000, <http://www.guardian.co.uk/society/2000/nov/09/NHS>, accessed May 27, 2013.

⁶ For more detail on the *hukou* system, see Chan (2009) and Chan and Buckingham (2008).

Due to distinct approaches to economic development, Chinese provinces diverge systematically in their approaches to social policy: while some provinces emphasize education as a means to foster economic development, other provinces utilize social policy primarily to protect vulnerable groups. Provinces that focus on economic development also tend to be wealthier and, due to key leadership appointments, have more autonomy to pursue a decentralized approach to health policy implementation. Meanwhile, poorer provinces are more dependent on central government transfers. Therefore, in these cases, provincial leadership employs a more top-down approach to social policy implementation, to demonstrate their compliance with central government edicts so that they may continue to receive subsidies for social policy. As a result, in wealthier provinces, health policy is more variably implemented by lower levels of government (usually the county), whereas poorer provinces tend to establish provincial standardization measures. Thus, wealthier provinces have more autonomy to implement health policy, but are also responsible for funding a greater proportion of rural health insurance. Meanwhile, poorer, inland provinces receive more targeted subsidies for healthcare but are also more constrained in policy implementation. In this way, pressure from provincial leadership (and sometimes from the central government) motivates local agents to implement policies according to targets set by higher levels of government in poorer provinces, but grants more autonomy to wealthier provinces.

Local government in China is also affected by societal pressure from below. Because local officials are held accountable for social stability in their community by higher levels of government, they seek to reduce incidents of protest or other expressions of mass discontent.⁷ Therefore, while the channels to express grievances available to villagers are more limited than

⁷ Previous research has demonstrated that mass discontent can lead to policy change (Bernstein and Lü 2003).

in democratic countries, local officials are, nonetheless, still susceptible to pressure from local communities. Healthcare and social policy are intrinsically linked to state legitimacy in China and social grievances related to healthcare spurred the central government to initiate healthcare reform at the national level. Nonetheless, while some aspects of the reform have ameliorated the health struggles of villagers, many challenges remain. I utilize data from my original survey of villagers and village leaders in three provinces to examine their expectations for healthcare provision. I argue that because villagers' expectations for healthcare provision are minimal, the government's current policies are sufficient to respond to villagers' demands.

This research seeks to address two glaring lacunae: a lack of research on welfare state performance in non-democracies and inattention to subnational variation in social policy implementation. Through an analysis of rural health policy reform and implementation in China, the dissertation addresses the larger issue of welfare state performance in non-democratic developing countries, which comprise half of the world's people and nations. Despite the significance of this issue, the dominant research paradigms ignore or misrepresent authoritarian systems and, instead, focus on the impacts of democratic forces, such as civil society and electoral competition.

Furthermore, another gap in the current literature limits its utility for policy analysis in the quest for good governance. Much policy analysis of welfare regimes in developing countries is overly focused on policy adoption at the national level. In reality, all regime types have to grapple with the difficulties inherent to the geographic and regional diversity that produces the complex realities of local communities. Without understanding variation within a country, an analyst cannot fully grasp the factors driving policy successes and failures. This research

addresses this lacuna by providing a subnational analysis of healthcare reform and delivery in China.

The Politics of Social Welfare Expansion in Developing Countries

Without a doubt, democratic institutions and the process of democratization impact social policy reform, particularly in the context of social welfare expansion. But can existing theories based on democratic cases elucidate experiences in an authoritarian regime such as China? To what extent does regime type determine the timing and nature of social policy reform? Or can we explain this phenomenon in the context of factors that are not intrinsically linked to democracy, such as political leadership, veto players, and social forces?

Social policy reform, particularly the phenomenon of welfare state expansion in developing countries, is often linked to processes of democracy and democratization. From a cross-national perspective, democracies are more likely to expand social policy than non-democracies (Haggard and Kaufman 2008). For recent democracies, the transition from authoritarianism can provoke social policy expansion. As the process of democratization enfranchises new constituencies and provides space for the inclusion of new societal actors in policymaking, political elites may expand social welfare benefits as a strategy to garner support with key groups (Wong 2004). Not all democratic transitions facilitate social welfare expansion, however. Some Latin American countries faced seemingly insurmountable obstacles in expanding social policy programs after democratization, including the dominance of an austere economic paradigm and the institutionalization of the political power of former authoritarians; these obstacles were overcome by encompassing peak associations of major societal actors in

cases such as Chile, but not in Brazil (Weyland 1997). In the Chinese case, the Hu-Wen administration placed social policy back on the national agenda in 2003, after their predecessor, Jiang Zemin, had prioritized economic growth throughout the 1990s.⁸ This shift towards social policy included a rhetorical shift, an increased financial commitment to social policy, and new programs initiated from the central government. My research seeks to explain this policy shift in the absence of political reform or democratization.

There are few detailed accounts of the factors leading to China's contemporary health reform.⁹ Most cursory descriptions of China's recent healthcare reform focus on the SARS crisis as the primary impetus for change and neglect changes in the Chinese policy process that occurred maintaining authoritarian party-state. By contrast, I argue in Chapter 2 that domestic and international factors in the late-1990s and early-2000s created the political environment necessary for the SARS disaster to catalyze reform. After 1978, revenue constraints caused Chinese state retrenchment in social policy, while healthcare costs began to rise. This confluence left the healthcare system in crisis, with challenges such as a spike in out-of-pocket expenditures and the withering of community clinics. By the early 1990s, tax reforms alleviated the central government's revenue crisis and the increasing influence of think tanks in policymaking created new potential pathways for the state's role in social policy. Concurrently, the international community began to advocate state re-engagement with social policy provision. As a result of pressure from below, shifts in governance style, and encouragement from domestic and

⁸ Throughout the 1980s and 1990s, China engaged in retrenchment of social policy with varying societal response, but this process has been examined elsewhere. See, for example, Duckett (2010) on healthcare, Frazier (2010) on social security, and O'Brien and Li (2006) on resistance to the state.

⁹ See Huang (2013) for a notable example. Kornreich and colleagues (2012) and Duckett (2010) also provide insightful analysis of some aspects of the reform.

international organizations and think tanks, the Chinese government initiated a dialogue on healthcare reform that culminated in the 2009 plan to overhaul the system. This reform, however, is ongoing and incomplete. Due to political considerations, national leaders were hesitant to take a clear stance on certain contentious issues, such as hospital reform. This reticence regarding reforming politically sensitive aspects of healthcare is not unique to authoritarian regimes, however.¹⁰ My national-level analysis furthers our understanding of healthcare reform in this significant case and of the policy process in authoritarian regimes more broadly.

Subnational Variation in Social Policy Provision

Although the central government has committed to healthcare reform, implementation relies on local government, resulting in significant variation in subnational social policy provision, which is evident both within and across provinces. The issue of subnational variation in social policy is certainly not unique to China, but prevalent in a number of federal or decentralized countries, such as Mexico (Lakin 2008; Homedes and Ugalde 2006), Brazil (Coelho and Shankland 2011), India (Krishna 2011; Yip and Mahal 2008), and the U.S. (Haeder and Weimer 2013), to name just a few. Yet comparative research on social policy tends to focus on cross-national variation rather than explain subnational divergence in policy implementation. I build on the insights of cross-national research in examining the inter-provincial variation in social policy in China.

Categorization of welfare regimes typically uses Esping-Andersen's (1990) seminal "worlds of welfare" framework as a point of departure. Esping-Andersen argues that there are three distinct approaches to social policy that reflect the economic and political conditions of the

¹⁰ See, for example, the unresolved debates (as of time of writing) over the tax exclusion for employer-sponsored health insurance and the proposed excise tax in the context of the Affordable Care Act in the U.S. (Gruber 2010a, 2010b).

country: liberal (U.S., Canada); corporatist (Germany, France); and social democratic (Sweden). Esping-Andersen's (1990) seminal "worlds of welfare" framework, however, relies on a state-centric model in which the majority of workers are employed in the formal sector. This approach advanced understanding of welfare regimes in developed countries, but analysis of social policy provision in developing countries has required new models to capture how the economic and political environments of developing countries affect social policy. By definition, developing economies rely more heavily on the agricultural sector and the informal economy. In addition, state-society relations may be clientelistic or even predatory, often leaving non-state, non-market actors, such as families and communities, to provide a social safety net. Gough and Wood (2004) advanced this research by differentiating between the welfare state regimes of developed countries and the systems observed in developing countries, which they classify as informal security regimes and insecurity regimes. Informal security regimes are characterized by uneven development, a weak state, pervasive patron-client relations, but some social policy provision through communities with some state support. Insecurity regimes, in contrast, are characterized by predatory states with no commitment to social policy or stability, leaving the vast majority of the population vulnerable and without social welfare.

While this typology advanced the research by elucidating the distinctions between social policy regimes in developed and developing states, further research has provided new categories for understanding the divergence in social policy provision among developing countries. Huber and Stephens (2005) classify Latin American countries based on whether their social policies are aimed at developing human capital through social policies, such as education, as compared with those policies that protect workers from the market, such as pensions and social insurance. This

distinction has been further developed by Rudra (2008, 2007) and, subsequently, by Martínez Franzoni (2008) and Pribble (2011). Rudra (2007) argues that developing states have diverged systematically, thereby producing three dominant types: productive, protective, and dual welfare states. These three types are determined by the economic development strategy of the country. As a variation on this typology, Martínez Franzoni incorporates a third category, nonstate familiarist, in order to capture those societies that rely mainly on the community for social support. Additionally, Pribble (2011) argues that the process of industrialization has interacted with the nature of political incorporation of marginalized groups and the proportion of ethnic and racial minorities to create four distinct social policy regimes in Latin America. While providing insight into Latin America social policy regimes, this typology is limited in its applicability to other regions. I posit that variation in provincial social policy regimes in China can be classified by expanding on Rudra's productivist/protectivist typology.

Rudra (2008) argues that developing countries that pursue an export-oriented industrialization strategy tend to invest in social policy that will improve human capital (health and education) while keeping the cost of labor low, in order to attract foreign investors and keep the costs of exports competitive (e.g. South Korea), which she terms a productive welfare regime. By contrast, Rudra's protective welfare regimes emphasize shielding workers from market fluctuations by providing benefits such as subsidized housing, generous pensions, or ample unemployment insurance. "Protective" welfare regimes tend to develop these priorities due to their state-led development strategy, such as import substitution industrialization (ISI). Thus, largely as a function of economic approach, developing countries systematically diverged in the

development of welfare regimes that were in large part a reflection of the economic development strategy that leaders pursued.

Using Rudra's productive/protective typology, in Chapter 3, I demonstrate the variation in social policy priorities and outcomes across Chinese provinces is analogous to the diverse results found cross-nationally. Using provincial-level data, I demonstrate that Chinese provinces vary systematically in their social spending priorities: some provinces tend to emphasize education spending, while others emphasize social insurance, pensions, and housing. This finding indicates that some provinces have a "productive" approach to social policy, while others are more "protective," reflecting distinct strategies for economic development and different policy styles across provinces.

However, several dimensions of subnational variation in social policy are not captured by provincial-level analysis, including the gap between rural and urban welfare systems, qualitative variation in healthcare provision, and the role of municipal and local governments in social policy implementation. Within-province variation in social policy is often overlooked in China, particularly in rural areas, due to the paucity of reliable local-level data.

In Chapter 4, I posit that wealthier provinces take a more decentralized approach to health policy funding and implementation than poorer provinces. The central government utilizes distinct methods to retain control over the provinces. Provincial leaders in wealthy provinces are selected for their regime loyalty, or "bureaucratic integration" (Sheng 2010). By contrast, poorer provinces seek to ingratiate themselves with the central government because they are dependent on progressive fiscal transfers from Beijing. As a result of these distinct center-province dynamics, wealthy provinces further devolve funding and the authority for policy design to lower

levels of government, whereas poorer provinces tend to standardize health policy across the province, reducing the role of local-level government. Additionally, Chapter 4 examines some of the weaknesses in new health policies and some of the health-related grievances that persist in rural China, particularly in poor regions.

Social Forces, State Legitimacy, and Healthcare

The degree of inclusion of social forces, such as civil society and medical lobbies, certainly impact the timing, nature, and effectiveness of social policy reform and implementation.

Previous research contends that the presence of strong left-wing parties will facilitate expansion, while excessive veto players can stymie attempts at expanding social policy. For example, Kay (1999) demonstrates that the level of mobilization is not sufficient to explain variation in social security privatization. While the executive branch successfully dominated the privatization process in Argentina, the Uruguayan anti-privatization coalition managed to utilize institutional features, such as plebiscites, to prevent reform.

More effective reforms tend to include social groups in the policymaking process, but the state manages to maintain sufficient autonomy to implement policy, without succumbing to clientelistic relationships. At one end of the spectrum, Ewig (2004) finds that the exclusion of social actors in the Peruvian reform process resulted in a “piecemeal” reform. By contrast, Weyland (1998) argues that previous capture of state agencies by societal groups prevented successful reform in Brazil. Alternatively, Kwon (2007) argues that advocacy coalitions were instrumental in putting health reform on the agenda after democratization in Korea. Nonetheless,

strong medical lobbies can also impede redistributive policies as in Latin America (Nelson 2004; Weyland 1996).

The participation of vulnerable groups (of lack thereof) also has implications for social policy expansion. Pribble (2006) posits that variation in the degree of female participation in the labor force resulted in different levels of mobilization of women in the two countries and, thus, divergent approaches to social policy. Then, in the Chilean case, the dictatorship was able to suppress mobilization and social pressures for social policy, thereby further institutionalizing policies that maintain gender inequity.

Moreover, the quality of links between the state and society matter for the content of social policy. Kurtz (2002), for example, argues that without linkages that connect state actors to society, the state will generally opt for a social assistance model rather than a universality approach to social policy. Similarly, conditional cash transfer programs often constitute a politically viable, but minimal approach to social policy, because they require less significant spending and target the poor, and therefore are less likely to be the target of political opposition (Teichman 2008). In a democratic context, Teichman (2008) does find that cash transfer programs may have mobilized groups in civil society to advocate for more comprehensive programs, as an unintended consequence.

In broad terms, China lacks the type of interest groups and societal coalitions that would pressure the state for healthcare reform in a democracy. Moreover, collective action is strongly discouraged and often met with repression.¹¹ In terms of possible lobbying groups, there is no strong autonomous medical association to affect policy; the medical profession is controlled by

¹¹ For a recent example of a violent clash between protesting villagers and local police, see James Pomfret, "Special Report: Freedom fizzles out in China's rebel town of Wukan," *Reuters*, February 28, 2010, <http://www.reuters.com/article/2013/02/28/us-china-wukan-idUSBRE91R1J020130228>, accessed May 27, 2013.

the state.¹² Hospitals are still predominantly public and hospital directors are appointed by the communist party. Like other developing states, China is affected by some of the factors identified by Rudra and others, but in the context of a non-democratic institutional context. Uncertainty and vulnerability vis-à-vis globalization is certainly a salient issue in China. However, “social reactions to the market” (Rudra, 2007: 381) are filtered through Chinese political institutions; there are channels for societal grievances to reach state actors, but they are neither transparent, nor public.

In stark contrast to democratic contexts, Chinese villagers and other marginalized groups must delicately traverse a political minefield to express their grievances. Protest and dissent are channeled through myriad, sometimes diffuse, outlets, such as protests, the petition system, and investigative (“watchdog”) journalism (Liebman 2005). Nonetheless, informal social unrest may affect policy in China, as both central and subnational levels of government pay particular attention to protests, petitions, and sometimes even media reports as indicators of social “instability” (Zhao and Sun 2007; Diamant et al. 2005; Thireau and Hua 2005; Bernstein and Lü 2003; Huang 1995). Through these informal channels, rural residents’ grievances have, to some extent, been heard in Beijing. But, in countries where democratic institutions are absent or malfunctioning, how do we understand state engagement with social policy expansion? My research addresses this question by examining villagers’ expectations for healthcare provision as well as the links between healthcare and state legitimacy.

Despite advances made in health reform over the past decade, including some progressive initiatives from the central government, villagers in impoverished regions express greater

¹² Officially a “charity,” the Chinese Medical Doctor Association (CMDA) was formed in 2002, but it does not control licensing or have the capacity to mobilize doctors as an effectively lobbying group. Cao (2011) provides an excellent analysis of the CMDA’s potential as an actor in health policy debates.

dissatisfaction with healthcare and encounter more health challenges than villagers in wealthy provinces. In particular, health reform has yet to reign in rising costs and rural health infrastructure is sorely deficient. Nevertheless, villagers no longer target the state for their healthcare grievances. While there were reports of petitions related to healthcare grievances prior to 2003, those reports appear to have subsided. I argue that current government policy has appeased villagers' minimalist demands for healthcare. Although social policy is linked to state legitimacy in China, I argue that many villagers have relatively low expectations for provision of healthcare because of past experiences.

In this dissertation, I examine several important questions regarding health policy adoption and implementation in China. In the process, this research further advances our understanding of the policy process, the impact of center–province relations on policy implementation, and sources of state legitimacy in China. Due to the paucity of publicly available data on social policy implementation at the subnational level in China, a major empirical contribution of this dissertation is to present an original survey and semi-structured interviews to examine rural health policy. My original survey of villagers and village leaders¹³ provides a worm's eye view of health policy implementation that would not be possible otherwise.

¹³ A note on terminology: Throughout the dissertation, I generally use the term “village leaders” or “officials” to refer to village “cadres” (*ganbu* 干部), who are members of the village committee (either elected or appointed). Technically, it is worth noting that village committees are not considered part of the government per se, although, increasingly, members of the village committee are paid by higher levels of government. However, in Chapter 2, I discuss the role of cadres during the Maoist period and use the term “cadre” to emphasize the ideological and political importance of the cadre class and the significance of the privileges that were bestowed to them during this period.

Research Methods

I utilize multiple sources of evidence to examine the factors affecting health policy reform and its impact on rural China. Throughout over 14 months of qualitative fieldwork, I have compiled information on healthcare provision from national Health Statistics Yearbooks, provincial Public Health Yearbooks, provincial- and county-level websites, local government documents, national and subnational laws and regulations as well as the media. I have conducted 38 semi-structured interviews with county-level Public Health Bureau officials, office bureaucrats who administer rural health insurance, Petitions' Office bureaucrats, and hospital personnel in three provinces: Jiangsu, Hunan, and Gansu. A list of local government officials who served as interview subjects is available in Appendix D. In each county that I visited, I also visited at least one village and conducted semi-structured interviews with villagers, sometimes one-on-one and sometimes in small groups. In addition, I conducted interviews and informal conversations with local scholars who are knowledgeable about the health reform process through their research or their first-hand experience serving as consultants for policymakers.

In addition to qualitative research, I conducted an original survey of villagers and village leaders in three provinces in collaboration with Leah Larson-Rabin (Ph.D. Candidate, University of Wisconsin–Madison). The sample comprises 169 villages in 27 counties and yielded over 1000 completed questionnaires.¹⁴ The survey examines villagers' expectations and perceptions of local healthcare provision, the role of local government in providing healthcare and public goods, and villagers' use of health systems. The survey was also administered to village leaders

¹⁴ The survey sample conforms to social science norms. Provinces and municipalities have been purposefully selected to reflect socio-economic and geographic diversity. Counties and villages were selected randomly using a multi-stage sampling procedure. Further detail on sampling and the process of conducting the survey is available in Appendix D.

to examine how they perceive their role in social policy provision, their relationship to villagers, and to collect village-level administrative data that are not publicly available. Detailed discussion of how the survey was conducted is available in Appendix D. Few surveys in China combine questions related to social policy with local governance. Moreover, surveys are rarely administered to both village and villagers leaders. Thus, the information gathered from this project provides insights into social policy and village governance that would not be attainable otherwise.

Overview of the Dissertation

The dissertation proceeds as follows. In Chapter 2, I provide an historical overview of healthcare policy and reform in China since 1949, focusing on the effects of policy change on rural communities. This brief history identifies major policy shifts in four distinct periods: the early Mao period (1950s), the Cultural Revolution (1960s to 1970s), market reform and healthcare retrenchment (1980s to 1990s), and state reengagement with healthcare reform (2003 to 2013). Chapter 2 culminates in an analysis of the main factors that explain the timing and nature of the 2009 Health Reform Plan. In Chapter 3, I analyze the systematic divergence in social policy priorities among Chinese provinces, arguing that some provinces utilize social policy to foster economic development, while others focus on protecting vulnerable groups. In Chapter 4, I argue that China's decentralized approach to health policy implementation is contingent on the relationship between the provincial to the central government. Wealthy provinces tend to be more decentralized in both the funding and policy implementation of health policy. By contrast, because poorer provinces depend on progressive central government transfers, their leadership

tends to standardize health policy within the province to demonstrate compliance with central policy. I conclude Chapter 4 by examining some of the challenges that persist in health policy implementation and how villagers' evaluations of healthcare are negatively associated with living in poorer provinces, despite recent reforms. Since health policy implementation is uneven and significant healthcare-related grievances persist in rural areas, I offer an explanation for why we do not observe more contentious action from society targeting the state regarding healthcare in Chapter 5. Using original survey data, I argue that the state is satisficing villagers' current demand for healthcare, because of their relatively minimalist expectations for healthcare provision. In the conclusion, I restate the main arguments and the implications of this research for debates on social welfare, decentralization, and good governance in developing countries more broadly.

Chapter 2

China's National Health System: Ideological Oscillations and Incomplete Reform

Since 1949, the role of the state in health policy has fluctuated with the vicissitudes of Chinese politics, oscillating between neglect and an instrumental use of healthcare to promote state legitimacy.¹⁵ Due to post-war stabilization of the country and eventual economic growth, significant gains were made in healthcare outcomes, but largely in spite of central government policy rather than because of it. Prior to market reforms, two main factors hindered the Ministry of Health in improving health services: 1) budget constraints and 2) political oscillations that reduced the Ministry's independence, favoring political fervor over a technocratic approach to health policy. After market reforms, healthcare and social policy were subordinated to economic growth, debilitating the Ministry of Health. Meanwhile, local-level health facilities that had functioned intermittently during the Maoist period were undermined both financially and politically. It was not until the late-1990s that policy experiments in the health sector and the increasing involvement of research organizations in policymaking laid the groundwork for future healthcare reform, but the impetus for central leadership to fund new policies was still lacking. In 2003, the crisis caused by severe acute respiratory syndrome (SARS) enabled the Hu-Wen administration to strike their own course and precipitated healthcare reform by putting public

¹⁵ While state engagement with health policy is an important topic prior to 1949, this chapter focuses on the period following the Communist Party assumption of power. I focus on the CCP era because this is the most appropriate precursor for understanding current health policy challenges. Communist rule, however, does not represent a complete departure from previous policies. Rather, some policy approaches were retained, such as the basic organization of the health sector, while others were adapted to the Communist style of governance, such as tactics associated with the mass line. Pre-1949 health organizations were heavily influenced by the Soviet Union and the experiences of both the Nationalist (*Guomindang* 国民党) and Communist parties. For more on the pre-1949 legacy in health policy, see AnElissa Lucas, *Chinese Medical Modernization: Comparative Policy Continuities, 1930s-1980s* (New York: Praeger Publishers, 1982), and Ka-che Yip, *Health and National Reconstruction in Nationalist China: The Development of Modern Health Services, 1928-1937* (Ann Arbor, MI: Association for Asian Studies, 1995).

health on the national (and international) agenda. The reform, however, ultimately represented a compromise between various state and non-state actors, seeking a middle path between state and market solutions. The timing and nature of this reform was contingent on changes in the policymaking process in post-Mao China.

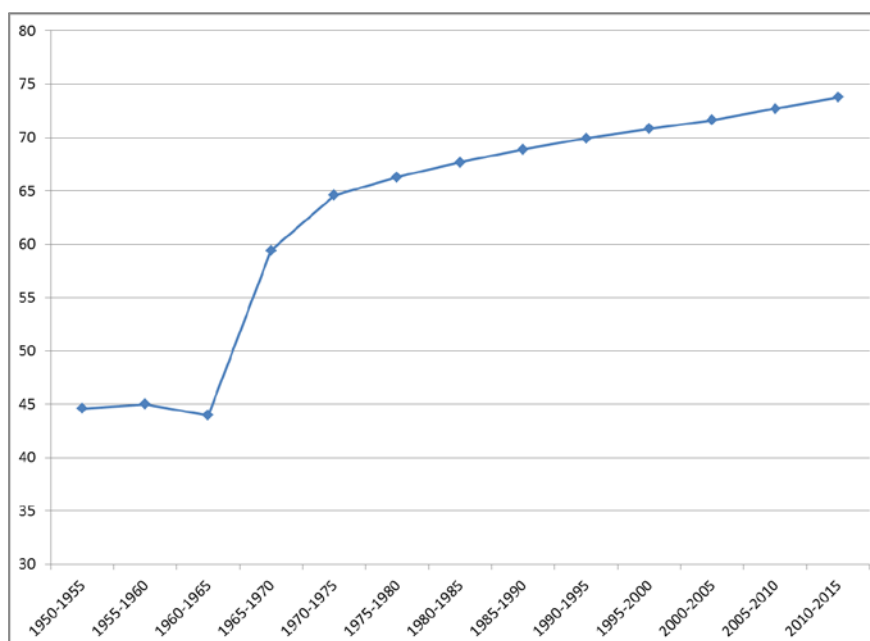
Historical and political context is necessary to understand preexisting health systems and institutions, embedded interests in healthcare, and the expectations (or lack thereof) that villagers may have for healthcare, based on their life experiences and previous interactions with state health institutions. Accounts of the contemporary healthcare reform and current policy evaluations tend to ignore or misrepresent the reality of healthcare during the Maoist era, thereby failing to appreciate how the historical context affects current reforms. Moreover, cursory examinations of post-Mao era state retrenchment in healthcare exaggerate the importance of market reforms and the role of the SARS crisis, while underestimating shifts in domestic elite politics, state–society relations, and international discourse regarding the role of the state in healthcare provision.

This chapter examines the history of health policy in China after 1949, focusing on health systems in rural areas. I focus on healthcare in rural China and provide an overview of state involvement in healthcare provision. To identify broad trends and shifts in health policy approaches, I examine four phases of healthcare policy: the post-war period (1949 to 1950s), the Cultural Revolution and ideological radicalism (1960s to 1970s), market reforms and state retrenchment (1980s to early 1990s), and state reengagement with healthcare (late 1990s to 2013), including the recent (and ongoing) 2009 reform.

From Stabilization to Politicization in the Post-War Period: 1949 to the 1950s

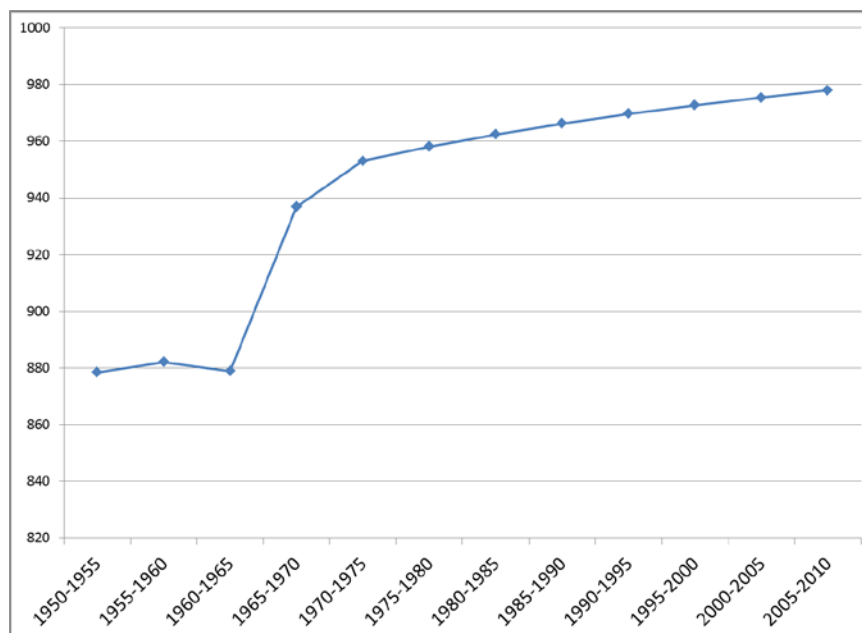
Upon defeat of the Nationalists in 1949, the Communist party encountered a dire state of affairs in healthcare: population health was poor and the country was lacking infrastructure and medical personnel. Decades of war coupled with lack of hygiene and inadequate health systems had resulted in an average life expectancy of less than 45 years in 1949 (Figure 2.1) and infant survival rate was very low (Figure 2.2).

Figure 2.1: Life Expectancy in China, 1950-2015



Source: United Nations Statistics Division, data.un.org.

Note: These data largely coincide with those published by the China Statistical Yearbook and the China Health Statistical Yearbook. However, the United Nations also provides estimates for years that are unavailable in the statistics published by the Chinese government.

Figure 2.2: Infant Survival Rate in China, 1950-2010

Source: United Nations Statistics Division, data.un.org.

Note: Infant survival rate calculated by subtracting infant mortality rate per 1000 live births by 1000. Therefore, higher numbers represent a greater proportion of infants surviving. These data largely coincide with those published by the China Statistical Yearbook and the China Health Statistical Yearbook. However, the United Nations also provides estimates for years that are unavailable in the statistics published by the Chinese government.

Chinese Communist rhetoric, such as Mao’s 1944 statement that healthcare should “serve the whole army and the whole people,”¹⁶ indicated that healthcare would be a priority, but health reform post-1949 got off to a false start. While the Ministry of Health (MOH) initially had some autonomy in directing the reconstitution of a national health system, budget constraints, regressive allocation of resources based on political criteria, and ideological conflicts stalled progress in healthcare within the first decade of the Communist regime.

¹⁶ Mao Zedong, “Inscription for the Health Exhibition in Yanan” (1944) in *Xin Ren Wei* (新人卫, New People’s Health), Peking: People’s Health Press, 1967, quoted in Lampton 1974: 12.

In contrast to other government ministries in China at the time, the Ministry of Health initially operated as a relatively autonomous government department and was able to set the priorities for national healthcare. Established in 1949, the MOH was staffed by trained physicians as well as an elite group of physicians who had been trained in prestigious universities in Europe, the U.S., Japan, or China. These physicians, referred to as “medical politicians,” had contributed invaluable service and expertise during wartime and, after 1949, were appointed to direct healthcare policy (Lampton 1973: 28-29). Doctors in the MOH were chosen both for their expertise and their ideological commitment; several “red doctors” (doctors who had served in the communist army) were appointed to vice-ministerial positions (Huang 2013: 25). Nonetheless, the Ministry of Health was able to guide policy with a substantial degree of autonomy from the Communist party (Lampton 1973: 28-29). While other ministry-level leaders (and government officials of all levels) were pressured to demonstrate their fealty to the Party by enthusiastically implementing Mao’s policy directives, the MOH initially had somewhat more room to maneuver, until its approach to modern medicine conflicted with Mao’s anti-intellectual beliefs.

The MOH used its autonomy to advocate for development of facilities and training of personnel. China’s healthcare system in the 1930s and 1940s had suffered from conflict and inattention, resulting in inadequate facilities and a lack of medical personnel. There was about one hospital bed per 6,667 people, with a significant proportion of hospitals concentrated in urban areas (Huang 2013: 24). Regarding personnel, estimates place the ratio of doctors to population in 1949 at between 1 to 14,000 and 1 to 50,000 (Huang 2013: 24; Lampton 1974:

4).¹⁷ The MOH sought to respond to these needs by allocating a significant proportion of the budget to the construction and maintenance of health facilities. An estimated 38 to 59 percent of the health budget was destined for building or maintaining health facilities in the early 1950s (Table 2.1).

Table 2.1: Estimated Budget Priorities for Health, 1951-1956

Category	Proportion
Facilities (construction and subsidies)	38-59 %
Healthcare for cadres	19-25 %
Maternal and child health	2-4.3 %
Other	20-30 %

Source: Compiled from Zhen, 1976: 24.

When state-supported hospitals exceeded their budgets, the government would provide subsidies, resulting in a high proportion of funding being allocated for facilities. The MOH emphasized training of medical personnel and dramatically increased enrollment in medical training programs. Expanding medical programs dramatically increased the doctor to population ratio to approximately 1 to 4,500 by 1966 (Lampton 1974: 4). Later, the Ministry of Public Health's emphasis on a scientific approach to medical education would clash with Mao's belief that ideological correctness and enthusiasm were more powerful than technical knowledge.

Early health policy was not completely insulated from political considerations, however. Mao and the central leadership were concerned about maintaining cadre¹⁸ loyalty, which led to

¹⁷ Lampton (1974) refers to "western-style physicians," perhaps producing a lower estimate of physicians than Huang, who relies on the 1983 China Health Yearbook.

¹⁸ In this chapter, I use the term "cadre" (*ganbu* 干部) rather than "leader" or "official" to differentiate between those who had a formal position within the state apparatus and therefore received significant benefits, such as healthcare, housing, education, and pensions. Since cadres played an important role during this time period both in

regressive spending in healthcare. Cadres accounted for less than 2 percent of the population and, yet, 19 to 25 percent of the budget was allocated to providing for their medical care (Table 2.1). Initially, cadres were only remunerated by state provision of their essential needs, such as housing, food, schooling, and healthcare. However, after the state transitioned to a salary-based system for cadres (following the Soviet Union's model), these perquisites were maintained, diverting a disproportionate amount of resources to a small elite (Zhen 1976: 26). Furthermore, as most cadres were located in the cities, this policy also resulted in de facto preferential treatment for urban healthcare facilities, which became increasingly developed while rural clinics lagged even farther behind.

Budget limitations due to high military expenditures both at home and abroad,¹⁹ precluded the development of a comprehensive, nation-wide network of clinics in rural areas. Rather than providing transfers to rural localities for healthcare, the MOH and central leadership tasked agricultural producers collectives (and eventually larger communes beginning in 1958) with providing health services for their members in the form of what would later become the Cooperative Medical System (CMS, *nongcun hezuo yiliao zhidu* 农村合作医疗制度). Throughout the early 1950s, at the urging of the party-state, rural collectives begin to establish their own rudimentary clinics and free health services were virtually ubiquitous among communes, once these were established in the late 1950s. These clinics typically provided basic services and family planning. They were staffed by physicians' assistants with varying levels of training and, by the late 1950s, "barefoot doctors" (*chijiao yisheng* 赤脚医生), who were

terms of ideology and governance, I use this term in this chapter. Elsewhere in the dissertation, I use the term local official or leader to refer to individuals who serve on the village committee or those who have a post working for the state.

¹⁹ The new regime was focused on restoring order throughout the country and entered the Korean War in 1950.

villagers with a few months of basic medical training who continued to work as farmers while attending to patients part-time (Zhen 1976: 35; Sidel and Sidel 1973: 81). While the funding structure of the CMS clinics varied widely across localities, a common approach was to provide low-cost healthcare through a combination of funds from the commune budget and villagers' premiums (Zhen 1976: 36). While the central and provincial governments would subsidize the operating costs of county hospitals, rural clinics did not receive this privilege. Meanwhile, rural patients tended to use these free services excessively and indiscriminately. Therefore, when the Great Leap Forward caused a devastating agricultural crisis, communes could no longer sustain the minimal services that had been provided through the CMS.

By the late 1950s, a confluence of political and economic factors created a perfect storm for rural healthcare and the CMS. From 1959 to 1961, China suffered an agricultural crisis and famine due to the disastrous policies of the Great Leap Forward which, coupled with the lack of experience of village clinics and overuse of free coverage, caused many commune health services to close their doors. Because these clinics depended on subsidies from the commune budget and farmers' premiums, both of their main sources of funding were simultaneously depleted by the crisis. When farmers' disposable income dropped precipitously, they often stopped paying premiums. Meanwhile, the lack of experienced medical personnel had facilitated patients' overuse of free services. Therefore, as funds dissipated, some communes ceased provision of services while others continued to operate clinics on a fee-for-service basis. Subsequently, county hospitals were inundated with referrals from crippled commune clinics (Zhen 1976: 35). As the crisis abated and pragmatic, market-regarding economic policies facilitated recovery in the early 1960s, many communes reinstated health centers that were

subsidized by the commune budget, but began to charge fees for services to reduce overuse (Zhen 1976: 36).

Healthcare was not immune to the Maoist style of governance, however, and the initial autonomy of the MOH soon dissipated.²⁰ Concurrently with the Great Leap Forward, Mao would mobilize farmers to participate in mass campaigns, sometimes related to healthcare. These campaigns served two important purposes: building legitimacy by apparently addressing grievances in rural areas and further developing the Communist party's political apparatus by extending the reach of the state further into the private sphere. In this way, health work increased regime legitimacy. The campaign to eradicate schistosomiasis provides an instructive example of the Maoist style of governance. In 1958, rampant schistosomiasis became a priority for the party and the government. These parasitic worms, whose eggs are carried by water, were easily spread through waterways where fishermen would urinate and defecate, thereby contaminating the bathing and drinking sources of communities downstream (Li 2010). Infection rates reportedly reached 72 percent in some areas (Li 2010: 216). One county had an infection rate of over 50 percent among villagers, over 66 percent among fishermen, 33 percent among factory workers, and 40 percent among officials (Li 2010: 209). To address this pervasive scourge, the Ministry of Public Health recommended further research and study before taking action. Instead, Mao decided to mobilize the masses to eradicate the snails that facilitate the spread of the parasite. The central leadership created a separate institutional structure for the eradication of the parasite (Li 2010: 214). Then, the party implemented a multi-faceted education blitz explaining that the snails were the source of the problem to villagers through "lectures, film shows, posters, and

²⁰ Another example of the politicization of healthcare is the exclusion of former landowners from participating in cooperative medicine. According to Zhen (1976: 72), "[t]his practice is used as a device to drive home Mao's dictum to the poor and lower-middle class peasants: 'Do not forget classes and class struggle.'"

radio talks” (Horn 1969: 96). Finally, the villagers were mobilized in a mass campaign against the snails. Horn observed that the villagers readily and enthusiastically participated in campaigns against the snails:

Twice a year, in March and in August, the entire population in county after county, supplemented by the voluntary labour of all available army men, students, teachers and office workers, turned out to drain the rivers and ditches, dig away and bury their banks and tamp down the buried earth. (Horn 1969: 96-97)

Thus, the mass-campaign style of governance was utilized in addressing public health problems.

There were, however, significant conflicts between politics and medicine in the early communist period. Dr. Joshua Horn, who provides a detailed and sympathetic account of the communist period through the perspective of his experiences there as a doctor at the time, acknowledges these dynamics. He describes how advocates of a scientific or technocratic approach to health policy often clashed with those who prioritized ideological fervor. According to Horn, “[f]or example, in the attack on diseases such as syphilis and schistosomiasis, there was a clash between those who relied chiefly on the political consciousness and enthusiasm of the mass of the people, and those who attached first importance to experts and technique” (Horn 1969: 177). Tensions mounted until Mao directly denounced MOH leadership at the onset of the Cultural Revolution.

Stabilization of the country and, subsequently, establishment of a health system (although rudimentary) led to dramatic improvements in health outcomes including life expectancy, and infant and maternal mortality, particularly after the end of the Great Leap Forward. These improvements, however, were short-lived and largely undermined by the subsequent political turmoil of the 1960s. Initiatives such as the barefoot doctors and the CCP’s emphasis on hygiene and prevention, if divorced from Mao’s ideological fervor, were rather innovative for the time

and provided inspiration for community-based medicine on the international stage.²¹ Generally, the international medical community emphasized curative medicine until the 1978 Declaration of Alma-Ata, although the international social medicine movement had existed concurrently with the dominant curative approach as early as the 1820s. In this regard, some aspects of the party-state's approach to healthcare were innovative and had the potential to be effective in health promotion in developing countries.

Ideology, Fragmentation, and Stasis: 1960s-1970s

“In medical and health work put the emphasis on the countryside!”
Mao Zedong, Directive on Public Health, June 26, 1965

After the disastrous effects of the Great Leap Forward, top party leaders—including the leadership in the Ministry of Health—began to criticize previous policy and advocate a more pragmatic, bureaucratic approach. Among these leaders were Deng Xiaoping and Liu Shaoqi, the top party leaders responsible for domestic policy.²² If we are to assume Mao's ideological sincerity (and not, or not only, political goal of regaining power), then Mao believed that Deng, Liu, and other top leaders were reversing his policies and instituting what Mao called capitalism and, therefore, he mobilized the masses to initiate another wave of ideological fervor in 1966: the Cultural Revolution. He began this ideological campaign with a sharp criticism of the Ministry

²¹ See, for example, Djukanovic, Mach, and the World Health Organization (1975). In this report, the case study touts China's emphasis on improving rural healthcare systems and concludes by saying that “the greatest lesson that China offers is that it can be done—that a nation can within one generation move from a starving, sickness-riddled, illiterate, elitist semi-feudal society to a vigorous, healthy, productive, highly literate, mass participation society. If China can accomplish it, other nations can too.” (Djukanovic, Mach, and the World Health Organization 1975: 49)

²² Deng Xiaoping was the General Secretary of the Secretariat and Liu Shaoqi had succeeded Mao as Chairman of the People's Republic of China in 1959. At the 1961 Guangzhou conference, Deng famously commented that “it doesn't matter whether the cat is black or white, as long as it catches mice,” as a metaphor for a pragmatic, rather than ideological, approach to economic policy.

of Health, the June 26th Directive (discussed below), which was intended to be a thinly veiled attack on Deng Xiaoping and Liu Shaoqi. Deng and Liu had close allies among the MOH leadership and were united in their preference for a pragmatic approach to policymaking, thus incurring Mao's retaliation (Huang 2013: 40). The political turmoil that ensued essentially left a power vacuum in national health policy. Very few new health directives were issued during the Cultural Revolution (Huang 2013: 19). Meanwhile, in terms of rural health, villages muddled through by ostensibly continuing the policies of the Cooperative Medical System and barefoot doctors, although most local clinics either closed or failed to provide even basic care.

In the lead up to the Cultural Revolution, Mao criticized the Ministry of Health for an elitist approach that favored urban areas and neglected healthcare in the countryside. His 1965 "Directive on Public Health" asserted that the MOH should focus on rural health, basic medicine, and expedite training of medical personnel to provide more health workers to the countryside. According to Mao's personal physician, Dr. Li Zhisui, the June 26th Directive, as it became known, was based on a conversation he had with Mao in which Mao lambasted the Ministry of Health:

They [the MOH] are providing health care to only 15 percent of the people of this nation. Of these 15 percent, it's those lords in the national and local governments who receive the best care. The ministry thinks that so long as those lords are happy, its work is being done well. But the vast percentage of people in the countryside have no health care at all—no medicine, no doctor. I'm going to write a poem dedicated to the Ministry of Public Health— 'Health care, health care, it benefits high officials; peasants, peasants, their life and death are nobody's business.' (Li Zhisui 1994: 419-420)

The June 26th Directive reiterates this critique of the Ministry and emphasizes the importance of rural healthcare (see Appendix A for the full text). The Directive also calls for abbreviated

training for medical personnel and an increased emphasis on “widespread diseases,” rather than “rare” ones. Mao also called for experienced doctors to be sent to the countryside and for recent medical school graduates to remain in the city (Appendix A). Since the June 26th Directive is vague regarding how these reforms should be implemented, the Directive did not result in significant policy change. Rather, the political turmoil of the Cultural Revolution consumed the political leadership until the mid-1970s, paralyzing policymaking and implementation.

During the early years of the Cultural Revolution, officials from the Ministry of Health were criticized for failing to implement or opposing Mao’s health policies and “the normal functions of the ministry came to a virtually complete stop” (Zhen 1976: 39). According to Yanzhong Huang’s analysis, “[b]y June 1968, the ministerial leadership was completely purged and army representatives with little or no medical experience assumed control. During 1968-73 the MOH ceased to be an effective participant in the policy process, which led to the concentration of policy-making power on the leaders at the Party Center, especially Mao” (Huang 2013: 43).

Health budget as a percent of GNP was meager during this period. For example, in 1973, some estimates claim that China was spending only 1.76 percent of GNP while other communist countries were spending much higher proportions: for example, in 1964, health spending was estimated to be 4.5 percent, 4.9 percent, and 6.4 percent of GNP in Czechoslovakia, Poland, and Hungary respectively (Zhen 1976: 23). By the mid-1960s, “publicly funded health care was provided to no more than 10 percent of the population” (Zhen 1976: 31), that is, ever more serving the political elite. Due to the comparatively limited and uneven development of the Chinese health system in the first two decades of the communist regime, the subsequent state

retrenchment during market reforms failed to provoke public outcry, in contrast to similar processes in other post-socialist countries.

As a continuation of policy from the previous decade, rural communities were expected to fund their own health services, through the principle of “self-reliance” (*zili gengsheng* 自力更生), but most communities were too poor to provide sufficient funds. Historical accounts and my interviews with older villagers and village officials clearly indicate that the original CMS did not provide villagers with meaningful healthcare. A district-level bureaucrat in Gansu province explained that the CMS began in Gansu in 1957, but after 1966 it “existed in name only” (*mingcunshiwang* 名存实亡), due to the Cultural Revolution and insufficient resources (Interview GS W58, June 29, 2010). In the early 1970s the proportion of brigades with cooperative health services varied widely from province to province, ranging from about 50 percent in Shandong and Anhui to claims of full coverage (although with differing levels of service across provinces) in provinces such as Hubei and Guangdong (Zhen 1976: 47). In Hunan, the proportion of brigades with the CMS “declined from 90 percent in February 1972 to 50 percent in June 1972. In 1975 the rate rose to 79 percent—still far from the 97.4 percent that had been achieved as early as 1970.” (Zhen 1976: 45) According to a district-level bureaucrat in Jiangsu province, “the reimbursement percentage was too little, so villagers had to depend on each other to raise money [for medical treatment]” (Interview JSK W49, March 9, 2009).

One of the suburban counties of Shanghai had some success with barefoot doctors and this inspired central leadership to promote the program nationwide. Barefoot doctors were farmers who received rudimentary training in order to provide basic medical services to their communities. They earned their name because farmers often worked barefoot in the fields. The

barefoot doctors mainly treated common ailments and encouraged preventive practices, such as hygiene. They have gained renown in international accounts of this period because they were a novel approach to improving healthcare in poor, rural areas. Nevertheless, with three or four months of training, they were not a substitute for trained physicians and considered themselves to be primarily farmers who did some health work in their spare time, rather than professional health workers (Sidel and Sidel 1973: 81).

Moreover, despite CCP rhetoric, the health infrastructure began to deteriorate throughout the 1960s and 1970s. In one historical account, Friedman and his co-authors vividly describe the deterioration of a typical county hospital in a village in northern China:

Crowded and overworked, it became shabbier and ever less hygienic. Patients who were largely immobile were told to defecate on the floors of their rooms, after which the site was swept up but not sanitized. There was no disinfectant to scrub the floor. (Friedman et al. 2005: 135)

Without proper funding or personnel, facilities that were established in the 1950s could not be maintained by local communities. With closed markets and rampant poverty, villages did not have the resources to obtain medical supplies or hire trained personnel. Moreover, during the Cultural Revolution (1966-1976), universities were closed and the education system was undermined as Red Guards and youths were encouraged to “struggle” against hierarchy, including their teachers. As a result, professions requiring substantial educational training, such as doctors and lawyers, experienced a dearth of qualified candidates when youth in the Cultural Revolution were working age. Therefore, throughout the 1980s and 1990s, professions such as medicine and law, in particular, were lacking educated professionals in their 30s and 40s to lead the field.

Because of Mao's purely political June 26th Directive to "put the emphasis on the countryside," rural healthcare continued to languish in the 1960s and 1970s. Development of rural health systems stalled as healthcare was sidelined by political turmoil. The regressive distribution of health resources in the 1950s had left rural communes ill-equipped to provide health services. And the state continued to provide health insurance only to employees of state-owned enterprises (SOEs) and cadres, while villagers were dependent on the under-funded commune.

The first two decades of communist rule featured significant innovations in healthcare despite substantial deficiencies in terms of implementation of health policy and the professionalization of medicine. The emphasis on primary healthcare and the innovation of "barefoot doctors," in particular, was revolutionary for this time period. Until the late 1970s, the dominant approach to healthcare internationally was curative, that is, focused on curing diseases rather than basic and preventive healthcare. The international health community only began to explicitly discuss the importance of basic medicine in 1978 at the conference of Alma-Ata, Kazakhstan (former Soviet Republic). The historic declaration of Alma-Ata drew inspiration from the rhetoric regarding community-based healthcare initiatives including China's barefoot doctors and led many developing countries to implement programs with an emphasis on basic healthcare. Nonetheless, rural health systems were still underdeveloped and underfunded when China was on the cusp of the transition to a market economy.

The healthcare system under Mao Zedong is often touted as dramatically improving the health of Chinese people through its three-tiered organizational system and its emphasis on providing access to basic healthcare for the majority of the population. Although life expectancy

increased after the CCP's post- 1949 reorganization of the healthcare system, the Great Leap Forward and Cultural Revolution consisted of policies that required villages to maintain health facilities, while depriving the country of trained, professional physicians. The rhetoric of Mao-era China was certainly one of universal national healthcare. According to official documents, over 90% of villages were covered by the CMS in 1976 (Chan et al. 2008: 116). The reality, however, was far more complicated.

Thus, the benefits of healthcare policies in the Maoist era were limited for rural China. While urban workers in state-owned enterprises (SOEs), state officials, and their families were provided with free comprehensive medical care, rural communities were responsible for the costs of their own healthcare. In sum, the political chaos of the late-Mao period coupled with extreme poverty prevented the maintenance of a comprehensive rural healthcare system.

Market Reforms and State Retrenchment: 1979-1990s

“Crossing the river by feeling for the stones”

Deng Xiaoping on using gradual experimentalism in designing economic policies.

As China moved from a planned economy to a mixed, state-capitalist economic system, attention to healthcare and social policy waned. The central leadership shifted its policy focus to economic growth and championed a market-oriented approach to social policy. The central government reduced its relative contribution to healthcare yet further and local governments were incentivized to prioritize economic growth over social policy.²³ Coupled with reduced state financing and growing demand, perverse incentives led public hospitals to overprescribe new

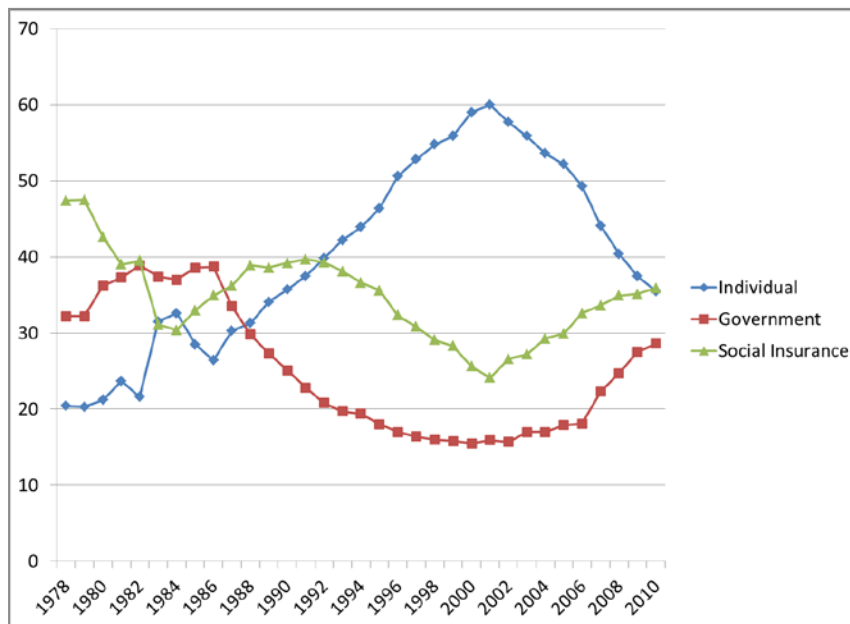
²³ In addition, state funding for healthcare was still allocated regressively; in the 1990s, a former Vice-Minister estimated that 80 percent of the government healthcare budget was used for medical coverage to cadres, who comprised less than 1 percent of the population (Huang 2013: 67).

drugs and high-tech treatments with high profit margins. Meanwhile, societal response to these shifts was minimal. While workers may engage in “rightful resistance” (O’Brien 2006) to pressure the state to fulfill its commitments regarding pensions, similar movements against retrenchment in health did not emerge. This could be a challenge that is intrinsic to healthcare; it is unusual for social movements to mobilize around health policy unless it has already been put on the agenda by political elites (Kaufman and Nelson 2004). Moreover, population health had improved overall in previous decades and there would be a lag in the societal effects of retrenchment (Figures 2.1 and 2.2). Finally, for rural areas, the so-called socialized system privileging those in the state sector had been gravely flawed and, therefore, satisfaction with the old system was not high, which reduced expectations for state healthcare provision, as discussed further in Chapter 5.

After Mao Zedong’s death in 1976 and a brief power struggle among elites, Deng Xiaoping assumed control and initiated economic reforms and, in the early 1980s, began the process of opening the economy to foreign markets and investment, dismantling and reforming some SOEs, and further reducing the state’s role in healthcare provision. The market-oriented approach to social policy was espoused by top leadership: according to Premier Zhao Ziyang, “the major reason why service industry and public institutions failed to develop well in the past was that we failed to treat them as enterprises, instead they were treated as a welfare undertaking, even charities; [therefore] whoever runs them will lose money, and there is no vitality at all” (China Health Yearbook 1986: 420, quoted in Huang 2013: 56). Additionally, the central government further reduced its contributions to health services due to its new emphasis on economic development and a reduction in revenue until the 1994 tax reforms. Figure 2.3 depicts

the change in health funding from the government, social insurance, and individuals as a proportion of total health expenditures from 1978 to 2010.

Figure 2.3: Individual, Government, and Social Insurance Contributions as a Proportion of Total Health Expenditures, 1978-2010



Source: Ministry of Health Statistical Yearbook, 2010.

Lower levels of government were also in a fiscal squeeze and responsible for funding social policy, including healthcare, through local taxes. Through decentralization and hard budget constraints on provincial and local governments, the central government held local actors fiscally accountable for health spending. Meanwhile, the central government had established economic growth as the top policy priority for all levels of government. Because local officials were evaluated for promotion based on local economic growth, rather than effective social policy or public goods provision, many local officials focused on attracting foreign investment and promoting economic development (Saich 2006; Li and Zhou 2005; Edin 2003). Thus, there was little incentive or support for local leaders to improve healthcare provision. As a result, local

officials' emphasis on economic growth often occurred to the detriment of social policy, environmental protection, and other public goods that were not directly linked to economic growth.

Concurrently with economic reforms, the central government established fiscal decentralization in most policy areas, including health. As part of this initiative, the MOH reduced hospital budgets and began to allow market mechanisms to determine the prices of some medical treatments. Hospitals could no longer rely on government support, but rather were required to be more fiscally independent and increase economic efficiency. To increase revenue, healthcare providers began to inflate user fees and over-prescribe expensive pharmaceuticals or high-end treatments. By the 1990s, most public hospitals received less than 10 percent of their revenue from the government, but 60 percent from selling pharmaceuticals (Lin and Legge 2010: 304). Health workers also insisted on bribes to support their income, leading to the common practice of providing a "red envelope" (*hongbao* 红包) of cash to the doctor prior to procedures to ensure a good outcome.²⁴

Therefore, although private hospitals were introduced gradually and still constitute a small proportion of providers,²⁵ public hospitals began to function like profit-maximizing firms. Hospitals were now accountable for their expenses. However, to ensure accessibility of

²⁴ Shen, Yimin (申毅敏) & Hou Huiqin (侯慧琴), "医生收红包 "潜规则" 探秘" [Probing the 'hidden rule' that doctors accept red envelopes], *Procuratorial Daily*, June 17, 2004, <http://review.jrb.com/zyw/n273/ca258338.htm>, accessed June 1, 2013; "南京医生自曝送红包经历 医患关系岂能为交易" [Nanjing doctors expose their experiences of accepting red envelopes; how can the doctor-patient relationship be based on under-the-table deals?], *Xinhua Net*, March 22, 2006, http://news.xinhuanet.com/politics/2006-03/22/content_4332282.htm, accessed June 1, 2013.

²⁵ Smaller private clinics are relatively common, but large hospitals are still generally public.

fundamental healthcare, the government regulated prices of some basic medicines.²⁶ Public hospitals faced price restrictions on what they could charge for routine visits, standard diagnostic tests, and common pharmaceuticals. By contrast, hospitals were allowed to earn profit from specialized treatments or new drugs and state-of-the-art treatments, particularly as new drugs lacked a price history from which to determine appropriate pricing. Profit margins for these specialty treatments could reach as high as 15 percent (Blumenthal and Hsiao 2005: 1167).

Meanwhile, the government adjusted the salary structure for physicians, by including bonuses based on the income created for their hospitals (Blumenthal and Hsiao 2005: 1167). Prior to market reforms, physicians were compensated by stable salaries, but now their remuneration was tied to the hospital's revenue. Furthermore, in comparison to other professional careers, physicians' salaries in China are well below that of their peers abroad (Cao 2011). Thus, in order to generate revenue for the hospitals and themselves, physicians began to favor new, expensive, high-tech tests and treatments. This salary structure has been maintained and over-prescription of pharmaceuticals and expensive tests continues to be a source of concern. In February 2013, the State Council issued a guideline to reform this remuneration system, but successful implementation of this aspect of the health reform is uncertain as of the time of writing.²⁷ Perverse incentives have encouraged irresponsible medical practices such as the over-prescription of antibiotics which could threaten public health as well as lead to increases in the cost of those treatments that are not state-regulated (Eggleston et al. 2006).

²⁶ Some localities, especially wealthier provinces, provided subsidies to the poorest patients through the Ministry of Civil Affairs (Interviews in with villagers in Counties A, B, C, H, and I, in Jiangsu).

²⁷ Xiao, Xiangchen [潇湘晨]. “我国严禁医生收入与药品收入挂钩” [China prohibits linking doctors' salaries to prescriptions], *Xinhua News*, February 21, 2013, http://news.xinhuanet.com/fortune/2013-02/21/c_124371680.htm, accessed June 7, 2013.

The economic reform period is often associated with a reduction in benefits for employees of urban SOEs, but rural areas also experienced repercussions from the shift in policy towards market-oriented economic reforms. Throughout the 1990s, villages lost both medical personnel and the Cooperative Medical System, without any concerted effort to build a new rural healthcare system. First, barefoot doctors, which were only qualified to provide minimal care, no longer received state funding and could only practice medicine as private providers. Moreover, a lack of regulation, a lack of patients due to mistrust in uneducated rural health workers, and new incentives for revenue led many barefoot doctors to abandon their previous mandate of preventive and basic medicine. Rather, like their urban peers, they sought to offer more high-tech treatments and expensive pharmaceuticals that would increase revenue. However, few had adequate training to practice this type of care (Blumenthal and Hsiao 2005: 1167). Former barefoot doctors found that pharmaceuticals could produce a substantial profit; as a result, prices of medicine continued to rise and quality of care was further compromised. Trained doctors were no longer obligated to practice in the countryside and, thus, chose to practice in more affluent areas where the quality of life and working conditions were better, leaving rural areas without adequately trained medical personnel and further undermining rural health systems.

The Cooperative Medical System was also dismantled during this period. A crucial aspect of economic reforms was decollectivization through the Household Responsibility System, which mandated that villagers could gain profit from the land that they worked, rather than working in communes under a centrally planned economy, enabling agriculture to rebound and food production to stabilize. However, since the communes had funded the rural cooperative medical system, the CMS subsequently lacked stable funding. Thus, with the adoption of the

Household Responsibility System and the elimination of commune welfare funds, the CMS lost its funding structure. In addition, the CMS was eroded politically as well as financially. In 1982, a new cohort with political rather than medical credentials assumed the leadership of the MOH (Huang 2013: 56). Shortly thereafter, the Ministry of Health sought to curry favor with the Politburo through opposition to the CMS due to its association with the Maoist period (Duckett 2011). Repudiation of programs that were associated with the Maoist period was a common way for post-Mao elites to demonstrate their support for market reforms and recent policy shifts away from central planning and the Maoist style of governance.

Typically, scholars of welfare states assert that retrenchment of universalist welfare programs is politically untenable because of the possible backlash from recipients. According to Pierson (1994, 1996), the expansion of the welfare state in developed countries in the post-war era created constituencies of beneficiaries that could frustrate attempts at retrenchment. If this is generally the case, why did villagers not resist the dismantling of the CMS? In addition, research on healthcare reform in Latin America indicates that basic healthcare rarely provides the motivation for strong social movements (Kaufman and Nelson 2004). When society does resist retrenchment, research on health reform in other regions indicates that a strong dictator can override societal objections to retrenchment through repression (Castiglioni 2005, 2001) or that crisis can facilitate retrenchment (Ewig 2010; Haggard and Kaufman 2008). Do these hypotheses explain the Chinese state's successful retrenchment in healthcare? While the party-state in China has utilized targeted repression, this was not the case in terms of healthcare in the 1980s. While some groups would organize around other issues, such as pensions in arrears or students movements for democracy, there was no notable social movement opposing healthcare

retrenchment. Most importantly, villagers' support for the CMS was weak, at best, due to their dismal experiences of the Maoist period. In some cases, the CMS was either not particularly effective or was tarnished because of its association with other negative experiences of the time. Also, villagers were not adequately organized to form a regional or national movement in defense of the CMS, had they been so inclined (Duckett 2010). Villagers' low expectations for healthcare provision are discussed in further detail in Chapter 5.

The lack of societal opposition may also have been due to the opacity of the policy process and the dearth of public information about which policies would be enacted and how they would impact ordinary citizens. This is another aspect of state–society relations in China that has changed dramatically since this period. While the policymaking process is not transparent, the central government has begun to post policy proposals on-line for public comment, notably including the 2009 health reform proposal. While an atomized society contributed to a lack of organizing in general, the specific lack of a social movement opposing healthcare retrenchment should also be attributed to the deficiencies of the original CMS and, therefore, villagers' low expectations for healthcare provision.

Because of both political and economic factors, the inadequate health systems that had persisted in rural areas collapsed by the early 1990s. The CMS was eliminated in all but a few counties²⁸ that maintained the system independently through the 1990s or even until the present day. Any remaining village health stations were no longer supported by local communities and

²⁸ For the most part, counties that maintained the CMS also benefitted from strong economic growth during the 1980s and 1990s. Reports of counties that maintained the CMS throughout the reform period generally focus on counties in wealthy regions, particularly around Shanghai. A few examples of localities that maintained the CMS include: Jiao County in Shanghai (郊县); Zhaoyuan County in Shandong (招远); Wu, Wuxi, and Changshu in Jiangsu (吴县、无锡、常熟); and Wuxue in Hubei (武穴) (Zhu 2012). All but Wuxue in Hubei are located in wealthy provinces that prospered during economic reforms. These counties then provided part of the inspiration for a revival of the CMS in the late 1990s. By following these models, policymakers sought to reinvent the system as a risk-pooling, insurance-style program.

had difficulty generating sufficient revenue to operate. Even city and county hospitals struggled to earn enough revenue to keep their doors open. The proportion of villages with health stations, which were often rudimentary, declined from 71 percent in 1979 to 55 percent by 1993 (Lin and Legge 2010: 305). Meanwhile, the number of tertiary hospitals in urban areas increased by over 55 percent from 1980 to 1995 (Lin and Legge 2010: 305).

Lack of funding and decentralization also affected public health. Local authorities were now responsible for sanitation, regulation, and other public health affairs, but often neglected these duties. The cadre evaluation system gave primacy to economic growth, rather than social metrics (with the exception of population control); therefore, cadres would prioritize economic development over social policy (Saich 2006; Li and Zhou 2005; Edin 2003). Corruption coupled with incentives to prioritize economic development led to general disregard for these issues by local officials. Thus, in the context of this general vacuum in public health, it is not surprising that SARS severely affected China in 2003.

China's healthcare in the 1990s was characterized by government retrenchment and marketization of healthcare which led to rising prices, increased inequality between rural and urban healthcare systems, and reduced accessibility. The lack of oversight with regard to the quality of care enabled profit-maximizing behavior to drive medical decisions resulting in over-prescription and over-treatment, with particular abuse of new, high-tech treatments with high profit margins. Inattention to public health and weak healthcare systems created optimal conditions for a virus such as SARS to spread unchecked.²⁹

During this period, the policy approaches and political leadership that resulted in successful, rapid economic development on an unprecedented scale further undermined existing

²⁹ Doctors treated SARS with Traditional Chinese Medicine (Hanson 2010).

health systems (however shoddy, ineffective, and uneven) and neglected to create new institutions to fill the void.

Decentralization was a boon for economic development, resulting in local governments competing to maximize economic growth and resulting in dramatic improvements in living standards for millions of urban Chinese. However, these strategies that were so effective in fostering economic development (Montinola et al. 1996) created perverse incentives that further undermined the quality, access, and cost effectiveness of healthcare. Entrepreneurialism and new opportunities to create revenue coupled with limited government support and hard budget constraints created a highly dysfunctional healthcare system. Hospital directors refer to this system as the “hospital as a firm” model (Interview HNFH24, December 17, 2009). Rural hospitals have had particular difficulty competing in a profit-driven system. Many of these hospitals are public, People’s Hospitals, but their government funding remains dismally low; they are still required to generate substantial revenue. Hospital directors in the hinterlands are frustrated with the system and often request more funds from the central government in particular (Interviews HNFH24, December 17, 2009; GSH56, June 24, 2010).

In some ways, this reform process was strikingly similar to neoliberal approaches to healthcare and structural adjustment in other developing countries. However, structural adjustment programs were typically implemented by governments compelled by loan conditionalities from the World Bank and donor countries.³⁰ By contrast, the CCP adopted fiscal discipline independently, but retained a strong role for the state in the economy through regulation, public financing, and state-owned enterprises. The resulting health system no longer resembled state socialism, except insofar as the communist party maintained control over the

³⁰ One exception to this trend was Chile under the military regime of Augusto Pinochet.

appointment of key personnel, such as hospital directors. In addition, the party-state has not permitted an autonomous professional association for doctors to emerge.³¹ Rather, the profession of medicine is regulated by the state.

The incentive system for hospital revenue coupled with hard budget constraints that were established in the early 1980s remains largely in place today and, as a result, over-prescription of expensive treatments and pharmaceuticals continues to plague the system. In February 2013, the State Council issued additional reforms to hospitals and doctor remuneration; although the success of these policies remains to be seen at the time of writing. In particular, Chinese medical professionals continue to over-prescribe antibiotics, creating a serious public health concern. Furthermore, market reforms exacerbated inequality between urban and rural areas (Yip 2010). Overall, market-oriented reforms resulted in a healthcare system plagued with inequities, inefficiencies, and ballooning costs.

Reengagement and Incomplete Reform: Late 1990s to 2013

“The ‘hospital as a firm’ model is not working; we need more investment from the central government.”

Hospital Director of a People’s Hospital in rural Hunan Province, 2010
(Interview HNFH24, December 17, 2009)

Since the late 1990s, the central government has gradually intensified its emphasis on social policy both rhetorically and fiscally. In the context of an authoritarian regime with limited mechanisms to hold leaders accountable to their constituencies, what explains this shift toward increasing state provision of social welfare? In China, changes in the domestic political climate,

³¹ In 2002, the Chinese Medical Doctor Association (*zhongguo yishi xiehui* 中国医师协会), was founded under the Ministry of Civil Affairs, but it does not operate autonomously from the state.

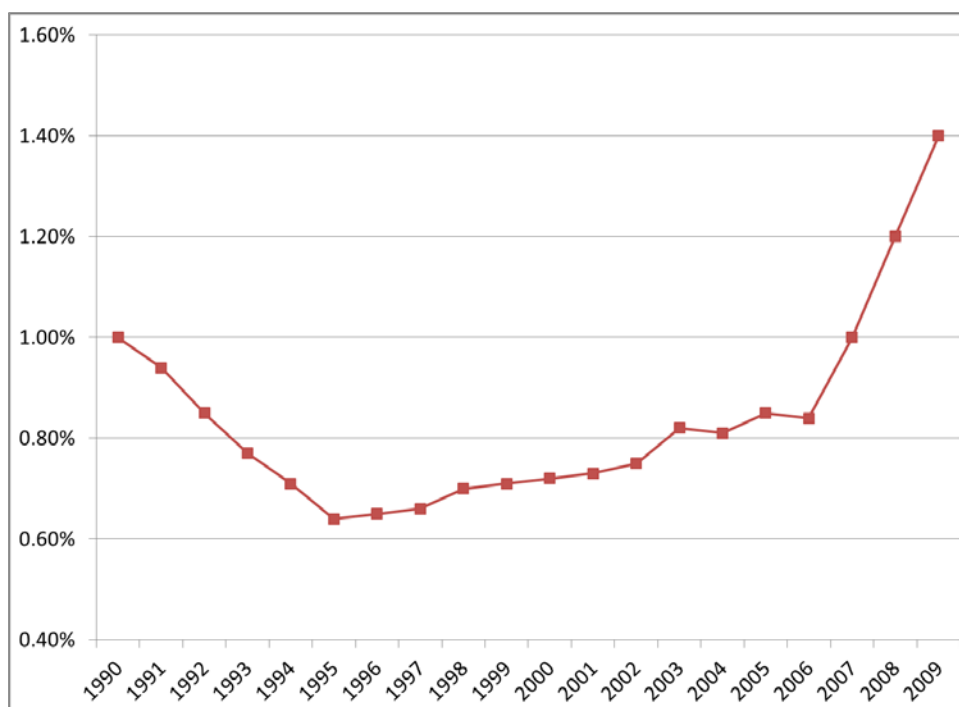
an increasing institutionalization of the policymaking process, and augmented central government revenue coinciding with a shift in the international community's stance on state involvement in social policy provision facilitated a central government reengagement with healthcare. Increased domestic involvement of think tanks and research organizations provided information about the dire situation in healthcare to relevant authorities. The universe of conceivable policy options at the beginning of the 21st century included some state provision of social welfare due to a shift in views on best practices and governance in international organizations such as the World Bank and the United Nations. While central government leaders had already been exploring options for alleviating the burden of healthcare, the SARS crisis served as a catalyst to precipitate government action and place healthcare at the forefront of the national policy agenda.

Healthcare reform thus far has taken place in two waves: 1997 and 2009. The 1997 reform emphasized competition among service institutions, market institutions, and the creation of state regulatory mechanisms. The reform was initiated to respond to former state-sector employees who were left without benefits after marketization. These workers constituted a politically threatening group, as they had benefited under the planned economy and were now losing out under market reforms. During this period, SOE workers challenged the state to uphold its end of the social contract. They would protest, using state slogans to emphasize their political loyalty, under the condition that they received the benefits they were promised (O'Brien 2006). The primary goal of the 1997 reform was to pacify these former state-sector employees, the losers of the economic reforms.

The 1997 reform was a closed process that did not include public debate or consultation. The MOH enlisted a small group of elites with technical expertise to advise the government on the issue. The health reform was announced at the Second National Health Conference in December 1996 and the Health Reform and Decision Paper, published January 15, 1997 (Zhao and Fang 2010: 330).

By the late-1990s, the government had begun to address the problem of healthcare and government spending in particular. In 2003, President Hu Jintao and Prime Minister Wen Jiabao took office. Notably, their government adopted slogans such as “harmonious society” (*hexie shehui* 和谐社会) and “scientific development” (*kexue fazhan* 科学发展) to indicate that equity would now be a priority as well as growth.

Figure 2.4: Government Health Spending as a Percent of GDP in China, 1990-2009



Source: Ministry of Health Statistical Yearbook, 2010.

Another popular phrase that emerged in the early 2000s is “moderately well-off society” (*xiaokang shehui* 小康社会). This phrase is from Confucian classics, but has reemerged to indicate an emphasis on health and general wellbeing. Figure 2.4 shows government health spending as a percentage of GDP from 1990–2009. This demonstrates that, while health spending is still low as a percentage of GDP, the Hu and Wen administration has begun to dramatically increase government spending on healthcare.

The central government began to experiment with the precursors to healthcare reform in the late 1990s. Changes in domestic politics, including increased revenue and a diversification of actors in the policymaking process, were crucial in enabling government reengagement with healthcare provision. First, the central government benefited from an increase in revenue due to the 1994 tax reform. Although China experienced unprecedented economic growth during the 1990s, the central state’s extractive capabilities had been severely reduced by decentralization in the 1980s. Reduced revenue for the central state further restricted Beijing’s capacity to subsidize healthcare in the regions until the 1994 tax reform, which dramatically increased the relative share of government revenue taken by the central government as compared to subnational levels of government (Table 2.2). As a result of the tax reform, by the mid-1990s, the central government had increased its share of tax revenue significantly, facilitating funding for social policy provision.

Year	Expenditures		Revenue	
	Central Government	Subnational Government	Central Government	Subnational Government
1978	47	53	16	84
1980	54	46	25	75
1985	40	60	38	62
1990	33	67	34	66
1991	32	68	30	70
1992	31	69	28	72
1993	28	72	22	78
1994	30	70	56	44
1995	29	71	52	48
1996	27	73	49	51
1997	27	73	49	51
1998	29	71	50	51
1999	31	69	51	49
2000	35	65	52	48
2001	31	70	52	48

Source: China Statistical Yearbook, 2002

Second, the government began to recognize the severity of the healthcare problem. By the late 1990s, the effects of state retrenchment were palpable, particularly among rural residents and the poor. As state support for healthcare diminished, the cost of medical care became an increasing concern for many Chinese. Nationwide, the state had reduced its financial support for healthcare and most health expenditures were paid by individuals. Figure 2.3 illustrates the relative decline in state spending on healthcare and the rise in out-of-pocket expenditures as a proportion of total healthcare expenditures during this period, with a marked increase in state spending in 2003. The remaining spending on healthcare is accounted for by other sources, such as insurance programs or other social organizations. As a result of economic reforms, about 90%

of rural residents were left uninsured through 2003 (Saich 2006: 22). Rural residents were often unable to afford medical treatment and catastrophic medical expenditures became a significant cause of poverty, which led to the development of two new idioms: “poverty due to illness” (*yinbingzhipin* 因病致贫) and “poverty due to catastrophic illness” (*dabingzhipin* 大病致贫) (Wang 2006; Liu et al. 2003). One survey from 2003 indicated that 25% of respondents did not visit a doctor because of prohibitively high cost and the Ministry of Health reported in the early 2000s that 22% of the rural poor identified “unmet medical needs” as the cause of their poverty (Saich 2006: 22). Many lower income Chinese were faced with the choice of impoverishment from medical expenditures or foregoing treatment. In response to this growing problem, the Ministry of Health began to encourage pilot projects of rural health insurance programs to design risk-pooling schemes targeting villagers, in particular.

A third change in Chinese domestic politics contributed to the nature of healthcare reform: the gradual inclusion of think tanks and research organizations in policymaking. Scholarship on policymaking in China has, to some degree, examined the impact of research centers and think tanks on policy design. Throughout the 1990s, the role of research and think tanks on policymaking increased dramatically and elites have emphasized the importance of research in policymaking.³² Previous scholarship has demonstrated the importance of think tanks on the policy process in areas such as foreign policy (Glaser and Saunders 2002), economic policy (Naughton 2002; Oksenberg 1982), international relations (Shambaugh 2002), and police and public security (Tanner 2002). Previous research has examined how Chinese think tanks affect policy through both official and unofficial channels. While some have explicit direct access to

³² State Council Development Research Center, “李克强在国务院发展研究中心调研时强调” [Li Keqiang emphasizes research at the State Council Development Research Center], Nov. 10, 2011, <http://www.drcnet.com.cn/temp/20111111/index.html>, accessed Nov. 10, 2011.

high-level officials, others rely on informal channels and personal connections (*guanxi*关系) to relay their findings to policy makers. In economic policy in particular, think tanks “served as policy entrepreneurs” (Naughton 2002: 625) by provide policy alternatives that had not been considered by the government bureaucracy. In the economic sphere, however, government organs have evolved and been able to absorb and employ talented economists, thereby reducing the need for semi-autonomous think tanks (Naughton 2002). Moreover, approaches to economic policy have converged in China throughout the 1990s, allowing for less debate about basic economic principles (Naughton 2002). Meanwhile, in health policy, innovation originates from more independent actors; policy entrepreneurs in this field are comprised of domestic and international NGOs, academics, research centers, and international organizations such as the World Bank or WHO. Furthermore, various groups within both the political elite and the scholarly community continue to debate the role that the state should take in healthcare provision. For example, in the proposals submitted prior to the 2009 healthcare reform, various Chinese universities advocated divergent paths to health reform. Some scholars and politicians recommend a health sector dominated by the state (such as Li Ling of Peking University), while others advocate greater marketization (such as Liu Guoen of Peking University). A mixed state-market approach prevailed, drawing heavily on recommendations made by this process. But many important aspects of reform are still incomplete, such as hospital reform, and many of these issues are still fiercely debated.

Meanwhile, as domestic policymaking became more open within China, a significant paradigm shift in response to global inequities led international organizations to advocate for greater state involvement with healthcare provision. Simply put, many developing countries had

implemented austerity programs such as structural adjustment throughout the 1980s and 1990s, resulting in huge swathes of the developing world left without a social safety net such as provisions for basic education and healthcare. In the 1990s, however, state re-engagement with social policy provision began to gain currency. International organizations began to increase their emphasis on equity and social policy provision, including using state actors to provide funding or to implement new programs. Although the Chinese government may not feel compelled to follow international trends, policymaking, particularly in healthcare, is increasingly driven by empirical evidence and research. Some leading scholars feel that the most effective way to influence policy in China is to demonstrate empirically the deficiencies with current approaches.³³ Thus, as international organizations began to promote different alternatives for health policy, researchers at top universities in China marshaled evidence to advocate for increased government funding of healthcare. In this way, international trends affected policymaking in China through the involvement of domestic research organizations.

This shift in best practice is evidenced by several initiatives by international organizations. For example, the United Nations published the Millennium Development Goals, which seek to improve the welfare, health, education, and gender equity of the poor. Many nations were signatories to this initiative, supporting the idea at least pro forma. The World Health Organization has traditionally advocated on behalf of health issues, further stepped up its pressure on states in the 1990s. The World Bank, which had previously advocated austerity in social policy provision, began to encourage states to take a more active role in social policy. As the international development community shifted its view on the state's role in welfare provision,

³³ Informal communication from academic advisors to the health reform process at a top university in Beijing in 2011.

many developing countries followed suit, implementing new waves of reform.³⁴ This coincided with China becoming more open to foreign investment, business, as well as academic exchanges and development assistance. Thus, during the 1990s and the 2000s, internationally-sponsored projects related to social policy in China experienced a dramatic increase.

In the health reform process, both international and domestic groups utilized pilot projects and research to impact policymaking in China. Recent research on “adaptive governance” in China has explored how the government has utilized pilot projects and policy experiments to test new policies in relatively controlled environments before making them national policy (Heilmann and Perry 2011). The process of national health reform is an example of how pilot projects were conducted by both local and international actors and then subsequently evaluated by local and foreign researchers. For example, isolated experiments with the continuation of the cooperative medical system in the 1990s inspired pilot projects and, ultimately, the nation-wide rural health insurance plan (New Cooperative Medical System, NCMS) in 2003. Shenmu county (Shaanxi 陕西神木县) has also been praised for using coal revenue to institute universal healthcare, although this has not been considered a tenable solution for most localities.³⁵ Also, privatization of a Suzhou (Jiangsu 江苏苏州) hospital has contributed to debate on hospital

³⁴ See, for example, Ewig (2010).

³⁵ “‘全民免费医疗’追踪:‘神木模式’能否复制推广?” [In pursuit of ‘universal free healthcare:’ Can the ‘Shenmu Model’ be replicated elsewhere?] *Xinhua Net*, June 4, 2009, http://news.xinhuanet.com/society/2009-06/04/content_11485012_1.htm, accessed June 1, 2013. 唐昊 [Tang Hao], “警惕社会领域的‘神木模式’” [Raising awareness of the ‘Shenmu Model’ in the social sphere], *China.com*, May 17, 2013, <http://news.china.com/social/ms/11116778/20130517/17838914.html>, accessed June 1, 2013.

reform at the national level.³⁶ The province of Anhui served as a model for national policy on essential drugs, although implementation was problematic (Huang 2013: 75). This process of translating localized experimentation into national policy also reveals some problems with the government's approach to adaptive governance. For example, localities for pilot projects are often deliberately chosen to be areas where the project will likely succeed. In the initial wave of experimenting with the New Cooperative Medical System in the early 2000s, counties were chosen as pilot projects because they were relatively wealthy and were considered to have relatively developed health infrastructure and health services.³⁷ Examining the healthcare reform process and the role of experiments and research illuminates important shifts in the Chinese policymaking process towards a somewhat more open mode of policymaking that includes an increasingly important role for empirical research.

The healthcare reform also included greater public debate and deliberation than previous policymaking processes in China. The 2009 health reform proposal was posted on-line for public comment (Kornreich, Vertinsky, and Potter 2012). Health policy is also often featured in the news media. However, officials at all levels sometimes still consider some aspects of the policy or of the policymaking process to be classified (*baomi* 保密) or not public information (Interviews with officials in Gansu, June, 2010).

Finally, the SARS crisis of 2003 provided a catalyst to place healthcare at the top of the government agenda, enabling Hu Jintao to assert his leadership in social policy and differentiate

³⁶ Xing, Hua (辛华), “苏州允许设立私营医院” [Suzhou allows establishment of private hospitals], 人民日报 [People's Daily], 华东新闻 [Xinhua News], March 20, 2002, <http://www.people.com.cn/GB/paper40/5749/581937.html>, accessed June 1, 2013.

³⁷ Authors interviews with county-level health officials in Jiangsu, Hunan, and Gansu provinces, January to June 2010. In addition, the State Council has published statements that state that pilot projects should occur in wealthier areas, where experiments are more likely to succeed.

himself from his predecessor, who had retained informal influence over domestic politics. In early 2003, an outbreak of SARS, a viral respiratory disease that is carried by animals, appeared in southern China, nearly resulting in a pandemic and provoking a global response. In part because of the disease's 10-day incubation period, it was passed between patients and health workers and, subsequently, to occupants of a Hong Kong hotel. The disease spread rapidly from Guangdong Province and Hong Kong to 27 other countries around the world including Singapore, Viet Nam, Germany, the U.S. and Canada. The epidemic resulted in 8,096 probable cases of SARS and 774 deaths (a death rate of 9.6 percent).³⁸ The SARS crisis focused international attention on healthcare in China, attracting particularly harsh criticism of general hygiene and public health system.

This public health crisis impelled the central government to begin to improve public health and infectious disease monitoring by creating an electronic disease reporting system at the district level and establishing infectious diseases hospitals in every district. As a district often comprises hundreds of thousands of people, this system still may not be sufficient in timely notification of an outbreak. Moreover, local governments are still neglecting to emphasize health education such as personal hygiene, sanitation, and preventive measures that could reduce the occurrence of epidemics in the future (Blumenthal and Hsiao 2005, 1169).

While the 1997 reform focused mainly on regulation of providers and expanding urban medical insurance, the 2009 reform had more comprehensive goals. The 2009 document specifies five major goals: develop universal insurance, promote equal public health, set a state essential drug policy, improve community-based facilities, and conduct public hospital reform.

³⁸ World Health Organization, "Summary of probable SARS cases with onset of illness from 1 November 2002 to 31 July 2003," http://www.who.int/csr/sars/country/table2004_04_21/en/index.html, accessed June 9, 2013.

While universal insurance has been achieved and progress has been made on the essential drug policy, community-based facilities and public hospital reform have lagged behind, in part because of the ambiguity of the initial reform and the lack of consensus regarding how to move forward with implementation. Table 2.3 summarizes the major characteristics of the 1997 and 2009 reforms.

Table 2.3: Health Reform, 1997 and 2009

	1997	2009
Stated goals	<ol style="list-style-type: none"> 1. Financing through basic insurance in urban areas 2. Regulatory framework to reduce abuse by providers 	Five Tasks: <ol style="list-style-type: none"> 1. Develop universal insurance 2. Promote equal public health 3. Set state essential drug policy 4. Improve community-based facilities 5. Conduct public hospital reform
Policy process	<ol style="list-style-type: none"> 1. Small group of elites selected by MOH 2. No previous public consultation and few media reports 	<ol style="list-style-type: none"> 1. Task force: Health Reform Leading Small Group 2. Proposals invited from: WHO, World Bank, McKinsey, Peking University, Qinghua University, Fudan University, Beijing Normal University 3. Proposal posted on-line for public comment and closed reported by the media
Key stakeholders	MOH, National Development Resource Council, Ministry of Finance Relatively easy to reach consensus	MOH, National Development Research Council, Ministry of Finance, Ministry of Labor and Social Security, Food & Drug Administration, National Price Administration Difficulty reaching consensus
Government implementation	Mainly regulatory Little state financing	Proposals followed by government financing

Source: Adapted from Zhao and Fang 2010: 330.

The early 2000s reform process, culminating in the 2009 Health Reform Plan, was different from 1997 in both procedure and substance. Recognizing that healthcare costs and access were severe problems beyond former state-sector employees, the government began to experiment with pilot projects for risk-pooling health insurance plans. For these efforts, the

government enlisted proposals from local and foreign academics. For example, the government solicited expert advice from scholars at the Harvard School of Public Health in designing an effective New Cooperative Medical System. Throughout the process, universities, research centers, the World Bank, the WHO, and private consultancies submitted proposals for healthcare reform advocating various plans. Some have promoted a program similar to the U.K.'s National Health System with universal coverage. Others advocated for market-oriented solutions. When compared to previous policy decisions, this relative transparency and inclusion of foreign academics indicates a notable shift in Chinese governance. The 2009 healthcare reform process suggests that we may observe more inclusive discussion and deliberation of policy alternatives with non-state actors as the government confronts future policy challenges, such as environmental degradation.

As a consequence of this reform, the government mandated private firms and SOEs to provide workers medical savings accounts and catastrophic insurance. This policy was largely inspired by the Singaporean model (Blumenthal and Hsaio, 2005: 1169). However, this has not entirely resolved the healthcare issue for workers, because many do not work for formally organized employers and some employers refuse to follow state mandates. Private health insurance has also emerged for the wealthy.

In addition, the government has begun to allow public hospitals to enter into public-private partnerships. Some public hospitals have been able to contract out management to private companies. In addition, private investment has been used for hospital construction, particularly in coastal provinces like Jiangsu and Zhejiang, where private business has been active since special economic zones were established in the region in order to promote economic

development. Private medical facilities now represent an emerging market of interest for foreign investors (Hornby 2011). Foreign investors, however, continue to face barriers to entry insofar wholly foreign-owned are still prohibited in China, rather foreign companies must enter into joint-ventures.

As evident from Figures 2.3 and 2.4, the 2009 reform has resulted in a significant increase in government expenditure as well as reductions in out-of-pocket expenses for individuals. Yet a cohesive approach to healthcare reform has, thus far, been elusive. Government agencies with divergent views have been involved, complicating both policy design and implementation. Agreement among agencies involved in the 2009 reform was difficult and the Ministry of Health has been criticized for its reluctance to take a strong stance. A lack of leadership in the Health Reform Leading Small Group, which was tasked with coordinating the health reform, resulted in an incomplete and vague reform document.³⁹ Various government departments have also jockeyed for healthcare tasks. For example, there are currently three forms of insurance in China: Urban Employees Basic Medical Insurance (for employees of the state or large formal entities), Urban Residents Basic Medical Insurance (for other urban residents), and New Cooperative Medical System (for rural residents). The two urban insurance programs are run by the Ministry of Human Resources and Social Security (MHRSS), while the NCMS is run by the Ministry of Health.

One of the major goals of the 2009 was expanding and improving health insurance, particularly in rural areas. Initiated in 2003 as pilot projects, the New Cooperative Medical

³⁹ The head of the Health Reform Leading Small Group, Li Keqiang, waited until 2011 to take a stance on reform. Some observers speculate that, as Executive Vice Premier, his equivocation was politically motivated because he was in line to become Premier, which he did in March 2013 (Huang 2013: 79). As posited by Huang, Li may have been concerned that his public endorsement of an unsuccessful reform would have compromised his chances at the position of Premier.

System (NCMS) has achieved basic insurance coverage nation-wide in rural areas. Throughout the early years of their government, the Ministry of Health continued to conduct pilot projects and refine the insurance plans for rural and urban residents. As part of this initiative to increase access to healthcare, the New Cooperative Medical System (NCMS) combines small household contributions with subsidies from the central and local government in a risk-pooling insurance program. Participation is voluntary, although there have been accusations of coercion from village cadres (Brown 2009). Because the responsibility for NCMS administration and program design is explicitly left to local governments, reimbursement rates and the specifics of the plan tend to vary significantly, even within the same province. Funding for the NCMS includes transfers made from the central government for central and western provinces for each participant. Meanwhile, wealthy, coastal provinces are wholly responsible for funding the NCMS. In this way, the program represents a somewhat progressive attempt at redistribution. The NCMS seems to have increased access to healthcare. Hospital directors report a large increase in patients and villagers are somewhat satisfied, but concerns remain (Interviews with hospital personnel in Hunan and Gansu). According to villagers and some local officials, there are several problems that persist: reimbursement rates vary significantly across localities (discussed further in Chapter 4); reimbursement rates are lower at higher levels of facilities, which disproportionately affects villagers in poorer localities with less developed health facilities; reimbursement rates are lower for out-of-area facilities, which is a particular problem for migrant workers (discussed further in Chapter 5); drugs that are not on the essential drug list are often excluded from reimbursement, but patients may be unaware of these limitations until they are at the pharmacy counter (Interviews with villagers in Hunan, 2010). Moreover, there have been scattered reports of the

NCMS attracting corruption and cases of fraudulent illnesses to extract subsidies from the government (*jia bingli* 假病历) (Interviews with hospital personnel and media reports in Hunan, 2010). Some policy evaluations of the NCMS have also found that the program has increased the use of preventive care, but has not decreased out-of-pocket expenditures, most likely due to rising costs (Lei and Lin 2009).

As of the time of writing, the most recent steps in healthcare reform at the 12th session of the National People's Congress and Chinese People's Political Consultative Congress in March 2013 have been: (1) declarations of future additional government investment in health including establishment of emergency medical funds for the poorest patients (which would be administered by local government);⁴⁰ (2) declarations of the intent to proceed with hospital reform; (3) the merging of the Ministry of Health, the National Population and Family Planning Commission, and State Administration of Traditional Chinese Medicine to become the National Health and Family Planning Commission;⁴¹ (4) the promotion of the State Food and Drug Administration to a ministry-level agency entitled the General Administration of Food and Drug; and (4) clarifying which government agencies are responsible for various public health-related tasks, such as supervision and quality control and agricultural products.⁴² Based on these institutional and financial commitments, it is likely that the government will continue to proceed with reforms

⁴⁰ "China to establish emergency medical funds," *Xinhua*, March 1, 2013, http://www.chinadaily.com.cn/china/2013-03/01/content_16268242.htm, accessed March 15, 2013.

⁴¹ Shan, Juan, "New health commission set to be established," *China Daily*, March 11, 2013, http://www.chinadaily.com.cn/china/2013npc/2013-03/11/content_16296446.htm, accessed March 15, 2013.

⁴² "China to elevate food, drug agency to general administration," *Xinhua*, March 10, 2013, http://www.chinadaily.com.cn/china/2013npc/2013-03/10/content_16295085.htm, accessed March 15, 2013. In early 2013, 16,000 dead pigs were found floating in the Huangpu River (which provides water to Shanghai), leading to public outcry and government response. See Adam Jourdan, "Overcrowding on farms behind mystery of China's floating pigs," *Reuters*, April 24, 2013, <http://www.reuters.com/article/2013/04/24/us-china-farming-pigs-idUSBRE93N1C720130424>, accessed May 12, 2013.

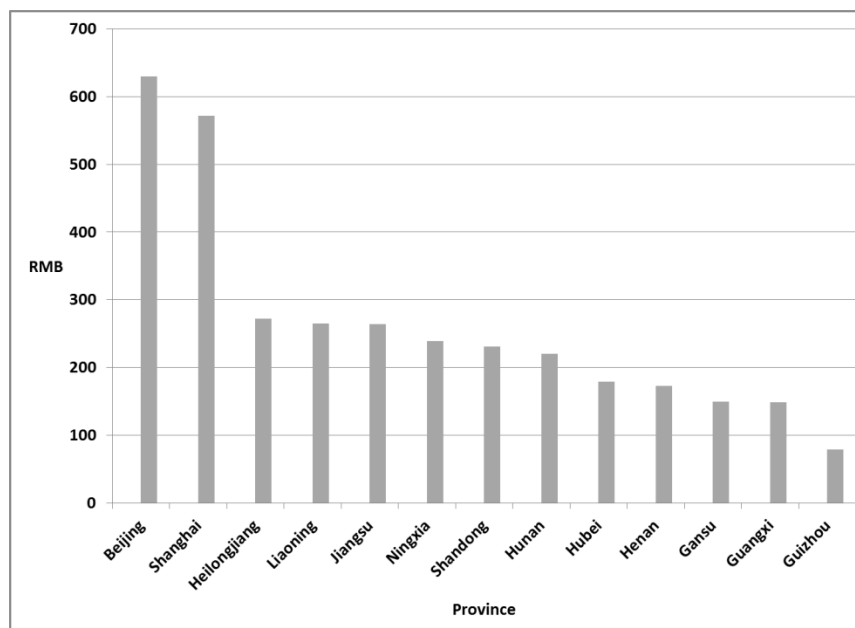
with an increasing role for the market, particularly on the supply side. There is also some speculation that the new institutional configuration is designed to strengthen the Ministry of Health, while discretely marginalizing the role of Family Planning⁴³ and, perhaps, Traditional Chinese Medicine, which had been promoted by Mao for political purposes (Taylor 2005). But the implications of this new arrangement have yet to be determined.

Despite reforms, challenges remain. For example, health outcomes are still highly contingent on local conditions. For example, the life expectancy for residents of different provinces ranges from 78 years (Shanghai) to 64 years (Tibet) (From 2000, Ministry of Health Statistics Yearbook, 2010).⁴⁴ In addition, provinces have demonstrated an uneven commitment to healthcare. Figure 2.5 illustrates some of the variation in per capita rural healthcare spending at the provincial level, by depicting a selection of provinces reflecting the country's geographic and socio-economic diversity. In wealthy provinces and national-level metropolises, such as Beijing and Shanghai, government spending on rural healthcare is more than six times that of Guizhou, the poorest province in China. This variation is explored in greater detail in Chapters 3 and 4.

⁴³ Informal communications with a health policy adviser from a top Beijing university in 2013. While the one-child policy is unpopular among many segments of society, family planning is codified in the constitution, which makes it politically difficult to eliminate suddenly. Therefore, central leaders may have decided to take a more gradual approach to reforming family planning.

⁴⁴ On average, life expectancy has vastly improved since the 1950s, when it was estimated to be 45 years. See Figures 2.1 and 2.2 as well as Chapter 2 for more discussion.

Figure 2.5: Per Capita Rural Health Expenditures in 2008 (RMB, 2008)



Source: Ministry of Health Statistical Yearbook (2010).

Moreover, in the new systems, rising costs and corruption continue to be a problem. In rural areas, villagers have a number of concerns that had not been addressed by the current reform. In particular, most villagers complained of rising prices outstripping reimbursement rates.

According to one village in Hunan province (central China):

They have to monitor the medical market because after the NCMS some places started to increase prices. In this situation, the NCMS is of no use, [it] does not provide a benefit to villagers and the policy has no significance. So they have to control the costs of production and ensure that hospitals don't charge any inappropriate fees. (HND V17 Dec. 14, 2009)

In addition, rural health insurance does not always cover migrant workers when they are away from home. Finally, reimbursement percentages have a large range, some procedures are excluded, and outpatient reimbursement levels are very low (Interviews with villagers in Hunan and Gansu).

Further reform will also need to focus on the professionalism of physicians and perhaps empowering doctors to have their own autonomous, professional association (Cao 2011). The current practice of medicine suffers from generations of Chinese physicians whose professional career has been contingent on demonstrating loyalty to the state and communist ideology (Lim et al. 2004). A new culture of professionalism will need to be fostered among physicians in order to support concurrent institutional efforts to create incentives to improve quality, increase access, and reduce cost.

Perhaps the most significant challenge for healthcare reform is that, in general, local governments continue to prioritize economic growth over all other programs. The party-state is beginning to include health policy targets in rural cadre evaluation systems in some provinces. For example, participation rates and average reimbursement rates for the rural health insurance program are now included. Targets to meet are set by higher levels of government and the county aims to reach these targets (Interviews with county officials in Hunan and Gansu). Nonetheless, these targets are typically insufficient incentives to dramatically alter the behavior of local cadres (Kung et al. 2009).

Thus far, healthcare reform in China has been focused on improving access through cost reduction and some investment in improving basic health systems in villages and urban districts. However, further reforms will need to address rising costs and lack of regulation as well. Additional reforms targeting hospital management and doctor remuneration are currently underway. Despite an increase in government investment in healthcare, health inequality between urban and rural areas has not abated. Moreover, healthcare spending is focused on hospital care and urban areas; many rural areas still need investment in basic infrastructure.

Domestic and international factors in the late-1990s and early-2000s created the political environment necessary for the SARS disaster to catalyze reform. After 1978, revenue constraints caused Chinese state retrenchment in social policy, while healthcare costs began to rise. This confluence left the healthcare system in crisis, with challenges such as a spike in out-of-pocket expenditures and the withering of community clinics. By the early 1990s, tax reforms alleviated the central government's revenue crisis and the increasing influence of think tanks in policymaking created new potential pathways for the state's role in social policy. Concurrently, the international community began to advocate state re-engagement with social policy provision. As a result of pressure from below, shifts in governance style, and encouragement from domestic and international organizations and think tanks, the Chinese government initiated a dialogue on healthcare reform that culminated in the 2009 plan to overhaul the system. Thus far, the health reform has expanded health insurance to the majority of the rural population and increased government investment in medical facilities. However, the central government continues to engage in incremental reforms at the national level while local governments have varied in their implementation of current guidelines.

Chapter 3

Subnational Welfare Regimes: Provincial Variation in Social Policy Priorities

China's economic reforms were implemented largely by local governments, resulting in different regions internationalizing at different times and developing distinct economic development strategies. Concurrently, the central government devolved much of the responsibility for social policy to lower levels of government. Because of this decentralized approach to economic reform and social welfare, provinces also diverged in their social policy priorities. These distinct provincial worlds of welfare have had implications for the adoption, implementation, and ultimately, effectiveness of social policy. In this chapter, I demonstrate that Chinese provinces have diverged in their approaches to social policy and examine the nature of this variation. My analysis of both spending and outcome measures of social policy provision illustrates that provincial-level variation in social policy provision in China is comparable to the diversity that has been observed in cross-national research. Given the decentralized nature of social policy implementation in China, this result is not surprising. Nonetheless, the current research on social policy in developing countries focuses on the national level, eliding subnational variation. Moreover, the social welfare priorities of Chinese provinces vary systematically, providing the opportunity to classify provinces in a manner that is analogous to the classification of countries in social policy research.

I argue that a subnational perspective is crucial to understanding social policy variation within China and that this variation begins with distinct policy styles⁴⁵ established by the province. But the province is only the beginning of the story. Further examination reveals

⁴⁵ I use the term "policy styles" because it builds on the public policy literature and on Heilmann and his co-authors' conceptualization of "guerrilla policy style" in China (Heilmann et al. 2011).

additional variation within provinces that is rarely studied due to the paucity of reliable local-level data. The following chapters will examine within-province variation in greater depth using data from an original survey.

In this chapter, I expand on the theoretical framework developed by previous research on welfare regimes in developing countries in order to describe the nature of provincial-level divergence in social policy provision in China. First, I examine existing frameworks and adapt the typologies of “productive” and “protective” welfare regimes (Rudra 2008, 2007) for use at the subnational level in China. Then, I demonstrate that the variation in social policy outcomes in Chinese provinces is comparable to cross-national variation. I utilize cluster analysis to classify Chinese provinces as distinct welfare regimes based on the relative proportion of spending on different types of social policy. Finally, I identify the dimensions of subnational variation in social policy that are not captured by provincial-level analysis and preview the arguments that will be developed in the following chapters, by using a more detailed examination of three provinces that exemplify subnational variation both within and across provinces.

Theoretical Approaches

Comparative Politics, Levels of Analysis, and Chinese Politics

The current literature on Chinese politics, as well as comparative politics more generally, has emphasized “scaling down” the analysis for both methodological and substantive reasons (Snyder 2001). Subnational analysis has gained currency in comparative politics as an effective method to examine processes as diverse as economic development (Sinha 2005; Montinola et al. 1996), public goods provision (Tsai 2007), civil society and good governance (Putnam 1993),

and policy innovation and diffusion (Heilmann 2008; Landry 2008; Shipan and Volden 2008). Moreover, subnational analysis has proven to be particularly useful in the Chinese case, given the decentralized approach to governance coupled with the new policy alternatives available in the reform period beginning in 1978.⁴⁶

Both developing and developed countries have, at times, devolved power to subnational governments for an increasing number of social services. While countries such as the U.S. and India have had federalist institutions since their inception, other developing states have begun to devolve power to local governments even without explicitly federalist institutions, often in an effort to reduce central government's fiscal contribution to for social services (e.g. Chile, see Kubal 2006). Nonetheless, despite observed subnational variation in social policy provision, subnational analysis of social policy continues to be an emergent and overdue line of inquiry and the logical next step in this research agenda (Mares and Carnes 2009).

In China, decentralization has been identified as a cause of various phenomena ranging from economic growth (Montinola et al. 1996) to corruption (Cai and Treisman 2004), to authoritarian resilience (Heilmann and Perry 2011). Other scholars focus on identifying the nature of decentralization in China by developing models that can capture the relative power of the local state vis-à-vis the center over time (Shue 1988; Zhang, L. Y. 1999; Chung 2001; Mertha 2005; Sheng 2005; Wedeman 2003). An important contribution of this line of scholarship is to explain some of the reasons that explain how and why the central state has retained significant power over time despite decentralization. While the nature of Chinese

⁴⁶ Since 1978, the central government has delegated responsibility for policy implementation to local governments in many aspects of both economic and social policy (see Landry 2008). It would be a mistake, however, to assume that local government did not play a role prior to 1978. Scholars of Mao-era China have found that local government also determined implementation of policy pre-reform, in part due to the Maoist principle of self-reliance. For more on this period, see Friedman et al. 2005.

decentralization and its implications for the power of the local state vis-à-vis the central state continue to be contested issues, scholars generally concur that certain competencies have been devolved to the subnational level over the course of the reform period and that this decentralization has resulted in dramatic local variation that scholars have observed in many different policy areas.

At first glance, a decentralized approach to governance might be unexpected in the context of an authoritarian regime with a strong central state (Remick 2002). The observed subnational variation is less surprising, however, in the context of the personalistic, agency-based nature of Chinese politics. Rather than developing a consistent institutional structure that would constrain policymaking, Chinese leaders have opted for a “guerrilla” policy style, inherited from the Maoist era (Heilmann et al. 2011). This approach to policy-making includes an emphasis on experimentation and adaptability, in opposition to the constraints imposed by stable institutions. In terms of division of labor, the central leadership is responsible for grand strategy, while lower levels are charged with implementation. Thus, despite an increasing number of laws and regulations, the Chinese government tends to use the law as a means to an end to achieve certain goals—such as economic development and social acquiescence—rather than formalize a legal system that would fundamentally constrain the state’s behavior; this phenomenon has been described as “rule by law,” in contrast to the “rule of law” in democratic systems (Lubman 1999; for a discussion of “rule by law” in authoritarian regimes beyond China, see Ginsburg and Moustafa 2008). This emphasis on agency, rather than creating enduring institutions, further contributes to subnational variation, as local communities are subject to the preferences of their local leaders, with few viable options to hold local officials accountable

when they engage in illegal or corrupt behavior. Therefore, despite authoritarian, centralizing forces, decentralization and subnational variation constitute fundamental features of Chinese politics.

Research on social policy in China can be understood as comprised of three groups: research on national-level policy, policy evaluations, and ethnographic research on local communities. At the national level, scholars have examined social policy from an historical perspective or proposed explanations for change over time (e.g. Eggleston 2012; Duckett 2011, 2010; Wang 2011). Recall from the previous chapter that others have provided tentative appraisals of the ongoing healthcare reform process that began in the 2000s (Kornreich et al. 2012; Duckett 2009; Gu 2009). However, with few exceptions, research on social policy in China at the local level is mainly comprised of policy evaluations and ethnographic research. Policy evaluations have been enormously helpful in furthering our understanding of the impact of pilot projects, experiments, and new policies, but are typically from a practitioner's perspective and tend not to engage theoretical debates in political science (e.g. Lin et al. 2009; Sun et al. 2009; Wagstaff et al. 2009). By contrast, site-intensive, ethnographic research on social policy in China has provided a nuanced understanding of the local dynamics of social policy provision (e.g. Lora-Wainwright 2011; Solinger 2011). While these contributions have significantly advanced our understanding of state–society dynamics, my research offers an additional perspective. By using original survey data, I am able to compare both across and within provinces, thereby gaining a greater degree of generalizability. Exceptional research has explored how local dynamics affect social policy provision. In the case of social security reform, Frazier (2010) found that, because of implementation by local political actors, pension reform

that was intended to extend social security benefits resulted, paradoxically, in further inequality. In addition, Solinger and Hu (2012) argue that city-level factors affected the implementation of poverty assistance. Based on this recent research, I contend that the role of local government in social policy implementation requires further examination. Moreover, the attention afforded to social policy in China, particularly in political science, is not reflective of the significance of these issues to the Chinese people.⁴⁷

Comparative Social Policy

Comparative social policy of developing countries is flourishing as a field of study, yielding both explanations of reform as well as new frameworks to categorize divergence in the welfare regimes of developing countries. In previous chapters, I discussed competing explanations of welfare reform.⁴⁸ In this chapter, I expand on existing typologies of welfare regimes in developing countries in order to better understand provincial variation in welfare priorities in China.

The welfare regimes of developing countries require distinct frameworks for analysis from developed countries. By definition, developing economies rely more heavily on the agricultural sector and the informal economy. In addition, state–society relations may be clientelistic or even predatory, often leaving non-state, non-market actors, such as families and communities, to provide a social safety net. Esping-Andersen’s (1990) seminal “worlds of

⁴⁷ For example, in a recent Chinese Academy of Social Sciences survey, 43 percent of respondents stated that healthcare cost and access (the relevant idiom is translated literally as “seeing a doctor is difficult and expensive,” *kanbing nan, kanbing gui* 看病难, 看病贵) was among the top three problems facing China, which placed healthcare concerns second only to inflation (CASS 2011).

⁴⁸ For a few outstanding examples of this line of inquiry, see Ewig (2010), Haggard and Kaufman (2008), Cook (2007), and Wong (2004).

welfare” framework, however, relies on a state-centric model in which the majority of workers are employed in the formal sector. This approach advanced understanding of welfare regimes in developed countries, but analysis of social policy provision in developing countries has required new models to capture how the economic and political environments of developing countries affect social policy. Gough and Wood (2004) advanced this research by differentiating between the welfare state regimes of developed countries and the systems observed in developing countries, which they classify as informal security regimes and insecurity regimes. Informal security regimes are characterized by uneven development, a weak state, pervasive patron-client relations, but some social policy provision through communities with some state support. Insecurity regimes, in contrast, are characterized by predatory states with no commitment to social policy or stability, leaving the vast majority of the population vulnerable and without social welfare.

While this typology advanced the research by elucidating the distinctions between social policy regimes in developed and developing states, further research has provided new categories for understanding the divergence in social policy provision among developing countries. Huber and Stephens (2005) classify Latin American countries based on whether their social policies are aimed at developing human capital through social policies, such as education, as compared with those policies that protect workers from the market, such as pensions and social insurance. This distinction has been further developed by Rudra (2008, 2007) and, subsequently, by Martínez Franzoni (2008) and Pribble (2011). Rudra (2007) argues that developing states have diverged systematically, thereby producing three dominant types: productive, protective, and dual welfare states. These three types are determined by the economic development strategy of the country.

As a variation on this typology, Martínez Franzoni incorporates a third category, nonstate familiarist, in order to capture those societies that rely mainly on the community for social support. Additionally, Pribble (2011) argues that the process of industrialization has interacted with the nature of political incorporation of marginalized groups and the proportion of ethnic and racial minorities to create four distinct social policy regimes in Latin America. While providing insight into Latin America social policy regimes, this typology is limited in its applicability to other regions. I posit that variation in provincial social policy regimes in China can be classified by expanding on Rudra's productivist/protectivist typology.

Rudra (2008) argues that developing countries that pursue an export-oriented industrialization strategy tend to invest in social policy that will improve human capital while keeping the cost of labor low, in order to attract foreign investors and keep the costs of exports competitive (e.g. South Korea). In this case, a "productive" welfare regime tends to invest more heavily in health and education (tertiary or vocational education in particular) and less in pensions, unemployment insurance, and housing. Health and education spending tend to have more obvious links to improving human capital without triggering dramatic increases in the cost of labor. According to Rudra, productive welfare regimes seek to commodify workers, in contrast to Esping-Andersen's model in which OECD countries engaged in varying degrees of decommodification of labor.

By contrast, Rudra's protective welfare regimes emphasize shielding workers from market fluctuations by providing benefits such as subsidized housing, generous pensions, or ample unemployment insurance. "Protective" welfare regimes tend to develop these priorities due to their state-led development strategy. Latin American countries that employed import

substitution industrialization (ISI) typify this approach. Formal sector workers in state-owned firms received substantial benefits, but only comprised a small proportion of the population. In contrast, productive welfare states offered relatively shallow benefits to broad swathes of the population in order to improve human capital without causing a spike in the cost of labor. Dual welfare regimes engage in both productive and protective spending. In her research, Rudra classifies China as a dual welfare regime. Thus, largely as a function of economic approach, developing countries systematically diverged in the development of welfare regimes that were in large part a reflection of the economic development strategy that leaders pursued.

Through an analysis of subnational variation, I build on Rudra's contribution in order to understand what constitutes a "dual" welfare regime. I propose that systematic divergence in social policy priorities among Chinese provinces reveals clear tendencies towards either productive or protective welfare regime models. By disaggregating the state and looking more closely at the provincial level, I posit that China's decentralized and uneven process of economic development has created microcosms of productive and protective welfare regimes. I argue that provinces that developed an internationally-oriented economy earlier in the reform period (post-1978) have since developed productive approaches to social policy, whereas those provinces that continue to rely on state-owned enterprises (SOEs) for a large proportion of their economy have maintained protective welfare regimes. Furthermore, systematic provincial divergence cannot entirely capture subnational variation in social policy provision.

Categorizing Provincial Welfare Regimes in China

In the previous section, I reviewed the various efforts at classifying welfare regimes in developing countries. In addition, I argued that these methods should be applied to the subnational level in order to examine systematic variation in social policy provision in China. To this end, I conduct a cluster analysis of social policy spending in Chinese provinces. This analysis demonstrates that there is, indeed, systematic divergence in social policy among Chinese provinces.

Since economic reforms, China's income gap has widened with an estimated Gini coefficient of 0.47⁴⁹ and, in general, coastal provinces that internationalized their economies are far wealthier than inland provinces. In particular, economic inequality between rural and urban regions has risen (Khan and Riskin 2005; Sato and Li 2006; for further discussion, see Li et al. 2008). Therefore, we may expect that provinces would have corresponding differences in social policy outcomes such as literacy, disability-adjusted life expectancy, or infant mortality. Indeed, Chinese provinces do demonstrate as much variation in these outcomes as countries do.⁵⁰

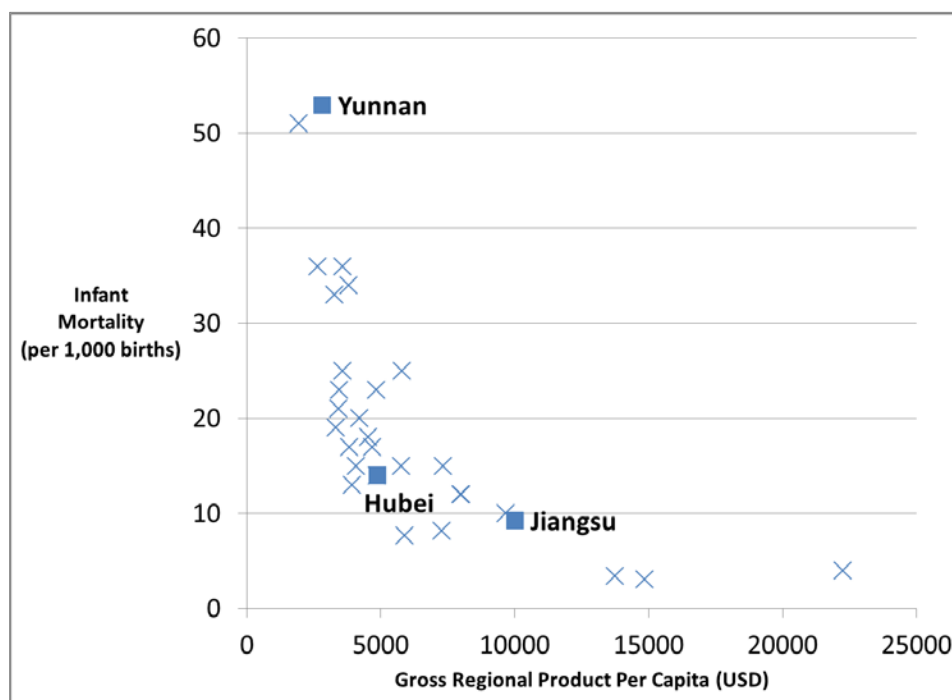
Figures 1 and 2 illustrate the variation in infant mortality rates and life expectancy, respectively, by province in 2006. The three provinces that will be discussed in detail in the

⁴⁹ The Chinese government had not been officially reporting its Gini index for several years until January of 2013. See Kevin Yao and Aileen Wang, "China lets Gini out of the bottle; wide wealth gap," *Reuters*, January 18, 2013, <http://www.reuters.com/article/2013/01/18/us-china-economy-income-gap-idUSBRE90H06L20130118>, accessed June 1, 2013. Prior to this announcement, the National Bureau of Statistics had claimed that the data are incomplete, but observers speculated that the government fears that a high Gini index would incite unrest (Fang, Xuyuan and Lea Yu, "Gov't Refuses to Release Gini," *Caixin Online* (财新网), January 18, 2012, <http://english.caixin.com/2012-01-18/100349814.html>). The World Bank reported China's most recent Gini index as 42 (on a scale of 0 to 100) from 2005 (<http://data.worldbank.org/indicator/SI.POV.GINI?page=1>). Sources from the Chinese state media, however, reported a Gini of 0.47 (on a scale of 0 to 1) in 2010 (Chen, Jia, "Country's wealth divide past warning level," *China Daily*, May 12, 2010, http://www.chinadaily.com.cn/china/2010-05/12/content_9837073.htm). To put this figure in context, a Gini index of 47 would rank China as having greater inequality than more than two-thirds of the world's countries, including Argentina and Mozambique, among others.

⁵⁰ For a discussion of rural-urban inequality in healthcare, see Yip (2010).

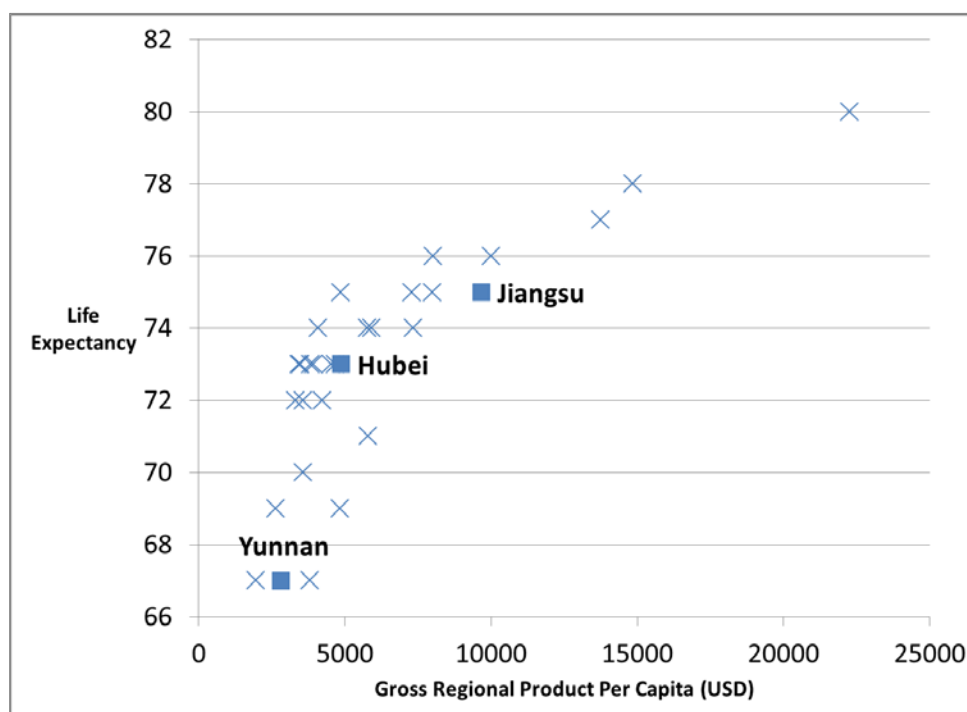
following chapters are labeled on the figures. By way of comparison, in 2006, Jiangsu, the wealthiest of the three provinces, was similar to Belarus in life expectancy (higher than Russia) and Costa Rica in infant mortality. Hubei, the middle-income province, was most similar to Albania in terms of infant mortality and Armenia in terms of life expectancy. Finally, Yunnan, the poorest of the three provinces, was most similar to India or Bolivia in terms of infant mortality and Mongolia or Uzbekistan in terms of life expectancy.

Figure 3.1: Infant Mortality (per 1,000 births) vs. Gross Regional Product Per Capita in Chinese Provinces (2006 USD) in 2006



Source: Gapminder China, www.gapminder.org

Figure 3.2: Life Expectancy vs. Gross Regional Product Per Capita in Chinese Provinces in 2006 (2006 USD)



Source: Gapminder China, www.gapminder.org

Beijing, on the other hand, had the same infant mortality rate as Denmark or Ireland and the same life expectancy as the U.S., although the Chinese capital's GRP per capita was significantly lower than these developed nations.⁵¹ These figures demonstrate that Chinese provinces are as variable as countries in terms of both economic and social indicators. Other large developing and even some developed countries also have significant wealth gaps and, thus, significant regional differences in social policy outcomes. Therefore, research on social policy should consider the factors driving subnational as well as cross-national variation.

⁵¹ The figures for these country comparisons are from Gapminder (www.gapminder.com) from 2006, the most recent available data for these measures at the provincial level in China, to my knowledge. These figures are more recent than those in the 2009 China Health Statistical Yearbook published by the Ministry of Health. In the 2009 Yearbook, the most recent data on life expectancy and infant mortality at the provincial level are from 2000 and 1990 respectively.

I contend that, controlling for level of economic development, Chinese provinces have systematically diverged in their social policy priorities since the economic reforms of the 1970s. In order to reveal this divergence, I use a cluster analysis of social policy spending as a proportion of provincial government spending. In this way, I effectively control for economic development by focusing on relative spending on social policy as a proportion of provincial budget. The provincial budget varies substantially depending on the revenue extracted by the province, which is heavily dependent on the level of economic development at the local level.

Because of the general trend of decentralization in social policy provision in China, provincial governments have been able to diverge in their social policy priorities. Some provincial governments invest more in education, while others spend more on housing or social insurance. An emphasis on education spending, in particular, indicates that the provincial government is investing in human capital and the work force, but perhaps wants to avoid an increase in the cost of labor through costly benefits such as pensions or social insurance. In this case, the province could be said to have a more “productive” approach to social policy and is, perhaps, engaging in the commodification of the workforce rather than using social policy to protect workers from the vagaries of the market. On the other hand, other provinces still rely on state-owned enterprises for a large part of their economy. The prevalence of SOEs in a province has implications for political as well as economic dynamics. In this case, if the provincial government has established social policy commitments in line with the legacy of SOEs, it would have difficulty with retrenchment in terms of pensions, housing, or social insurance. A province dominated by SOEs, or with a heavier reliance on SOEs, will engage in more “protective” social spending, often sacrificing investment in productive social policy.

To examine whether Chinese provinces constitute distinct welfare regimes, I analyze provincial-level data from 2010 compiled from the 2011 China Statistical Yearbook. The dataset encompasses all 31 provinces and province-level cities in mainland China, but excludes regions with semi-autonomous or contested status (Hong Kong, Macao, and Taiwan). Of the 31 provinces in mainland China, four are municipalities that have been granted provincial-level administrative status: Beijing, Chongqing, Shanghai, and Tianjin. Each of these cities is a metropolis with a population of over 12 million in the greater municipal area and a dynamic economy that is comparable to a province and, therefore, these municipalities are treated as provinces in the dataset.

Cluster analysis refers to a group of methods that use classification algorithms to determine how to categorize objects into groups of similar attributes. This method has been used widely in the medical and natural sciences to classify similar species such as plants, animals, and diseases. The research on social policy also applies this technique in order to group countries with similar social policy regimes into meaningful categories. I use the “tree clustering” method to classify Chinese provinces in distinct welfare regimes. Tree clustering categorizes objects into clusters based on the dissimilarities, known as distances, between them, and produces a dendrogram which provides a visual representation of how similar units are group together. Tree clustering relies on an examination of the distances between objects, which can be computed differently depending on the characteristics of the dataset; I use the most commonly used approach, the Euclidean distance. This approach is popular because of its resistance to outliers. In addition, a “linkage rule” must be defined; the research on social policy and in other fields prefers Ward’s method as a linkage rule. Ward’s method defines at what values two clusters are

similar enough to be linked together through an analysis of variance technique (Ward 1963). Scholars often prefer this method because of its efficiency, although it can produce smaller clusters.

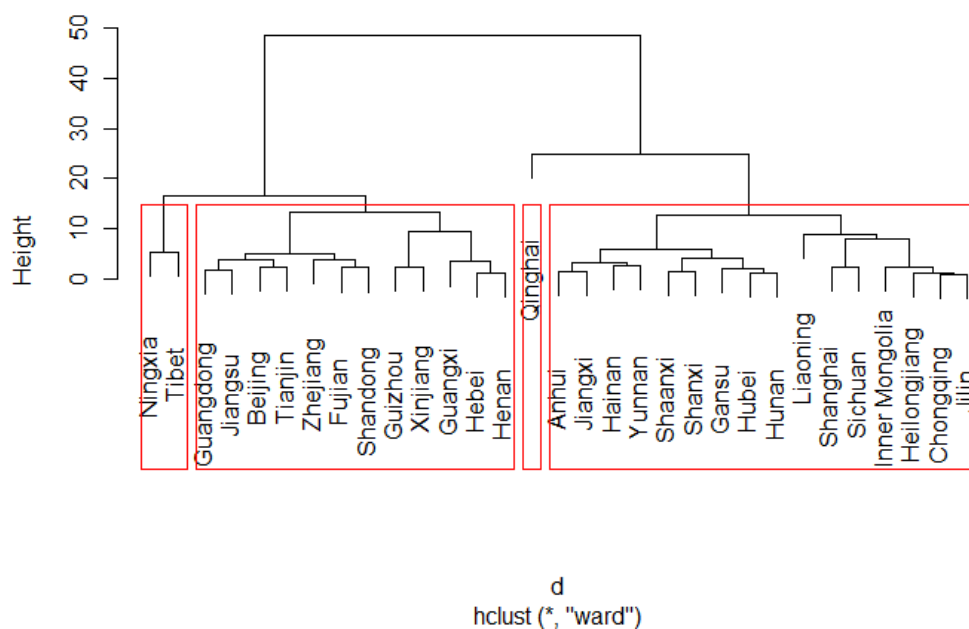
To examine variation in the government's commitment to social policy at the provincial level, I use provincial-level data on social spending in four categories: education, health, pensions and social insurance, and housing. I calculate each type of social spending as a proportion of total provincial government expenditures in order to measure the relative importance of these policies (Rudra 2007). I use social spending as a proportion of total provincial budgetary expenditures to capture the relative provincial commitment to that issue, as others have advocated in the literature on social policy in developing countries (Rudra 2007, 2008). Social spending as a proportion of total provincial budgetary expenditures also effectively controls for differences in wealth across provinces. Therefore, the clusters that are produced reflect differences in social policy priorities, rather than relative wealth. While some scholars prefer to use social policy spending as a proportion of GDP, recent research has concluded that social policy spending as a proportion of budgetary expenditures more accurately captures government commitment to a particular social policy issue (see Rudra 2007 for further discussion of this). Pan and Liu (2012) have developed a model to explain per capita general health expenditures by Chinese provincial governments by examining primarily economic explanatory variables such as general budget revenue, central government transfers, and demographic characteristics such as the degree of urbanization. Pan and Liu significantly advance our understanding of provincial-level variation in health expenditures, but this chapter

takes a different approach by examining the relative social policy priorities of the provinces, effectively controlling for the resources available to the provincial government.

Several scholars have expressed concerns about using expenditures as a measure because funds can be diverted from their intended purpose, particularly in corrupt environments. Therefore, many scholars incorporate outcome variables in their analysis (e.g. Rudra 2008; Pribble 2011). However, in this case, incorporating outcome variables poses two problems. First, outcome data would re-introduce the effect of wealth on variation in social policy. In general, wealthier provinces tend to have better social welfare outcomes than poorer provinces because of higher levels of economic development and past policies. Outcomes would almost be equivalent to a proxy for economic development, making it difficult to unpack differences in social policy priorities at the provincial level. Second, reliable outcome data comparable to national-level data are not consistently available for all provinces, which would further complicate an analysis based on outcomes. Thus, I focus on expenditures as an indication of the province's social policy intentions.

In the Chinese statistical yearbook, pension and social insurance spending are aggregated as "social safety net" expenditures. Education includes all levels of education. Although further disaggregation of these measures would be preferable to provide a more complete analysis of provincial welfare regimes, my goal in this chapter is to establish that social policy priorities differ among the provinces. In the following chapter, I conduct in-depth analysis of social policy provision in three provinces with different policy styles: Jiangsu, Hubei, and Yunnan.

Figure 3.3: Cluster Dendrogram of Provincial Social Policy Priorities



NB: Cluster analysis conducted in R, version 2.13.1.

The results of the cluster analysis reveal two main clusters that comprise 28 of the 31 provinces, with the exception of Ningxia and Tibet, which are grouped together, and Qinghai, which is grouped by itself in its own cluster. First, I will discuss the two main clusters that emerged and then I will examine the three provinces that were classified as distinct clusters.

The first large cluster in Figure 3 roughly corresponds to provinces with a productive approach to social policy. As shown in Table 1, the mean spending for education is higher for provinces in the first cluster and the mean spending for housing, pensions, and social insurance is lower. This result indicates that the governments of these provinces tend to emphasize investment in the workforce, through education, rather than protecting workers from market

fluctuations as might be accomplished through spending on housing, pensions, or social insurance. I refer to this first large group as productive welfare regimes. By contrast, the second large cluster in Figure 3 is characterized by higher spending on social insurance, pension, and housing and lower spending on education. These provinces tend to emphasize social policies that protect workers from the market, rather than investing in human capital. I refer to this second large group as protective welfare regimes.

To test the statistical significance of the productive and protective clusters, I conducted a two-sample Student's *t* test; these results are shown in Table 2. The significance test confirms that the difference in mean spending in education, housing, pensions, and social insurance between the group of productive and protective provinces is statistically significant. For the education and social insurance and pensions categories, there is strong evidence that the means are different; there is also evidence that the means of the two groups in the housing category are different, but with a somewhat larger *p*-value. On the other hand, Table 2 does not provide evidence to support that mean health spending in the aggregate between the clusters of provinces is distinct. Given observations about differences in the nature of healthcare provision between provinces, this result indicates that aggregate relative health expenditures at the provincial level may be an insufficient measure to understand subnational variation in healthcare provision. I will return to this point later in the chapter.

Table 3.1: Summary Statistics of Cluster Analysis

Province	Education	Health	Social Insurance and Pensions	Housing
Productive Cluster				
Means	17.95	6.76	9.74	2.20
Beijing	16.57	6.88	10.15	1.69
Fujian	19.34	6.94	8.75	1.66
Guangdong	17.00	5.61	8.66	1.63
Guangxi	18.27	8.24	10.81	2.94
Guizhou	17.90	7.83	8.63	5.37
Hebei	18.24	8.35	12.72	1.84
Henan	17.84	7.91	13.50	2.26
Jiangsu	17.61	5.08	7.42	1.48
Shandong	18.59	6.05	10.05	0.85
Tianjin	16.67	5.09	10.00	0.46
Xinjiang	18.47	6.10	9.79	5.30
Zhejiang	18.91	7.00	6.43	0.92
Protective Cluster				
Means	14.77	6.34	13.70	3.50
Anhui	14.93	7.12	12.91	3.61
Chongqing	14.07	5.55	13.87	4.68
Gansu	15.54	6.84	14.65	3.96
Hainan	16.91	5.99	12.69	4.10
Heilongjiang	13.28	6.00	13.58	4.83
Hubei	14.65	7.16	14.73	2.26
Hunan	14.92	6.68	14.67	3.03
Inner Mongolia	14.17	5.31	12.86	3.68
Jiangxi	15.47	7.80	12.12	3.54
Jilin	14.00	6.21	14.18	4.86
Liaoning	12.69	4.74	18.14	2.62
Shaanxi	17.03	7.06	14.22	3.10
Shanghai	12.63	4.85	10.98	1.59
Shanxi	17.01	5.90	14.21	2.76
Sichuan	12.70	6.18	12.06	2.51
Yunnan	16.40	8.04	13.33	4.91
Others				
Means	12.25	5.72	12.52	5.05
Tibet	11.03	5.81	5.79	1.90
Ningxia	14.63	6.10	6.28	5.03
Qinghai	11.09	5.24	25.49	8.22

Source: Compiled by the author from China Statistical Yearbook 2011.

Table 3.2: Two Sample T-Test of Clusters A and B

Type of Social Policy	Student's <i>t</i> Test Statistic	Pr(> t)
Education	6.93	0.0000***
Social Insurance and Pensions	-5.62	0.0000***
Housing	-2.47	0.0242*
Health	1.00	0.3283

Significance codes: '***' 0.001 '**' 0.01 '*' 0.05
Two sample T-test conducted in R, version 2.13.1.

There are three provinces, however, that are not easily classified into productive or protective welfare regimes: Tibet, Ningxia, and Qinghai. All three of these provinces have characteristics that make them distinctive and difficult to compare with China's wealthy littoral region or middle-income interior provinces. All three of these outliers have a significant concentration of ethnic minorities (see Table 3.3). Considering that most provinces are over 90% Han Chinese,⁵² the concentrated population of an ethnic minority has implications for local governance. Tibet is perhaps the most well-known example of tension between Han Chinese and ethnic minorities, with Tibetans comprising 90% of the population. Another large ethnic minority, the Hui (回), which is spread over several provinces, constitutes a significant 34% of the population in Ningxia. Qinghai, on the other hand, is home to a more diverse group of ethnicities, mostly comprised of Tibetans and Hui (24% and 15% respectively) as well as small populations of other ethnic groups. Although several other provinces (such as Xinjiang, Guizhou, Yunnan, and Inner Mongolia) also have significant ethnic minority populations, the politics of social welfare provision appears to operate distinctly in Tibet, Ningxia, and Qinghai. This could be attributed to the perceived potential for unrest among ethnic minorities in these regions. However, Xinjiang

⁵² Only 10 out of 31 provinces and province-level cities have a population of ethnic minorities of greater than 10% according to the 2010 census (Census Office of the State Council 2012).

has experienced significant unrest among the Uyger population, but does not deviate from the main categories of productive and protective spending. Further examination of these cases may be necessary to uncover the dynamics leading to deviations in relative social policy spending.

Table 3.3: Concentration of Ethnic Minorities in Selected Provinces (2010)

Province	Population	Ethnic Minorities as a Percent of the Provincial Population	Dominant Ethnic Groups	Dominant Ethnic Groups as a Percent of the Provincial Population
Tibet	3002165	92%	Tibetan	90%
Xinjiang	21815815	60%	Uyger	46%
Qinghai	5626723	47%	Tibetan	24%
			Hui (回)	15%
Guangxi	46023761	37%	Zhuang (壮)	31%
Guizhou	34748556	36%	Miao (苗)	11%
			Buyei (布依)	7%
			Tujia (土家)	4%
			Dong (侗)	4%
Ningxia	6301350	35%	Hui (回)	34%
Yunnan	45966766	33%	Yi (彝)	11%
			Hani (哈尼)	4%
			Miao (苗)	3%
			Bai (白)	3%
			Zhuang (壮)	3%
			Dai (傣)	3%
Inner Mongolia	24706291	20%	Mongolian	17%

Source: Population Census Office, China State Council, Tabulation on the 2010 Population Census of the People's Republic of China (2012).

Provincial Welfare Regimes

Recalling the cluster analysis at the provincial level, I have chosen three provinces to examine in greater detail at the local level in the following chapters: Jiangsu, Hubei, and Yunnan. Jiangsu typifies a province with a productive approach to social policy, while Hubei represents a

province with a protective approach to social policy. As shown in Table 1, the proportion of spending on education, health, social insurance and pensions, and housing in Jiangsu is similar to the mean relative spending in those categories for the group of productive provinces. By contrast, spending on social policy in Hubei is similar to the mean for provinces oriented toward protective social policy provision. Therefore, Jiangsu and Hubei represent appropriate cases to examine the lower level dynamics within a productive and protective province. Yunnan also falls within the protective welfare regime category, but engages in more relative spending in education and health than a typical protective province. Yunnan is at the upper end of relative spending for education, health, and housing, which makes it somewhat different from other provinces in this group. Nonetheless, Yunnan has registered particularly poor social welfare outcomes historically. Subnational variation in rural health policy will be examined in these three provinces in the following chapters.

Chinese productive provincial welfare regimes, as exemplified by Jiangsu, tend to share other characteristics as well. In general, productive provinces are more integrated with the global economy and are more reliant on exports than other provinces. In addition, because these provinces tend to be wealthier than other regions, the central government provides less direct support for social policy and the province is relatively autonomous in terms of social policy provision, both in terms of funding and determining the specifics of policy implementation. For example, in the case of rural health insurance, the central government provides about one-third of the funding for most provinces, with the exception of wealthy coastal provinces. Productive provinces also typically provide more autonomy to municipal and county governments to tailor policy to local conditions. In one city in northern Jiangsu, six rural counties and one urban

district decided to standardize their rural health insurance programs. They hold monthly meetings within the municipality and disseminate information in order to create a uniform program (Interviews JSAW01, JSBW07, JSCW10). Notably, this collaborative process was initiated by local actors, rather than the provincial or central governments. In contrast, other provinces (such as Hubei and Hunan) have established provincial-level guidelines to standardize the implementation of ostensibly the same rural health insurance program within the province.

As a result of this relative autonomy in social policy design, productive provinces are also more likely to adopt new policies early or to initiative innovative solutions to social policy problems. Productive provinces are also, therefore, more likely to utilize public-private partnerships in social policy provision. For example, Suzhou in Jiangsu is well-known for being the first to privatize a hospital (Author's fieldwork, 2009). As another example, implementation of rural health insurance in Jiangsu (and other coastal regions) occurred two to three years before implementation in Hubei (and other interior regions) (Author's fieldwork, 2009-2010) and Jiangsu has also instituted direct billing for rural health insurance ahead of other provinces (Author's fieldwork, 2011). Consistent with notices from the Ministries of Health and Finance,⁵³ wealthier areas with better medical, human, and financial resources at their disposal are more likely to be chosen for pilot projects and early implementation of new policies (Interviews JSAW01, HNGW30).⁵⁴ This approach to pilot project selection reflects a broader strategy for decentralization; wealthier regions are often permitted greater autonomy, while less developed

⁵³ See, for example, the Ministry of Health and Ministry of Finance, “关于做好新型农村合作医疗试点有关工作的通知” [Notice on proper implementation of the New Cooperative Medical System pilot projects], August 11, 2005.

⁵⁴ Of course, selecting favorable conditions for pilot projects is probably not a wise approach to testing a new policy, but this issue is beyond the scope of this chapter.

localities are more strictly regulated. Because of these conditions, productive provinces are also more likely to have greater within-province variation.

By contrast, protective provinces tend to rely more heavily on state-owned enterprises and have not internationalized as much as productive provinces. In these regions, the central government provides relatively greater subsidies for social policy and the province tends to institute regulations to standardize social policy at the provincial level, resulting in less within-province variation. For example, the funding structure from rural health insurance, including per capita contributions from the province, county, and individual, has been standardized at the provincial level in Hubei and Hunan.⁵⁵ Of course, some variation remains and local governments do not immediately comply with provincial-level regulations, but this effort from the provincial government does tend to reduce within-province variability. Due to the greater involvement of the provincial government, protective provinces are generally later adopters of new policy and tend to exhibit less innovation at the local level. In addition, these provinces are also more likely to use social policy clientelistically to co-opt certain groups, a dynamic which I will examine in the following chapters.

The cluster analysis also classifies Yunnan as having protective social policy priorities. Yet, due to the relatively rural and ethnically diverse nature of the province, governance and social policy provision have been qualitatively different. Further examination of local state–society relations within Yunnan will enable me to explore these dynamics in greater detail.

⁵⁵ For Hubei, see “湖北省人民政府关于全面推进新型农村合作医疗制度建设的指导意见” [Hubei Province People’s Government Instructive Opinion on the Full Promotion of the Construction of the New Cooperative Medical System], Hubei Provincial Government Bulletin (湖北省人民政府公报), May 2008. For Hunan, see “湖南新农合补偿标准进一步提高, 湖南省人民政府网站” [Hunan NCMS Reimbursement Standards Raised, Hunan Provincial People’s Government Website], published Nov. 13, 2009, available at <http://www.xinshao.gov.cn/info/bmlf/9290.shtml>, accessed March 15, 2010.

Ideally, local survey data would be gathered from Tibet, Ningxia, or Qinghai, but the sensitive political environment in these provinces precluded a systematic survey in these regions.

Therefore, an analysis of local dynamics in Yunnan enables us to better understand how social policy is implemented in poor, rural provinces with a more ethnically diverse population.

There are, of course, other exceptions to these tendencies. For example, Shenmu (神木) County in Shaanxi province—a protective welfare regime according to my cluster analysis—has gained notoriety for using the revenue generating by coal mining to establish an extensive social welfare system for county residents, including universal healthcare, free education through secondary school⁵⁶, housing subsidies, and poverty relief programs.⁵⁷ This case could be considered a form of innovation, although Shaanxi province is classified as a protective welfare regime in this framework. Nonetheless, the productive/protective heuristic does provide some useful generalizations in understanding the subnational variation in social policy adoption and implementation in China.

As Tibet, Ningxia, and Qinghai might indicate, there are several aspects of subnational variation in social policy that classification at the provincial level does not capture. Provincial-level analysis obfuscates three important dimensions in social policy variation: the gap between rural and urban welfare systems, qualitative variation in provision, and the role of municipal and local governments in social policy implementation.

⁵⁶ Typically, nine years of compulsory education, beginning at age six, are virtually free in public schools. Public secondary schools, however, increasingly charge various operating fees that can be a significant burden on lower income families.

⁵⁷ The county has received some media coverage from the state media for its efforts such as “Public welfare programs in Shenmu County, Shaanxi Province,” *Xinhua News Agency*, Dec. 27, 2009, http://www.china.org.cn/photos/2009-12/27/content_19138418.htm.

First, aggregating social policy at the provincial level obfuscates the separate and unequal welfare systems that persist for urban and rural residents in China. This division was institutionalized by the residence permit or *hukou* (户口) system. Chinese citizens are assigned a residence permit based on their place of birth and changing one's *hukou* can be an arduous process, particularly from rural to urban areas. Although there has been some relaxation of the *hukou* system in order to accommodate the need for migrant workers in urban construction, urban residents still have access to social welfare systems that are unavailable to rural residents.⁵⁸ For example, rural migrants working in the city are often prohibited from enrolling their children in local schools. Migration to the city also has implications for access to healthcare, given that the health insurance program for rural residents may not cover treatment outside of one's place of residence.⁵⁹ Inequality between urban and rural welfare systems has existed prior to the establishment of the CCP and the party-state. But, the establishment of SOEs in urban areas and the substantial benefits they conferred (such as welfare and housing benefits) reified the gap between urban and rural Chinese. In the reform period, social policy has persisted as two separate and unequal systems: urban and rural. Provincial-level statistics continue to reflect this bias. For example, housing and unemployment insurance are rarely provided to rural residents, but constitute a significant proportion of social spending. Regarding healthcare, rural residents are more likely to decline hospitalization because of the cost (Yip 2010: 154-157; Gu 2009, 28-29). In addition, rural residents have higher infant and maternal mortality rates and grow to a

⁵⁸ For an analysis of the current status of the *hukou* system, see Chan and Buckingham (2008).

⁵⁹ The rural health insurance plan typically treats medical treatment outside of the local area as out-of-network. In other words, some reimbursement may be offered, but reimbursement levels are lower. Moreover, the necessary paperwork to receive such compensation is often prohibitively stringent for migrant workers (Author's fieldwork, 2009–2010).

shorter height than their urban counterparts, reflecting the gap in healthcare outcomes (Yip 2010). Therefore, considering that rural residents still constitute half of the population, examination of the rural system of health policy adoption and implementation is crucial to understanding social policy in China as a whole.

The second issue obscured by provincial-level analysis is the within-province variation in the nature of social policy. As observed with the test of statistical significance, the difference of means of the two large groups in relative health spending is not statistically significant. However, a closer examination of the quality of healthcare provision reveals that variation among and within provinces does exist. For example, in the case of rural health insurance, which began in 2003 and has since been implemented nationwide, some provinces establish province-wide regulations for funding and reimbursement levels, while other provinces allow county governments to tailor the program to local conditions (Author's fieldwork, 2009-2010). Even a cursory look at policy implementation, such as the rural health insurance program, reveals that provincial governments have different policy styles and that further variation exists below the provincial level. Thus, further examination of healthcare provision at the local level is necessary to understand and explain subnational variation in social policy provision in China.

A provincial-level evaluation is limited in a third significant way. It obfuscates within-province variation that occurs at the municipal level and below and prevents analysis of the micro-foundations of subnational variation in social policy provision, particularly with regard to rural areas where existing data are scant and unreliable. For example, some provincial statistical yearbooks provide municipal-level data on literacy rates, but not other indicators of social policy

outcomes such as infant or maternal mortality rates.⁶⁰ In terms of participation in social programs, publicly available data may include participation in programs such as unemployment insurance or pensions for urban populations, but information on rural social policy is severely lacking. Moreover, the type and quality of data provided by statistical yearbooks differs across provinces and discrepancies have been found between provincial and national statistics (see Appendix D for further discussion).⁶¹ Because of a policy style that provides local governments, such as the municipality or county, with substantial autonomy in policy implementation, within-province variability is significant. Therefore, to capture subnational variation and examine social policy provision in rural areas, we need additional data from the local level. In the following chapters, I use a dataset compiled from an original survey of over 1,000 villagers and village leaders in Jiangsu, Hubei, and Yunnan provinces in order to elucidate local dynamics in provinces with distinct social policy priorities at the provincial level.

Conclusion

In this chapter, I demonstrate that a national-level analysis of social policy in China is insufficient. Rather, subnational variation in social policy occurs systematically and can be examined by looking at the local dynamics that affect policy adoption and implementation. My provincial-level cluster analysis illustrates that Chinese provinces differ systematically in their approach to social policy; some provinces place a relative emphasis on productive spending,

⁶⁰ See, for example, the Yunnan Statistical Yearbook, which provides the number of illiterate people in the workforce, but not in the total population of the municipality. Moreover, other outcomes measures for social policy are absent.

⁶¹ See, for example, Cyranoski, David, “China’s Emissions Estimates Don’t Add Up: National and Regional Figures Differ by More Than a Gigatonne,” June 13, 2012, *Nature*, <http://www.nature.com/news/china-s-emissions-estimates-don-t-add-up-1.10815>, accessed June 18, 2012.

such as education, while others focus on protective spending, such as pensions, social insurance, and housing. Tests of significance indicate that these differences are statistically significant. Therefore, this analysis of provincial-level divergence in welfare priorities indicates that classifying China as a mixed or dual welfare state has limitations. Rather, subnational analysis is necessary because it reveals important and systematic variation, which has both social and political implications.

However, the evidence examined in this chapter also indicates that variation in social policy cannot be wholly explained by provincial-level factors. First, provincial-level statistics aggregate social policy spending for urban and rural areas. Given that China has established distinct social policy systems for rural and urban residents and that half of China's population is still rural, further analysis of social policy provision in rural areas requires local-level data that focus on social policy provision for rural areas. Second, qualitative variation in social policy adoption and implementation is not captured by provincial-level statistics, as illustrated by the example of healthcare. Third, my research and other research on Chinese politics indicate that further variation occurs at the municipal and county levels, which is also not captured by this province-level analysis. In the following chapters, I use data compiled from an original survey of over 1,000 villagers and village leaders to examine health policy provision in Jiangsu, Hubei, and Yunnan provinces.

Chapter 4

Center-local Relations, Differentiated Decentralization, and Health Policy Implementation

In this chapter, I show that the central government seeks to bolster its legitimacy through progressive transfers for healthcare to poorer provinces. The center maintains legitimacy in poorer provinces through these progressive policies of redistribution and, as demonstrated by Sheng (2010), fosters loyalty in wealthy provinces through political appointments of particularly loyal provincial leaders. These two different approaches to the center–province relationship between wealthy and poor provinces also translate into varying degrees of decentralization in policy implementation. While the poor provinces that are dependent on the central government for transfers for health tend to standardize policy, wealthy provinces tend to decentralize both the sources of funding and decision making for healthcare. As a result, county officials in wealthier provinces tend to be more empowered and see themselves as policy makers rather than mere agents of the state. By contrast, county officials in poorer provinces tend to look to higher levels of government (generally the provincial government) for guidance in policy priorities. Despite the progressive tendencies of central government health policy, villagers have more healthcare-related grievances and rate local health facilities more poorly in poor provinces. This chapter furthers our understanding of decentralization, policy implementation, and healthcare at the subnational level in China.

The chapter proceeds as follows. First, I demonstrate that central government transfers to the provinces for healthcare are, indeed, progressive. Because of limited publicly available information on this issue, I use multiple sources of data to show that (1) central government

transfers to healthcare tend to favor poorer provinces; (2) the official designation of a “poverty county” is associated with villages receiving significantly more funds for health from higher levels of government; and (3) specific policies, such as the rural health insurance program (New Cooperative Medical System, NCMS), are designed to provide targeted subsidies from the central government to poorer provinces. Then, I examine how policy implementation differs across provinces through the case of the NCMS. Wealthy provinces take a decentralized approach to policy implementation, while poorer regions tend to institute provincial standards, reducing the opportunities for local officials to affect policy implementation. Finally, I examine villagers’ evaluations of local health facilities and the type of healthcare-related grievances that occur in poorer provinces.

The Central Government’s Progressive Approach to Health

Since the beginning of the Hu-Wen administration in 2003, the central leadership has made a concerted effort, both rhetorically and financially, to expand efforts at poverty alleviation and reduce the economically polarizing effect of market reforms. As discussed in greater detail in the Chapter 2, Hu Jintao expressed the intention to place social issues, such as poverty and healthcare, on the national agenda through his new slogans such as “harmonious society” (*hexie shehui* 和谐社会) and “moderately well-off society” (*xiaokang shehui* 小康社会). Previous central government leadership had prioritized economic development since the beginning of market reforms in 1978. By contrast, Hu and Wen expressed the importance of reducing the wealth gap as well as expanding state support for poverty alleviation programs and social policy, including healthcare. This shift in central government priorities is evidenced in rhetoric, new

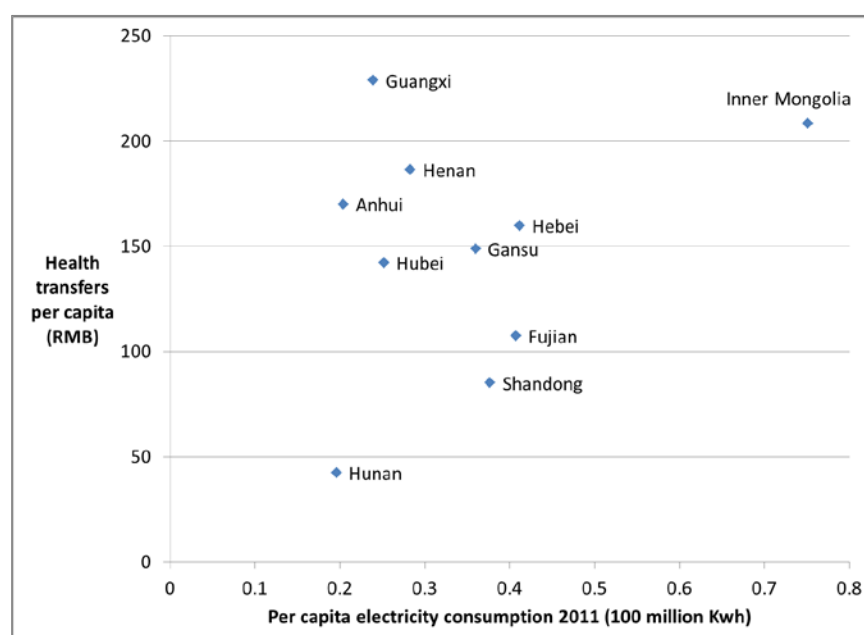
policies, and fiscal commitments. Major speeches include references to the importance of developing a “harmonious society” and a “well-off society.” New central government policies have sought to reduce poverty, including the minimum livelihood guarantee for urban residents (*chengshi jumin zuidi shenghuo baozhang* 城市居民最低生活保障) and new rural health insurance programs. Moreover, the central government has substantially increased funding for poverty reduction and other similar programs. The increase in government spending on healthcare as a percentage of GDP is depicted in Figure 2.4 in Chapter 2.

In accordance with these stated goals, the central government seeks to disburse funds for healthcare to the provinces progressively, by directing earmarked funds for healthcare to middle- and low-income provinces, but far less to wealthy coastal provinces. Assuming that central leadership seeks to maintain legitimacy among broad swathes of society, previous research has found that, since the 1994 tax reforms, the central government extracts revenue from wealthy provinces and redistributes funds to poorer provinces (Sheng 2010). In his methodical analysis of political appointments, Sheng (2010) identifies a fundamental dilemma facing the central government: central leaders seek to redistribute funds from the economic “winners” to the “losers” in the reform period, but how can they ensure that the wealthy provinces do not revolt? Sheng argues that the central government strategically appoints loyal leaders to provincial posts so as to ensure cooperation as revenue is extracted from these wealthy localities and redistributed to poorer provinces. Presumably, poorer provinces will continue to support central leadership as long as they are treated more favorably and receive subsidies from the center.

Because central government transfers to the provinces are not public information in China, I utilize other available evidence to demonstrate the progressive tendency of the central

government in terms of transfers for healthcare. First, I collected information on central government transfers to the provinces for healthcare directly from provincial governments and their websites; I was able to gather this information from ten provinces, since many did not respond favorably to the request for information.

Figure 4.1: Central Government Transfers to Provinces for Healthcare vs. Electricity Consumption in 2011 (per capita, 2011 RMB)



Sources:

Anhui, Fujian, Gansu, Guangxi, Hebei, Henan, Hubei, Inner Mongolia, Shandong: provincial communications.

Hunan Government Finance Website:

<http://www.hnczt.gov.cn/czt2011/czysgk/Index.html> (NB: Health transfers for Hunan are probably underestimated.)

Figure 4.1 shows per capita central government transfers to these provinces for healthcare in 2011, with per capita electricity consumption on the x-axis as a measure of economic

development.⁶² Although the data are incomplete, there is a clear tendency for less developed provinces to receive significantly more transfers for healthcare from the central government.⁶³

The provinces that are missing from this sample tend to be wealthier and receive less funding for healthcare from the provincial government, as evidenced by my interviews with county officials in Jiangsu, a wealthy province.

Previous research has diverged regarding fiscal transfers in China. My finding about the progressive nature of central government transfers for healthcare is consistent with Sheng (2010) who contends that, to maintain political stability, the central government seeks to redistribute revenue from economically successful provinces to reduce the inter-provincial wealth gap and reduce instability among the provinces that have been the economic “losers” or at least have not developed as quickly since economic reforms.⁶⁴ Shih (2008), however, posits that funds are allocated to economically successful localities as a reward for their success. But, his data do not distinguish between the possible origins of the funds, which could be the central or provincial governments. My research indicates that the center tends to be more progressive, rather than rewarding economically successful localities with fiscal transfers, but provinces may be regressive. These conflicting tendencies could explain Shih’s finding of a weakly positive association between total transfers and county gross regional product.

⁶² While electricity consumption is often a useful measure of economic development, the mean of electricity use perhaps overestimates wealth in Inner Mongolia.

⁶³ It is likely that regions with significant proportions of ethnic minorities receive higher transfers to quell political instability. Future research will examine this issue.

⁶⁴ Sheng’s (2010) analysis focuses on leadership appointment and demonstrates that the center seeks to improve its extractive capabilities among economically successful provinces by appointing “bureaucratically integrated” leaders to economically successful provinces, enabling the central government to ensure loyalty and a steady flow of revenue from economically successful provinces because those provincial leaders prioritize their long-term career prospects and will be seeking promotion to a central government position.

Other central government policies also have progressive aims, but well-intentioned goals can be stymied by local politics. For example, the State Council Leader Group Office of Poverty Alleviation and Development (*guowuyuan fupin kaifa lingdao xiaozu bangongshi* 国务院扶贫开发领导小组办公室) designates counties and villages for targeted development by bestowing the official designation of “Poor Counties and Villages” (*pinkun xian/cun* 贫困县/村). Ostensibly, counties are selected for targeted development based on both community and household criteria collected by local statistics offices and household surveys. An examination of counties with and without the poverty designation in my survey of village leaders indicates that poorer counties are indeed receiving additional subsidies.

Table 4.1: Sample Counties Gross Regional Product Per Capita Disaggregated by Poverty Designation in Hubei and Yunnan (2011, RMB)

	Observations	Mean	Standard Deviation	Minimum	Maximum
Non-poverty counties	11	16940	7820	8140	37356
Poverty counties	7	7393	3458	2999	11716

NB: Difference in means for poverty vs. non-poverty counties is statistically significant at $\alpha = 0.01$

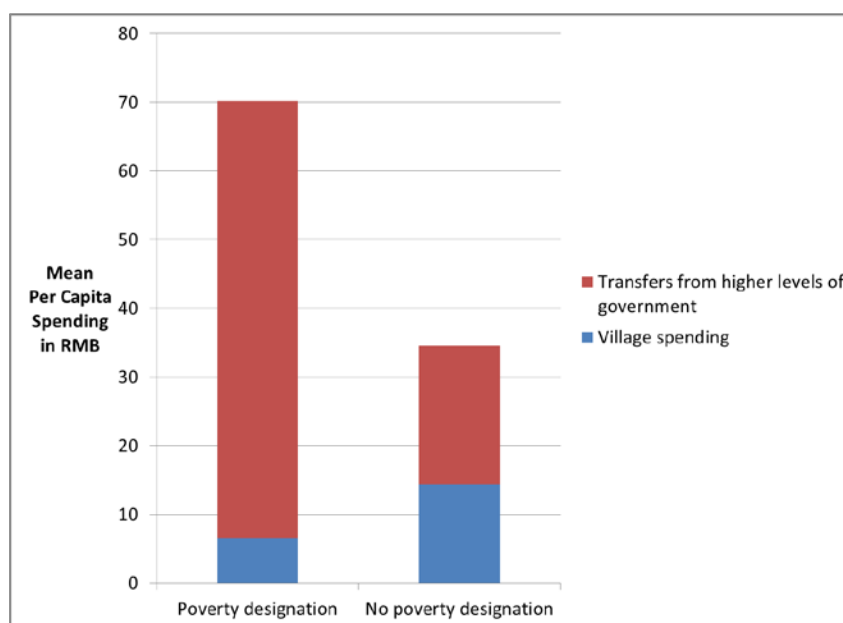
Sampled counties from Jiangsu are excluded from this table because localities in coastal provinces are no longer eligible for poverty designation.

Source: Hubei Statistical Yearbook 2012; Yunnan Statistical Yearbook 2012.

Table 4.1 presents the mean gross regional product (GRP) per capita in 2011 for poverty counties and non-poverty counties in Hubei and Yunnan that were sampled in our survey. The mean GRP per capita for poverty counties is less than half of that for non-poverty counties and a Student’s *t*-test confirms that the difference in means for these two groups is non-zero and statistically significant at the $\alpha = 0.01$ level. Therefore, in general, it would seem that poorer counties are, indeed, receiving the official designation.

Localities are eligible for many more programs and subsidies once they have obtained official poverty status. Villages in counties that are officially designated as “poor” do indeed receive more funding for health than villages that are not located in officially poor counties. Based on my survey of village leaders, villages that receive the official poverty designation report a substantially higher proportion of funding from higher levels of government for healthcare (which could include the county, municipal, provincial, or central government) than villages without the poverty designation. Figure 4.2 shows mean per capita spending on health at the village level grouped by villages with and without the official poverty designation.⁶⁵

Figure 4.2: Sources of Village-Level Health Spending in Hubei and Yunnan: Sampled Counties With and Without Official Designation of “Poor”



Source: Author’s survey of village leaders.

Number of observations: Villages with poverty designation=35; Without poverty designation=51.

NB: One village in the Yunnan sample is excluded because of enumerator error.

⁶⁵ I include only villages from Hubei and Yunnan in Figure 4.3 because Jiangsu does not have any localities eligible for poverty designation and, thus, the funding structure is not comparable.

The mean spending from the village level is also lower in officially poor localities; this could either be because the village simply cannot afford to invest in health (or is not so inclined) or because they are already receiving such significant health funding from higher levels of government that they do not have an incentive to invest further in health. On average, villages with the poverty designation in our sample report more than three times as much funding from higher levels of government than villages that do not have the poverty designation. A Student's *t*-test provides strong evidence that mean spending from higher levels of government is higher among poverty villages as compared to villages without this designation ($\alpha = 0.05$).

However, local officials are well-aware that receiving this designation will entitle them to additional transfers from higher levels of government. As a result, in some cases, the process of identifying poor localities has been marred by local politics. For example, county officials in Xinshao County (新邵县) in Hunan revealed their overzealous embrace of the program, when they posted an LED sign celebrating their poverty designation in late 2011. Subsequently, a photo of the sign went viral on the internet, attracting attention and criticism of the spectacle. By 2012, Xinshao County was no longer included on the poverty designation list; observers speculate that their ostentatious display led central officials to remove them from the list. In another case in early 2013, Datong County in Shanxi Province (山西大同县) was reinstated as an officially poor county after having been categorized as “well-off” since 1996.⁶⁶ Thus, attaining poverty status depends at least in part on actions by local officials. In some cases,

⁶⁶ “小康县“弃富逐贫”戴穷帽“贫困”为何成香饽饽?” [Well-off county goes from rich to poor, wears “poor hat,” how did wearing a “poor” hat become trendy?], 中青在线, February 25, 2013, http://article.cyol.com/yuqing/content/2013-02/25/content_7927672.htm, accessed May 15, 2013.

although local officials may feel that their locality was misclassified, they sometimes lack the knowledge or connections to complete the application process, as local leaders did successfully in Datong to have their county reinstated as poor. One news report on poverty alleviation policy references a “widespread joke” that a “head of a county said his area isn’t regarded as a poverty county because they are too poor.”⁶⁷ In other cases, local officials seek official poverty status to increase their revenue and may use funds inappropriately.⁶⁸

Finally, a third indication of progressive central government social policy is the funding structure of relatively new policies such as the rural health insurance program, the New Cooperative Medical System (NCMS). The NCMS is a risk-pooling government-subsidized insurance program for rural residents that officially began as pilot projects in 2003 and has subsequently been implemented nationwide, as discussed in Chapter 2. Individuals do contribute a small annual premium to the NCMS, usually around 10 or 20 RMB (about US\$1.50 to \$3.25), but the program is mainly funded by various levels of government. According to central-level regulations issued jointly by the Ministry of Finance and the Ministry of Health, the central government subsidizes the NCMS in the central and western provinces with a minimum of 60 RMB per enrollee.⁶⁹ Meanwhile, the NCMS is funded by provincial and lower levels of

⁶⁷ “Counties may be incorrectly labeled as poverty stricken,” *China Daily*, February 27, 2013, http://europe.chinadaily.com.cn/opinion/2013-02/27/content_16262137.htm, accessed May 15, 2013.

⁶⁸ “Genuine poverty alleviation,” *China Daily*, February 26, 2013, http://www.chinadaily.com.cn/cndy/2013-02/26/content_16255617.htm, accessed May 15, 2013.

⁶⁹ Ministry of Health, Ministry of Civil Affairs, and Ministry of Finance. 卫生部、民政部、财政部等关于巩固和发展新型农村合作医疗制度的意见 [Ministry of Health, Ministry of Civil Affairs, and Ministry of Finance opinion on the consolidation and development the New Cooperative Medical System], 卫农卫发[2009]68号, 部门规范性文件, CLI.4.119302, July 2, 2009.

Ministry of Finance and Ministry of Health. 财政部、卫生部关于中央财政资助中西部地区农民参加新型农村合作医疗制度补助资金拨付有关问题的通知 [Ministry of Finance, Ministry of Health notice on central government financial subsidies to the central and western regions for farmers’ participation in the New Cooperative

government in the wealthy, coastal provinces. Table 4.2 summarizes the contributions from various levels of government for 15 counties: seven in Jiangsu (a wealthy province) and four each in Hubei (middle-income province) and Gansu (poor, western province). As evident from the table, in poorer provinces, such as Hubei and Gansu, the central government funds as much as two-thirds of the per capita allowance for the NCMS, while the wealthy, coastal provinces do not receive this subsidy.

Table 4.2: Government Financing for New Cooperative Medical System (2009 RMB per capita)

County Code	Province	First Year of NCMS	Center	Province	Municipality	County	Individual	Total
D	Hunan	2007	40	20	10	10	20	100
E	Hunan	2007	80	20	0	0	20	120
F	Hunan	2006	40	28	6	6	20	100
G	Hunan	2006	60	20	10	10	20	120
M	Gansu	2007	40	30	0	10	20	100
N	Gansu	2006	60	45	15	10	30	160
O	Gansu	2003	60	50	12	8	30	160
P	Gansu	2005	60	50	0	10	30	150
A	Jiangsu	2004	10	20	20	20	30	100
B	Jiangsu	2004	0	60	2	18	20	100
C	Jiangsu	2004	0	40	30	30	20	120
H	Jiangsu	2003	0	60	0	20	20	100
I	Jiangsu	2004	0	20	20	20	20	80
J	Jiangsu	2004	0	40	10	25	20	100*
K	Jiangsu	2003	0	60	2	28	30	120

* In this county, the township also contributed 5 RMB per person enrolled in the NCMS.

Source: Author's interviews with county officials in 2009 and 2010.

Medical System and the problem of the appropriate amount of subsidies], 财社[2003]112号, 部门规范性文件, CLI.4.88335, August 25, 2003; Ministry of Health and Ministry of Finance. 卫生部、财政部关于做好2008年新型农村合作医疗工作的通知 [Ministry of Health, Ministry of Finance 2008 notice on proper implementation of the New Cooperative Medical System], 财政部/卫生部, 卫农卫发[2008]17号, 部门规范性文件, 卫生综合规定, CLI.4.103497, March 13, 2008.

With rare exception, in Jiangsu, the central government provides no funding for the NCMS. In Jiangsu, lower levels of government, including the municipal and county levels, provide significantly more funding for the NCMS than in Hubei or Gansu. This fiscal decentralization in Jiangsu as compared to other provinces will be discussed in greater detail in the following section of this chapter. Interviews with county officials indicated that this policy is applied consistently: poorer provinces in the interior receive subsidies for the NCMS, while wealthy, coastal provinces do not.⁷⁰

In broad terms, the evidence suggests that the central government does indeed subsidize healthcare progressively through center-to-province transfers and targeted policies that favor less developed regions. While the transfers from the central government to the provinces are the most direct approach to subsidizing healthcare, poor regions also benefit greatly from targeted policies, such as the official poverty designation of localities. In addition, while rural health insurance has been implemented nationwide, the funding structure includes significant central government subsidies for the central and western provinces, but not for the wealthy, coastal provinces. As Sheng (2010) posits, the central government creates policies that redistribute wealth to poorer regions and this tendency is evident in the financing and policy design for healthcare.

However, this differentiated approach to governing results in distinct approaches to policy implementation within the province. Wealthy provinces are led by regime loyalists (Sheng 2010) who are, thus, afforded significant relative autonomy in policy implementation, while poorer provinces seek central government support through subsidies. This may explain why wealthy provinces tend to further decentralize policy implementation, thereby empowering local

⁷⁰ Interviews with county officials in Jiangsu. County officials also reported regular exchanges with officials from other provinces and, therefore, obtained knowledge of policy implementation in other provinces.

government officials. By contrast, poorer provinces tend to create provincial guidelines and seek to standardize policy through a top-down approach to governing. These two models of governance are reflected in health policy implementation and discussed further in the following section.

Differentiated Decentralization and Health Policy

Center-local relations and decentralization is a crucial issue in Chinese politics, but existing research rarely focuses on the uneven nature of decentralization across provinces. Previous research on center-local relations and decentralization in China has focused on the degree of autonomy of local government vis-à-vis the center (Wedeman 2003; Sheng 2005; Chung 2001; Zhang, L. Y. 1999; Shue 1988) and the implications of decentralization for economic growth (Montinola et al. 1996; Solinger 1996) or revenue extraction (Remick 2002). Some scholars have begun to explore the factors that explain the variable autonomy of local leaders. For example, Oi and Rozelle (2000) argue that the extent of power of local cadres is contingent on the individual official's capacity to mobilize resources. Specifically, "the power of those elected hinges on ... the degree of village industrialization and the nature of villagers' ties to the economy outside their village's boundaries" (513-514). More recently, Oi and her colleagues (2012) have found a shift toward re-centralization and the diminished autonomy of the village and township governments, in particular. While previous research has certainly advanced our understanding of the evolution of center-local relations in China, the differentiated nature of China's decentralization and its subsequent impact on policy implementation remain unexplored.

Because authoritarian decentralization does not rely on clear and consistently applied institutional frameworks, unlike formally federal states, center-local relations vary wildly across provinces and policy areas. I posit that the Chinese central government selectively decentralizes policy implementation depending on provincial characteristics, resulting in further variation in policy implementation within the province. The central government retains some authority over local levels, but the center's instrument to ensure provincial compliance varies: in wealthy provinces, "bureaucratically integrated" officials are appointed to leadership positions (Sheng 2010), while poor provinces remain dependent on progressive fiscal transfers. This differentiated authoritarianism has implications for health policy implementation and the role of local officials in policy implementation.

The case of rural health insurance, the NCMS, demonstrates how decentralization has been applied selectively across provinces and the implications of this uneven decentralization for policy implementation. The 2003 regulation establishing the NCMS specified that the county-level government would be responsible for "carrying out the plan in its entirety."⁷¹ Further regulations in subsequent years did establish some broad guidelines for the implementation of the NCMS, but have continued to emphasize local autonomy in specific program design, as discussed in the previous section on the NCMS funding structure. As a result, some provinces have further decentralized NCMS policy design and funding to the county health bureau, while others have established more standardized provincial guidelines for NCMS implementation.

Due to distinct pressures from above (the central government) and below (societal grievances) in different regions, the provinces have diverged in their approaches to rural health

⁷¹ Notification of the Opinion of the State Council General Office published by the Health Bureau and other Departments Related to Establishing the New Cooperative Medical System, January 16, 2003, CLI.2.45115. (Translation by LawInfoChina)

insurance implementation. Wealthier provinces that are less dependent on fiscal transfers from the center and typically have fewer societal grievances related to healthcare tend to be more decentralized in health policy implementation. By contrast, poorer provinces must continually demonstrate that central transfers are necessary and appropriately utilized, resulting in top-down implementation of health policy to ensure compliance with central government policy. Also, health-related grievances tend to be more salient in poorer provinces, thereby motivating provincial leaders to intervene in health policy implementation to reduce social instability. Jiangsu (a wealthier, coastal province) and Hunan (a middle-income, central province) represent two very different examples of NCMS implementation. While Jiangsu has allowed counties and prefectures to tailor NCMS program design to their local conditions, Hunan sought to standardize many features of the program across the province, such as the proportion of funding contributed by each level of government as well as reimbursement percentages for treatment.⁷² In Hunan, the requisite financial contribution from each level of government is determined by the provincial government (Interview HNDX14), following guidelines set by the central government for the central and western provinces. In 2009, the Ministry of Health stipulated that the NCMS contribution from lower levels of government in the central and western provinces should be at least 40 RMB per enrollee and the individual contribution should be at least 20 RMB. Regarding coastal provinces, the Ministry of Health merely states that: “The average per capita contribution level in localities in the eastern region should not be lower than the central and western regions.” Moreover, according to the same document, localities (provinces, districts,

⁷² “湖南新农合补偿标准进一步提高” [Hunan NCMS subsidy standards take a step further, raised], Hunan Province People’s Government Website, published Nov. 13, 2009, <http://www.xinshao.gov.cn/info/bmlf/9290.shtml>, accessed March 15, 2010.

and municipalities are specifically mentioned) in the eastern region have more autonomy to determine their own funding structure.⁷³

The process of NCMS implementation illustrates the uneven and contingent nature of decentralization in China. The provinces of Jiangsu and Hunan represent the differences in health policy implementation between the coast and the interior. In Jiangsu, counties and cities tend to determine specific features of the NCMS program, in contrast to the more interventionist approach taken by the provincial Public Health Department in Hunan. Generally, in Jiangsu, NCMS reimbursement rates are determined by the county health bureau and vary significantly across counties. By contrast, Hunan has sought to standardize NCMS implementation across the province, resulting in somewhat higher reimbursement rates than would be typical in Jiangsu.

Table 4.3: Reimbursement Levels for Town and Village-Level Hospitals 2009

County Code	Province	GRP Per Capita (2008 RMB)	First Year of NCMS	Inpatient Percent	Outpatient Percent
G	Hunan	21000	2006	70	30
D	Hunan	16000	2007	70	30
E	Hunan	6000	2007	70	30
F	Hunan	5000	2006	70	40
J	Jiangsu	31000	2004	55	20
A	Jiangsu	21000	2004	55	25
C	Jiangsu	17000	2004	60	30
K	Jiangsu	14000	2003	65	20
B	Jiangsu	13000	2004	60	40
I	Jiangsu	12000	2004	80	20
H	Jiangsu	10000	2003	60	55

NB: GRP per capita is rounded to preserve the anonymity of informants.

Source: Author's interviews with county officials in 2009 and 2010.

⁷³ Ministry of Health, 卫生部办公厅关于做好 2009 年下半年新型农村合作医疗工作的通知 [Ministry of Health General Office notice on proper implementation of the New Cooperative Medical System in the second half of 2009], 卫生部, 卫办农卫发[2009]108 号, 部门规范性文件, CLI.4.118483, June 29, 2009.

Because of less favorable economic conditions in Hunan, a comparison of reimbursement levels reveals that NCMS benefits are somewhat more generous in Hunan,⁷⁴ where the gross regional product per capita is lower, with the exception of one of the poorer counties located in Northern Jiangsu (County I) where reimbursement rates are comparable to Hunan. Table 4.3 shows the reimbursement levels for inpatient and outpatient procedures at village and township medical facilities in selected counties in Jiangsu and Hunan. The unexpected inverse correlation between economic development and NCMS reimbursement rates is a result of a relatively standardized NCMS in Hunan, but a decentralized approach to the same program in Jiangsu. Hunan's Public Health Department has issued provincial-level regulations that standardize benefits, such as establishing target reimbursement levels of no less than 55 percent and 85 percent at different levels of medical facilities (Hunan People's Government 2009, Xinshao County Government Website 2009). Therefore, Hunan's NCMS program design is significantly more uniform than that of Jiangsu. Nevertheless, the degree of decentralization in the province is a contested issue among local authorities. For example, one director of a People's Hospital in Hunan (County D) thought that the village NCMS offices should assume a greater role in NCMS implementation and supervision. Yet he also remarked that the central government's investment in hospitals should increase substantially (Interview HNDH18).

By contrast, Jiangsu's implementation of the NCMS has been a more bottom-up process. For example, in one municipality in northern Jiangsu, the six counties (including Counties A, B, and C) and one urban district within the municipality's jurisdiction decided to standardize their NCMS program. They hold monthly meetings within the municipality and disseminate

⁷⁴ Some regions of Southern Jiangsu, such as Suzhou, are known to have much more generous benefits, but also much higher individual contributions.

information in order to create a more uniform NCMS program (Interviews JSAW01, JSBW07, JSCW10). Unlike Hunan, the impetus for this policy choice originated from county-level health bureaucrats, rather than the provincial government. And, despite their initiative to create more uniformity within the municipality, their reimbursement rates are not as uniform as in Hunan.

A primary reason for intervention in health policy by higher levels of government is the potential for social instability. Prior to the NCMS, health expenditures (from catastrophic illnesses in particular) were a significant cause of poverty (see Chapter 2). Because the majority of health-care costs were paid out-of-pocket, villagers would often be unable to afford treatment and resort to borrowing money from friends or family. Moreover, in Hunan, some villagers would seek help from the Letters and Visits Office by filing petitions for government assistance (Interviews HNFV28, HNFV27). An interview with an employee of the Letters and Visits Office in Hunan confirmed that health-related petitions were a significant problem prior to the NCMS (Interview HNGL29). Although the Letters and Visits Offices are an institutionalized channel for grievances, significant numbers of petitions on one issue can be perceived as an indication of social instability by higher levels of government. By contrast, in Jiangsu, the link between social stability and health care is far more tenuous. Because the general standard of living in Jiangsu province is higher, the financial effects of catastrophic illness have been less severe. In addition, several villagers and government officials in Jiangsu referenced the availability of financial assistance from the local Civil Affairs Bureau in the event of catastrophic illness striking an economically destitute family or individual in the years prior to the NCMS. However, relatively few villagers were aware of this subsidy, remarking that this would only be relevant in the case of the extremely poor (Interviews JSJP47, JSKP51). Thus, concerns about social stability

coupled with an interest in demonstrated compliance with central government policy led to greater provincial intervention in Hunan's NCMS implementation.

The case of rural health insurance also provides insight into the process of selecting counties for pilot projects. Consistent with regulations from the Ministries of Health and Finance,⁷⁵ wealthier areas are more likely to be chosen for pilot projects and early implementation of new policies (Interviews JSAW01, HNGW30).⁷⁶ Thus, implementation in Jiangsu (and other coastal regions) occurred two to three years before implementation in Hunan (and other interior regions). This approach to pilot project selection reflects a broader strategy for decentralization; wealthier regions are often permitted greater autonomy, while less developed localities are more strictly monitored and regulated. Thus, the process of decentralization in China is contingent on economic conditions and the potential for social instability.

This pattern of greater fiscal and policy decentralization in wealthier, coastal provinces is also evident in healthcare funding at the village level. Table 4.4 and Figure 4.3 demonstrate this pattern in terms of health spending at the village level. Table 4.4 shows the distribution of villages received various proportions of their health spending from the village level.

⁷⁵ See, for example, Ministry of Health and Ministry of Finance, 关于做好新型农村合作医疗试点有关工作的通知 [Notice on proper implementation of the New Cooperative Medical System pilot projects], 2005, Number 319.

⁷⁶ Of course, selecting favorable conditions for pilot projects is probably not a wise approach to testing a new policy, but this issue is beyond the scope of this project.

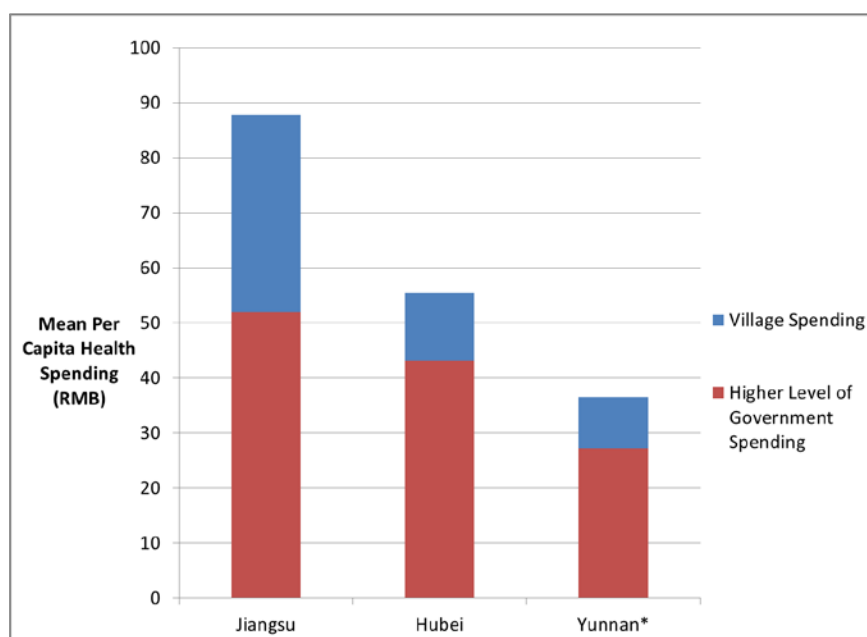
Table 4.4: Proportion of Health Spending from Village Level, by Province

Proportion of Health Spending from Village	Jiangsu		Hubei		Yunnan	
	Number of Villages	Proportion of Villages	Number of Villages	Proportion of Villages	Number of Villages	Proportion of Villages
0-20%	13	25%	27	51%	21	51%
21-40%	4	8%	2	4%	0	0%
41-60%	2	4%	1	2%	0	0%
61-80%	4	8%	2	4%	3	7%
81-100%	29	56%	21	40%	17	41%
Total	52	100%	53	100%	41	100%

NB: Percentages may not add to 100% due to rounding error.

Source: Calculated from author's survey of village leaders.

Village health spending divided by total health spending in each village as reported by village leaders.

Figure 4.3: Average Per Capita Spending on Health in Villages: Disaggregated by Province and Source of Funds (2011 RMB)

NB: Higher levels of government includes all levels higher than the village (i.e., township, county, municipal, provincial, and central levels).

Source: Author's survey of village leaders.

Village leaders that reported receiving over 80 percent of their funding for health from the village itself represent a highly localized approach to healthcare funding. By contrast, significant proportions of villages reported that less than 20 percent of their healthcare funding came from the village, indicating that they mainly rely on transfers from higher levels of government for healthcare. Only 25 percent of villages in Jiangsu reported less than 20 percent of health spending from the village level, whereas over half of the villages in each of Hubei and Yunnan reported that less than 20 percent of their health spending was from the village level. Similarly, Figure 4.3 shows the mean per capita health spending in sampled villages disaggregated by province and by the source of health spending (village or higher level of government). On average, villages in Jiangsu contribute far more to healthcare, than their counterparts in Hubei and Yunnan. However, higher levels of government (which would be the county, municipality, and province in Jiangsu) also contribute somewhat more for healthcare in Jiangsu as compared to Hubei and Yunnan. Nonetheless, as a proportion, villages in Hubei and Yunnan are far more reliant on transfers from higher levels of government for healthcare.

Health policy provides a case where the central government is strengthening its role by increasing financing, generally in a progressive way, but also allowing local governments to develop more autonomy. In Jiangsu, for example, to implement the NCMS, counties had to set up new offices and committees to determine reimbursement percentages. In Hunan, by contrast, counties generally followed provincial-level guidelines with little opportunity for local officials to shape policy implementation. In some ways, this also widens the gap in local government capacity and the quality of local governance between the provinces. On the one hand, Jiangsu has had additional opportunities for leadership and capacity building, while local officials in

Hunan are beholden to provincial (and central) authority, both financially and in terms of decision making. While policies such as the NCMS afford the opportunity for wealthier provinces to continue to build local state capacity, others are left waiting for government transfers and do not have the autonomy or resources to affect policy implementation.

Differentiated decentralization also has implications for future center–local relations in China. For example, some scholars have noted a recent trend toward “recentralization” (Oi et al. 2012).⁷⁷ Such a shift toward re-centralization would be more smoothly implemented in less decentralized province such as Hunan, as compared to a province such as Jiangsu where local officials have significant autonomy to tailor policy to local conditions. In Jiangsu, local officials are more likely to see themselves as policy makers than merely bureaucrats awaiting directions from higher levels of government to implement policy.

Villagers’ Evaluation of Healthcare

In general, despite progressive policies from the central government, villagers in poorer provinces are more likely to find fault with local health facilities, as evidenced by my survey of villagers. Table 4.5 summarizes the proportion of villagers in each province that rated as bad or very bad the quality of local health facilities, including village clinics, township hospitals, county hospitals, and big city hospitals.

⁷⁷ Oi and her co-authors focus on the reduced fiscal capacity of village and township governments, but if further re-centralization were to occur, county-level officials could be affected.

Table 4.5: Proportion of Villagers Rating Local Health Facilities as Bad or Very Bad, by Province

	Village Clinic	Township Hospital	County Hospital	Big City Hospital
Jiangsu	26%	10%	3%	1%
Hubei	29%	21%	2%	2%
Yunnan	38%	18%	0%	0%

Source: Author's survey of villagers.

In Jiangsu, the wealthier and more decentralized province, villagers are less likely to rate the village clinic or township hospital as bad or very bad, as compared to their counterparts in Hubei and Yunnan. Villagers in Yunnan are by far the most critical of village clinics, with 38 percent rating them as bad or very bad. Also, a striking gap emerges in villagers' evaluation of township hospitals: only 10 percent of villagers in Jiangsu rated them poorly, while 21 and 18 percent of villagers gave them poor ratings in Hubei and Yunnan respectively. Villagers' evaluations of local health facilities are presented in greater detail in Appendix B.

Moreover, when controlling for individual characteristics, villagers in Hubei and Yunnan are more likely to rate local health facilities poorly. Table 4.6 presents the results of a linear model of villagers' ratings of local health facilities with a number of control variables. Distinct approaches to health policy implementation, coupled with the challenges of implementing healthcare in a less developed environment where the health facilities are not as developed as those in Jiangsu, affect villagers' evaluations of local health systems. Despite progressive subsidies from the central government, economic factors in less developed regions have caused villagers to continue to have more frequent and dire health-related grievances.

Table 4.6: Linear Model of Villagers' Evaluations of Local Health Facilities

Response variable: Average rating of local health facilities	Pooled Sample		Used healthcare		Not used healthcare	
	(1)	(2)	(3)	(4)	(5)	(6)
	Coef.	P> t	Coef.	P> t	Coef.	P> t
Hunan	-0.272 (0.069)	0.000	-0.264 (0.081)	0.001	-0.384 (0.141)	0.007
Yunnan	-0.279 (0.084)	0.001	-0.232 (0.095)	0.015	-0.481 (0.187)	0.011
Age	0.007 (0.010)	0.499	0.006 (0.012)	0.580	0.000 (0.020)	0.990
Age ²	0.000 (0.000)	0.902	0.000 (0.000)	0.882	0.000 (0.000)	0.973
Female	0.137 (0.052)	0.009	0.165 (0.059)	0.006	0.037 (0.113)	0.742
Education	-0.014 (0.028)	0.615	0.000 (0.032)	0.990	-0.036 (0.062)	0.558
CCP	0.038 (0.089)	0.670	0.117 (0.104)	0.258	-0.172 (0.181)	0.342
Income	0.039 (0.016)	0.018	0.040 (0.019)	0.030	0.027 (0.034)	0.424
Non-local	-0.036 (0.062)	0.564	-0.059 (0.070)	0.399	0.051 (0.132)	0.699
Poverty county	0.046 (0.062)	0.456	0.017 (0.069)	0.800	0.123 (0.139)	0.379
Has insurance	0.187 (0.163)	0.251	0.128 (0.186)	0.494	0.363 (0.339)	0.286
Health status	0.046 (0.030)	0.119	0.082 (0.034)	0.015	-0.084 (0.065)	0.197
Has been refused reimbursement	-0.146 (0.079)	0.067	-0.181 (0.085)	0.033	0.125 (0.214)	0.559
Willingness to criticize gov't	-0.074 (0.037)	0.045	-0.035 (0.042)	0.399	-0.204 (0.079)	0.011
Contact with village leaders	0.057 (0.050)	0.252	0.000 (0.057)	0.998	0.195 (0.105)	0.067
Political participation	-0.064 (0.029)	0.029	-0.079 (0.034)	0.022	-0.020 (0.057)	0.722
Used health system	-0.067 (0.059)	0.260				
Observations	594		434		160	
R-squared	0.144		0.136		0.155	

Standard errors in parentheses. Source: Author's survey of villagers.

Villagers in Hunan and Yunnan tend to rate health facilities less highly than villagers in Jiangsu. This association is statistically significant among the entire sample of villagers as well as when the sample is divided between villagers who have used healthcare and villagers who have not.

In addition to rating local health facilities more poorly, villagers revealed a number of difficulties with the healthcare system in semi-structured interviews and focus groups. For example, villagers in Hunan were more likely to complain that their village health clinic or township hospital was unable to resolve health problems for themselves or their friends or family. As a result, they were forced to travel to the city, typically the provincial capital of Changsha, to receive treatment, where reimbursement percentages for rural insurance are much lower, thereby placing a greater financial burden on the individual. In a similar vein, villagers in Hunan complained that they were not informed by their doctor that certain medications would not be covered by the NCMS, thereby causing further financial stress. Others complained that certain procedures were not covered by the NCMS, resulting in a very small benefit to enrolling in the program. Approximately half of the villagers interviewed in Hunan cited these issues as a weakness of the NCMS, whereas none of the villagers in Jiangsu raised these problems, even when prompted (Interviews with villagers in all counties). Targeted policies and higher reimbursement rates at village and township medical centers in Hunan have not sufficiently addressed the deficiencies in healthcare infrastructure, such as inadequate treatment facilities and lack of trained personnel in rural areas. Nonetheless, although healthcare-related grievances remain, particularly in poorer provinces, there have not been significant indications of social instability directed toward the state motivated by healthcare. This question will be addressed in further detail in Chapter 5.

Conclusion

Because the central government is concerned about social stability and healthcare has become a source of concern for Chinese citizens (see Chapter 2 on the national healthcare reform), it is not surprising that the central government transfers funds progressively for healthcare. However, health policy design and implementation also reflects regional patterns of decentralization. While “bureaucratic integration” ensures loyalty from provincial leaders in wealthy provinces (Sheng 2010), leaders in poorer provinces rely heavily on transfers from higher levels of government. Thus, leaders in poorer provinces seek to ingratiate themselves with higher levels to continue to receive such transfers and qualify for lucrative designations such as the “poverty designation.” As a result, I posit that provincial leadership in wealthier provinces, such as Jiangsu, provides greater autonomy to local officials for policy implementation, such as the NCMS. By contrast, inland provinces are more likely to take a top-down approach to governing, by instituting provincials standards for policy. Thus, wealthier provinces have more autonomy to implement health policy, but are also responsible for funding a greater proportion of rural health insurance. Meanwhile, poorer, inland provinces receive more targeted subsidies for healthcare but are also more constrained in policy implementation.

This uneven decentralization has two important implications for state–society relations. First, local officials in decentralized regions have more opportunities to act as policy makers, rather than merely bureaucrats. Therefore, they can potentially build local state capacity and work with other local officials to improve local governance. Local officials in less decentralized regions lack this opportunity. Second, should the central government seek to re-centralize or

concentrate power in higher levels of government, such an initiative would be significantly more difficult in a decentralized province, such as Jiangsu, as compared to a province that relies on a more top-down approach to governing.

In the case of rural health policy, decentralization does not have a clear impact on policy effectiveness. On the one hand, health insurance reimbursement rates are more variable and, sometimes, lower in decentralized Jiangsu, despite the greater availability of local resources. On the other hand, healthcare provision confronts additional challenges in impoverished regions, resulting in worse evaluations of healthcare provision by villagers in poor provinces. Particularly in poor regions, villagers have significant healthcare challenges, but no longer raise those grievances with local government officials, as they did prior to the rural health insurance program, due to their generally low expectations for state healthcare provision. Villagers' expectations and the relationship of healthcare to state legitimacy will be discussed in greater detail in Chapter 5.

Chapter 5

Satisficing Rural Expectations for Health

“The government should vigorously act for the people, if it does not then [the people] do not support it.”

(*wei min zhengfu yinggai jiji, bu wei laobaixing jiu bu zhichi*, 为民政府应积极, 不为老百姓就不支持) (Survey respondent #1220, Jiangsu)

Although healthcare continues to be a primary concern for Chinese villagers, implementation of new health policies has been uneven, with particular challenges in poor regions that lack pre-existing health infrastructure. Nonetheless, the limitations of the current healthcare system do not seem to be a salient grievance among Chinese villagers. While complaints abound, reports of incidents related to healthcare are concentrated on isolated attacks on doctors, rather than actions taken against representatives of the state. In the context of the current (often abysmal) state of the Chinese healthcare system in rural areas coupled with traditional conceptions of the state as responsible for ensuring the social welfare of the citizenry, why do we not find more social unrest provoked by healthcare grievances? I argue that current expansion of healthcare in rural areas has been sufficient to satisfy immediate demands for improvement in the system, reducing the potential for healthcare-related grievances to be directed towards state authority. Using my survey of Chinese villagers and village leaders, I demonstrate that, while villagers do expect some state provision of social welfare policy, their expectations for specific health services are relatively low. Because of these generally low expectations, recent improvements in healthcare,

however meager by objective metrics, have been subjectively sufficient to ameliorate villagers' grievances.

I begin this chapter with a discussion of conceptions of state legitimacy in China. Then, I utilize original survey data from villagers and village leaders to demonstrate that although healthcare is important to rural residents: (1) villagers have low expectations for healthcare provision; and (2) village leaders tend to have somewhat higher expectations. As village leaders often serve as a bridge between villagers and higher levels of government, the perceptions of leaders are more likely to be communicated to higher levels of government, thereby impacting policy. This chapter goes further by explaining some of the variation in the expectations of villagers and village leaders. In particular, villagers' expectations are positively associated with age, education, having engaged in migrant labor, having acquaintances in large cities, and a willingness to criticize the government. While villagers do not seem to be particularly exigent in terms of state provision of healthcare overall, these findings indicate that: (1) social policy is linked to state legitimacy for a large proportion of the rural population; and (2) as villagers become more knowledgeable about life beyond the village, they are more likely to demand more social welfare locally.

State Legitimacy and Social Policy Provision

Historically, conceptions of the state have differed in China, compared to countries following a Western European philosophical tradition. In European and North American political thought, John Locke's classical liberalism has advocated the importance of protecting individual liberties

by limiting the power of the state.⁷⁸ By contrast, the Chinese conceptualization posits the ideal state–society relationship as a harmonious and hierarchical order of state–society relations that is analogous to that of the family. In this view, postulated in the writings of Mencius, the wife and children (the citizenry)⁷⁹ should respect and obey the father (state), while the father has the responsibility to protect and provide for the wife and children. Similarly, citizens ought to obey the state, but the state has the responsibility to provide a minimum livelihood for the citizens. This hierarchy involves responsibilities for both the governing and the governed. Based on this conception of state–society relations, the right to rule (i.e., legitimacy) is conferred upon the state (emperor) based on the state’s ability to provide a minimum livelihood for the citizens. When rulers do not fulfill their social welfare responsibilities, the citizens have the right and responsibility to rebel against the emperor and overthrow the state. This understanding of the state can be traced back to Mencius in the fourth century BCE. Also, the responsibility of citizens to rebel against illegitimate authority was reinforced and inculcated during the Maoist period and during the Cultural Revolution in particular (Perry 2008). For both Mencius during dynastic China and Mao after the founding of the People’s Republic, the state gains legitimacy from the support of the people and if the state does not provide a minimum standard of living, then the people ought to rebel and overthrow the regime.⁸⁰ More recently, the recent Hu-Wen administration further reinvigorated a Mencian approach to state legitimacy by shifting the

⁷⁸ See, for example, John Locke’s *Second Treatise on Government* (Locke 2009) and *A Letter Concerning Toleration* (Locke 1689).

⁷⁹ I use the term citizen as would be the norm in cross-national scholarship, but I also acknowledge that the concept of “citizen” has only recently begun to resonate in Chinese discourse on state–society relations.

⁸⁰ These general themes in Mencius and their reincarnations during the Maoist period have been well-established by previous scholarship. See, for example, Perry (2008).

central government's emphasis towards social issues, compare to the pro-growth regime led by Jiang Zemin (see Chapter 2).

Although methods of governing have changed significantly since the Maoist period, legacies persist. While campaign-style politics is not as extreme as it was under Mao, there is still a campaign approach to politics based in “the formative experience of guerrilla warfare and revolutionary mobilization” (Heilmann and Perry 2011: 11). And, more importantly for this argument, the regime sustains its legitimacy mainly from governance outcomes, rather than elections. Since market reforms began in 1978, the regime has prioritized economic development and successfully achieved unprecedented rapid economic growth, enabling hundreds of millions of people to rise out of poverty. Conventional portrayals of the Chinese state contend that steady economic growth is intrinsic to state legitimacy and regime stability. Since 2003, and the Hu-Wen administration, however, the central government has shifted its policy emphasis from entirely focused on economic growth to incorporating social policy and efforts to reduce inequality. This policy shift is apparent in both central government rhetoric and in funding and recent policy initiatives. National-level leaders perceived inequality, the lack of social safety net, and healthcare in particular as potential sources of social unrest. This central government shift toward state re-engagement with social policy and healthcare in particular is discussed in greater detail in Chapter 2.

As state legitimacy in China is intrinsically linked to policy outcomes that include providing some degree of social welfare, why has there not been greater social unrest related to healthcare in China? My argument focuses on the relatively low expectations of villagers, but first, I briefly address two alternative explanations. First, in authoritarian regime, citizens may be

reluctant to protest or engage in collective action. This is certainly not the case in China. Estimates of social unrest, or “mass incidents,” have reached 180,000 nationwide in recent years (Sun 2011). And some scholars argue that tolerance of these public protests can actually bolster regime stability (Lorentzen 2010). Worker protest as a negotiating tactic has become virtually ubiquitous; a superficial search of protests in the media produces innumerable accounts of isolated incidents in which workers engage in protest as a means to express their grievances, often resulting in some limited concessions by their employers.⁸¹ Previous scholarship has also established the willingness of Chinese citizens to strategically engage in protest to pressure the state to fulfill previously stated commitments (e.g., O’Brien and Li 2006). Likewise, the Chinese state has also used social policy to preempt social unrest (e.g., Solinger 2012).

Second, from a cross-national perspective, popular mobilization around healthcare tends to be uncommon (Kaufman and Nelson 2004). Therefore, we might expect other types of grievance to provoke protest in China, but perhaps not healthcare. However, in other social policy areas, such as pensions, Chinese citizens been quite active in demanding that the state fulfill its promises (e.g., Frazier 2010). Regarding healthcare, numerous incidents of dissatisfied patients engaging in violence against doctors and hospital personnel have been well-documented by the media.⁸² Moreover, healthcare was a significant source of grievances prior to recent

⁸¹ According to one report, workers “are more willing to stand up for their rights” regarding pay in arrears and dismal working conditions (David Barboza & Keith Bradsher, “Riot at Foxconn Factory Underscores Rift in China,” *The New York Times*, September 24, 2012, http://www.nytimes.com/2012/09/25/business/global/foxconn-riot-underscores-labor-rift-in-china.html?_r=0, accessed April 15, 2013). For other examples, see Liza Lin & Shunichi Ozasa, “LG Display China Strike Ends as Fresh Labor Protest Reported,” *Bloomberg News*, December 29, 2011, <http://www.businessweek.com/news/2011-12-29/lg-display-china-strike-ends-as-fresh-labor-protest-reported.html>, accessed May 28, 2013; Leslie Hook, “Chinese workers protest lead poisoning,” *The Washington Post*, June 14, 2011, http://articles.washingtonpost.com/2011-06-14/world/35265649_1_chinese-workers-protest-migrant-workers-foil, accessed May 28, 2013.

⁸² See, for example, Sharon LaFraniere, “Chinese Hospitals are Battlefields of Discontent,” *The New York Times*, August 11, 2010, http://www.nytimes.com/2010/08/12/world/asia/12hospital.html?_r=0, accessed May 3, 2013;

reforms, particularly in poorer localities, according to county officials. Although villagers did not engage in mass protests, they did take action that would be interpreted as political instability by higher levels of government when faced with catastrophic medical expenditures. For example, in Hunan, some villagers would file petitions with the Letters and Visits Office (Interview HNG L29), while others would beseech the public for charitable donations via the media (Interview HNF X23).⁸³ Through these means as well as public opinion surveys, the central government was able to learn of the grievances related to healthcare in rural areas. Had the government not taken measures to alleviate these problems, further instability may have resulted, particularly as the rising cost of healthcare was causing severe impoverishment among villagers, as discussed in Chapter 2. Therefore, as these grievances were very serious, we cannot simply assume that inadequate healthcare would not incite social instability in China.

Rather, I argue that the recent lack of mobilization regarding healthcare is a reflection of villagers' relatively low expectations for healthcare provision. While new policies have yet to overcome decades of neglect of the healthcare system, particularly in impoverished regions, this modicum of improvement is generally satisfying villager demands, at least for the short term, and has bolstered state legitimacy, at least symbolically. To parse the relationship between the state, society, and social policy in rural China, we do not have the luxury of examining frequent public opinion polls, elections, or the role of autonomous social groups such as lobbying organizations. Therefore, I analyze an original survey of villagers and village leaders to better understand their expectations regarding healthcare provision and how these expectations may be

Jaime FlorCruz, "Tensions rise between doctors and patients in China," *CNN On-line*, October 17, 2011, <http://www.cnn.com/2011/10/14/world/asia/china-doctor-attacks>, accessed May 3, 2013; Laurie Burkitt, "China Fears Rise in Doctor Attacks," *The Wall Street Journal*, October 22, 2012, <http://online.wsj.com/article/SB10000872396390444592704578066364234583312.html>, accessed May 3, 2013.

⁸³ For a discussion of the Letters & Visits system, see Cai (2004).

linked to state legitimacy. Using these data, I demonstrate that: (1) villagers' expectations for healthcare provision are rather minimal; (2) village leaders tend to have higher expectations than villagers; and (3) villagers with greater knowledge of life beyond their village are more likely to have higher expectations for healthcare.

Villagers' Expectations for Healthcare

Villagers and village leaders do consider healthcare to be a principal concern. This is evidenced in the responses to two survey questions in particular. First, the respondent was asked to rank the following issues that s/he considered to be most important for his/her life: increasing salary, a clean environment, children's health, respondent's health, or living a traditional lifestyle. The majority of villagers ranked children's health as the most important (55 percent), his/her health as second most important (42 percent), and third most important was divided between increasing salary (34 percent), clean environment (28 percent), and his/her health (22 percent) (Table 5.1).⁸⁴ Village leaders, by contrast, were less likely to rank their children's health or their own health as most important (36 percent and 15 percent respectively). These data do suggest that health is a priority for village leaders, however: the majority of village leaders ranked their children's health or their own health as their first choice and 70 percent chose their children's health or their own health as their second choice.

⁸⁴ Social security or pension was not provided as a choice in this question because very few villagers receive a pension. Social security reforms are also ongoing in China.

Table 5.1: Top Priorities for Villagers and Village Leaders

“Which three of the following items do you think are the most important in your life?”						
	Villagers			Village Leaders		
	First Choice	Second Choice	Third Choice	First Choice	Second Choice	Third Choice
Children's health	55%	26%	10%	36%	34%	14%
My health	16%	42%	22%	15%	36%	27%
Clean environment	15%	15%	28%	28%	15%	26%
Increase salary	11%	15%	34%	16%	12%	30%
Traditional lifestyle	1%	1%	5%	1%	0%	2%
Chose more than one	2%	0%	1%	3%	2%	2%

Source: Author's survey.

Observations: villagers = 738; village leaders = 274

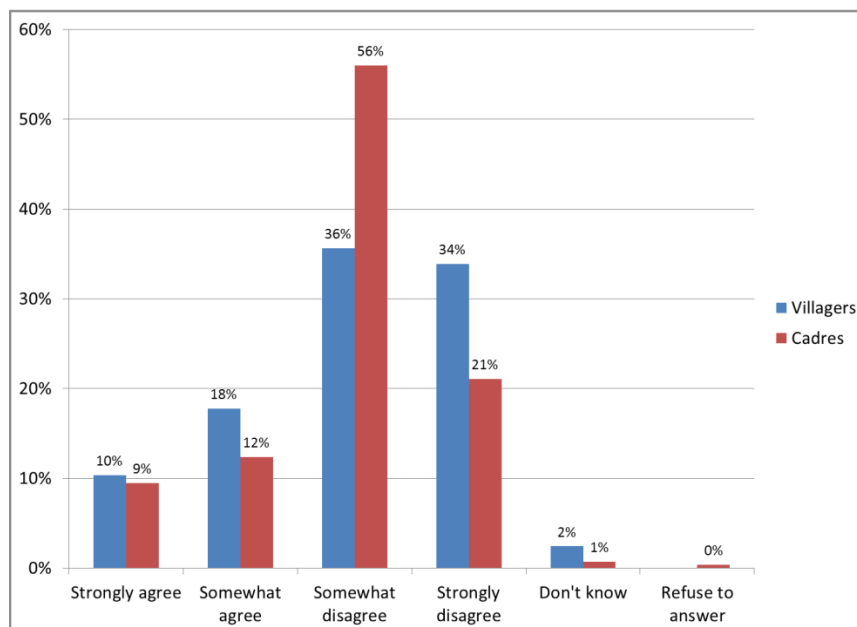
Percentages may not add to 100% due to rounding.

A significantly higher proportion of village leaders said that increasing their salary is the most important (16 percent, compared to 11 percent for villagers), but we might expect that village leaders would be, on average, more ambitious and career-minded than most villagers.⁸⁵ Also, women are a minority in our sample of village leaders (about 20 percent of surveyed village leaders are women, compared to 48 percent of villagers) and women are more likely than men to rank their health and their children's health more highly.⁸⁶ Similarly, the majority of respondents (70 percent of villagers and 77 percent of village leaders) disagreed with the following statement: “Compared to my health, I believe that increasing my income is more important right now” (Figure 5.1).

⁸⁵ Based on a *t*-test, the difference in means between these two groups is statistically significant at the 0.05 level.

⁸⁶ Among surveyed villagers, 70 percent of men and 76 percent of women ranked their health or their children's health as the most important; the difference in these proportions is statistically significant at the 0.10 level. Among surveyed officials, 52 percent of men and 65 percent of women ranked their health or their children's health as the most important; the difference in these proportions is statistically significant at the 0.0001 level.

Figure 5.1: Distribution of Responses to the Statement: “Compared to my health, I believe that increasing my income is more important right now.”



Source: Author's survey.

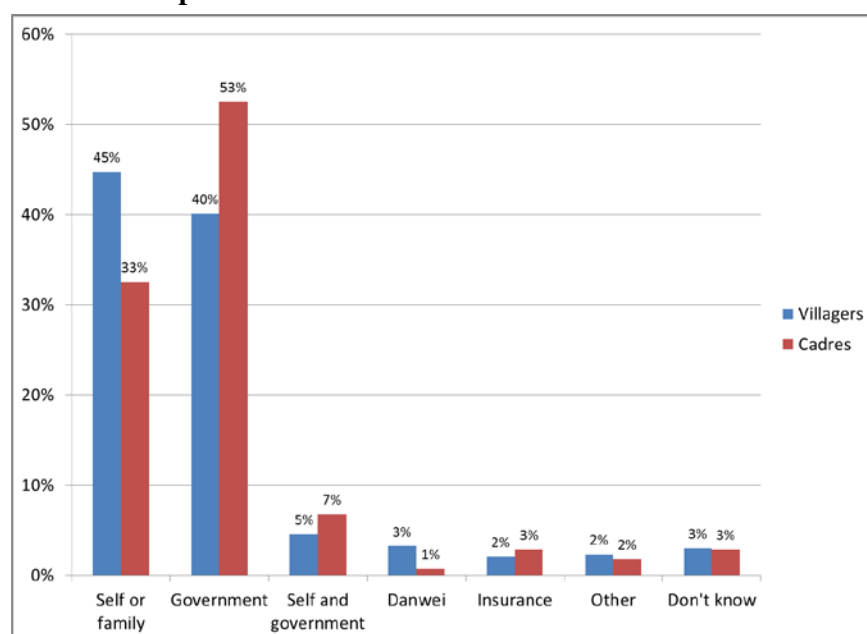
Observations: villagers = 744; village leaders = 275

These results indicate that healthcare is indeed an important priority for villagers and village leaders, even when compared to opportunities for increasing income. One village leader in Hubei emphatically stated that “health comes first” (#2303, *shouxian shi jiankang* 首先是健康). Other respondents linked the importance of good health to generating income; one villager in Hubei commented that: “Only once you are healthy will you be able to earn a salary” (#2095, *you jiankang cai you shouru* 有健康才有收入). Some respondents did state that salary was more important; one village leader commented that “if you have money, you have it all” (#1348, *you qian shenme dou you le* 有钱什么都有了), but this is the minority view. A large majority of villagers and village leaders clearly value health, and this finding is consistent with previous

research on public opinion in China. As discussed in Chapter 2, public opinion polls in recent years have found that healthcare is one of the top concerns of Chinese citizens (CASS 2012).

Not only is health important to rural residents, substantial proportions of villagers and village leaders expect the state to be responsible for healthcare provision. Yet rural residents are more divided on this issue than we might expect in a post-socialist context. More village leaders than villagers expect the government to be responsible for healthcare costs. While over 53 percent of village leaders said that the government should be responsible, only 40 percent of villagers had the same view (Figure 5.2). An additional 5 percent of villagers and 7 percent of village leaders thought that individuals should share the responsibility for the bulk of healthcare costs with the government. While over 53 percent of village leaders said that the government should be responsible, only 40 percent of villagers had the same view (Figure 5.2). An additional 5 percent of villagers and 7 percent of village leaders thought that individuals should share the responsibility for the bulk of healthcare costs with the government.

Figure 5.2: Distribution of Responses to the Question: “In general, who do you believe should be responsible for the bulk of your healthcare expenses?”



Source: Author's survey.

Observations: villagers = 773; village leaders=280.

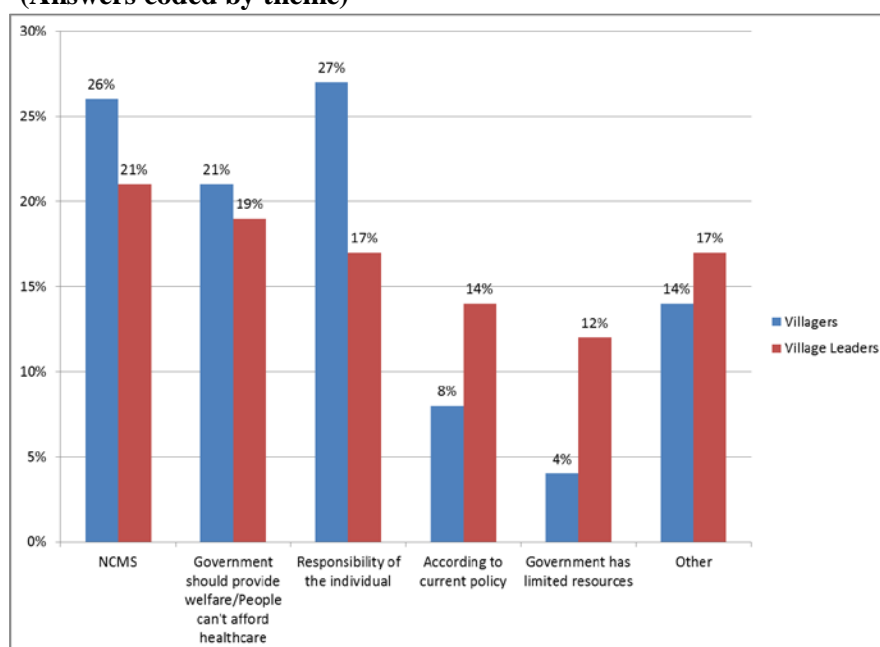
Taken together, almost half of villagers and over half of village leaders consider that the government should bear at least partial responsibility for healthcare costs. This finding indicates that healthcare provision and ensuring the wellbeing of the citizenry is indeed linked to state legitimacy from the perspective of rural residents.

Nonetheless, in our sample, 45 percent of villagers thought that the individual should be responsible for the majority of healthcare costs and, given China's socialist past, we might find this result surprising. In Eastern Europe, for example, there was broad consensus that much of the socialist safety net should be retained and the majority opposed state retrenchment and marketization of healthcare and other social services (Cook 2007; Kornai et al. 2001). Why do we not find such general consensus regarding socialized medicine in China? In contrast to Eastern Europe, rural areas in China had a mixed experience with socialized medicine. As discussed in Chapter 2, socialized health systems were far less developed in the Chinese countryside compared to cities, often leaving communes to fend for themselves in healthcare provision, despite an ostensibly socialized medical system. Therefore, based on past experience, Chinese villagers often may not expect the state to provide healthcare if it were so inclined.

This lack of consensus among villagers' perspectives on the state's role in healthcare provision reflects important dimensions of state–society relations in China. Over 40 percent of villagers and village leaders generally consider that the state has the responsibility to provide healthcare as part of the welfare state. Nonetheless, significant proportions of respondents report that healthcare is the responsibility of the individual. After replying to the question “In general, who do you believe should be responsible for the majority of your healthcare costs?,” respondents were asked to explain why they think they way they do. Figure 5.3 illustrates the

responses to this open-ended follow-up question with responses grouped according to theme. These qualitative responses elucidate three of the ways in which previous state–society interactions have produced contradictory perspectives on the role of the state in rural China: a Mencian view of the state as responsible for the welfare of the people; reduced confidence in state effectiveness at the local level; and an individualistic resilience.

Figure 5.3: Responses to the Open-Ended Follow-Up Question: “Why do you think the way that you do regarding who should be responsible for the bulk of your healthcare costs?” (Answers coded by theme)



Source: Author's survey.

Observations: villagers = 743; village leaders = 264

First, many villagers and village leaders believe that the state has a responsibility to provide for the welfare of the people. In our sample, approximately one-fifth (21 percent for villagers and 19 percent for village leaders) indicate that the government should provide social welfare as part of its mandate to “serve the people” or because villagers are too poor to afford healthcare. Additionally, significant proportions of villagers and village leaders (26 and 21

percent respectively) reference the rural health insurance program, the New Cooperative Medical System (NCMS), as their justification for why the state should be responsible for the bulk of healthcare costs. The NCMS is widely publicized and heavily subsidized by various levels of government (see Chapter 2). Since villagers pay small annual premiums, they believe that the government should reimburse them for the majority of their healthcare costs. In practice, reimbursement rates vary substantially across localities, levels of providers, and among various ailments.

Villagers and village leaders tended to use slightly different language in expressing this view. While village leaders may invoke Marxist rhetoric or state slogans, villagers simply stated that it was the government's responsibility to serve the people and sometimes referenced socialism. For example, one villager in Jiangsu said that "the government should care about the masses more, [and] serve the masses" (#1202, *zhengfu ying geng guanxin qunzhong, wei qunzhong fuwu* 政府应更关心群众,为群众服务). Several villagers referenced state socialism or simply replied: "state welfare" (#1283, *guojia fuli* 国家福利). For example, another villager in Jiangsu said that "[we are] a socialist society now, [which] should promote the government taking care of villagers. Villagers assume the responsibility for basic medicine, [but] the majority should be provided by the government" (#1255, *xianzai shi shehui zhuyi shehui, yinggai tichang zhengfu yang nongmin. Nongmin chengdan jiben yiliao, dabufen yinggai zhengfu tigong* 现在是社会主义社会,应该提倡政府养农民。农民承担基本医疗,大部分应该政府提供). Many villagers said that the government should be responsible because villagers are poor and/or healthcare is too expensive. According to a villager in Jiangsu, "the individual cannot bear the burden. Healthcare costs are rising" (#1275, *ziji fudan buqi, yiliao feiyong feizhang* 自己负担不

起，医疗费用飞涨)。A villager in Hubei stated that “[we] don’t have the money in the country; the only option is to die a slow death” (#2261, *nongcun genben chubuliao qian, zhi neng tuosi* 农村根本出不了钱，只能拖死)。Some villagers also referenced the recent economic development in China by stating that, because economic conditions are good, the state should therefore be responsible for healthcare. For example, one villager from Jiangsu, the most developed province in the sample, said: “the country is economically developed. [The state] should care more about the lives of the masses” (#1072, *guojia jingji fazhanle, yinggai geng guanxin qunzhong shenghuo* 国家经济发展了，应该更关心群众生活)。Moreover, the publicized goals of the state and current policies affect villagers’ expectations. Villagers also say that the government should provide for healthcare because of current policies or widely disseminated rhetoric; in the words of one villager in Hubei, the government should be responsible for the bulk of healthcare costs because “the state really emphasizes health” (#2244, *guojia dui yiliao feichang zhongshi* 国家对医疗非常重视)。Therefore, considering that Mencian conceptions of the state have been reinforced by more recent government rhetoric, many villagers do indeed consider ensuring a minimal degree of healthcare to be the responsibility of the state.

Second, villagers had a mixed experience with ostensibly socialized medicine under the Maoist period, thereby setting low expectations of the state for healthcare provision. A few villagers (but no village leaders) expressed that the government could not be relied on to pay for healthcare and therefore the individual has no choice but to take responsibility. For example, one villager in Yunnan said “you get sick, you pay for it. Depending on the government is not realistic” (#3288, *ziji shengbing ziji chu, kao zhengfu bu xianshi* 自己生病自己出，靠政府不现实)。Another villager in Yunnan expressed the opinion that the individual is responsible “because

[healthcare] has always been out-of-pocket” (#3187, *yinwei yizhi dou shi ziji fu de* 因为一直都是自己付的). This statement indicates that the respondent does not think that, despite widely publicized recent reforms, government will provide healthcare. Since the healthcare reform is incomplete and the implementation of new policies has been uneven, it is not surprising that some villagers do not expect the state to provide healthcare.

Third, the state has periodically emphasized the importance of “self-reliance” under Mao and an emphasis on individual responsibility during market reforms, reinforcing individualism and resilience among many villagers. Whyte and his co-authors have also demonstrated that many Chinese hold an individualistic view of success in society, in contrast to other post-socialist countries (Whyte and Im: unpublished; Whyte, 2012, 2010). This perspective was also apparent among villagers in our sample. A substantial 27 percent of villagers thought that healthcare should be the individual (or family’s) responsibility, while only 17 percent of officials held the same view; villagers’ held an individualistic view even more strongly than officials. For example, a village leader from Jiangsu commented that “you got sick, so it’s your burden to bear (i.e., your responsibility)” (#1438, *ziji debing ziji fudan* 自己得病, 自己负担). While some villagers quite clearly blame the individual for getting sick in the first place, others merely think that illness is a personal matter and has nothing to do with the government. Another villager from Jiangsu said: “It’s your problem, so you pay the money; it has nothing to do with the government” (#1065, *ziji de shi, ziji huaqian, he zhengfu mei guanxi* 自己的事, 自己花钱, 和政府没关系). These statements illustrate the lack of consensus in rural China regarding the role of the state. On the one hand, a significant proportion of villagers believes that the state should

provide social welfare, but, on the other, many villagers do not believe that the state will provide these services.

Villagers and village leaders do have different expectations regarding state healthcare provision. Overall, village leaders tend to be somewhat more demanding. However, village leaders are also more likely to refer to current policy when asked why they hold their views about healthcare provision and are more likely to cite the limitations of government resources when justifying why the individual should take responsibility for healthcare costs (Figure 5.2). On the one hand, village leaders may employ Marxist rhetoric in describing the role of the state in providing social welfare, but, on the other hand, they also are far more likely to understand and sympathize with the fiscal constraints facing the state. While villagers may say that the government is wealthy or collects taxes and therefore should provide healthcare, village leaders are more likely to say that individuals should contribute because the government has limited resources, although this is still a small proportion of respondents.

Expectations regarding healthcare provide insight into villagers' divergent views of the state. I posit that, although the state ought to "serve the people," past experiences have imbued many villagers with low expectations for local state capacity as well as an ethos of individualistic resiliency. Many people, particularly village leaders, strongly believe that social welfare provision is an important and appropriate role for the Chinese state. However, despite this conception of the state, other villagers are skeptical regarding the willingness and ability of the government to provide healthcare based on previous experience. Moreover, in part because of the state's neglect, many villagers have adopted a highly individualistic resiliency to life's

challenges, which reinforces the view that no one but the individual and the family can be expected to solve one's problems.

Despite the persistent healthcare-related grievances discussed in Chapter 4, my findings do not suggest that this situation is a threat to state legitimacy because villagers' expectations for healthcare provision are minimal. As discussed in the previous chapter, disillusionment with state capacity is reflected in perceptions of healthcare provision, insofar as villagers who have used the healthcare system tend to be more critical of it. Also, from a cross-provincial perspective, expectations regarding state provision of healthcare are even lower in Yunnan, where the health system is the least developed, compared to Jiangsu or Hubei.⁸⁷

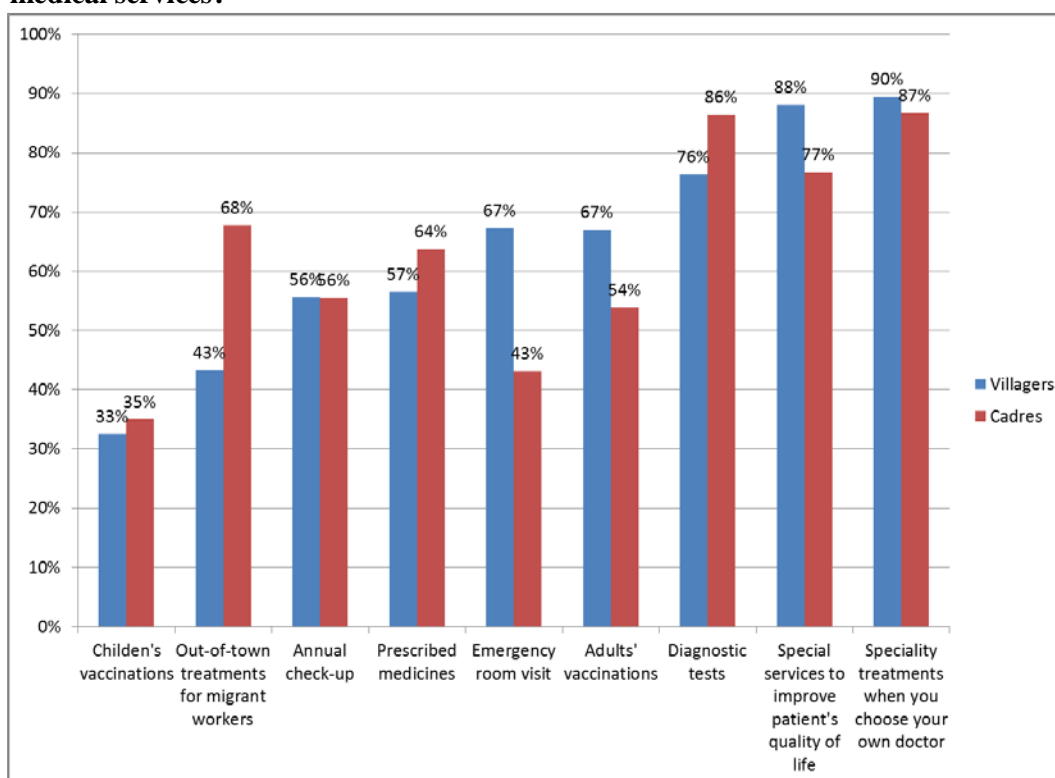
This phenomenon of "informed disenchantment" has also been observed in other types of interactions with the state, such as the legal system (Gallagher 2006). We might infer that unfavorable evaluations of state capacity at the local level constitute a threat to state legitimacy. Nonetheless, my findings indicate that, rather than eroding state legitimacy, past experiences may have reduced expectations for future provision of social welfare. Insofar as past experiences are translated into low expectations, instead of mobilizations motivated by dissatisfaction with the state, uneven implementation of social policy may not prove to be a sufficiently salient grievance so as to provoke widespread actions targeting state agents.

Upon closer examination of villagers' specific expectations, I find that villagers' expectations regarding which healthcare services the government should provide are rather

⁸⁷ For example, villagers in Yunnan were far more likely to express the view that individuals should be responsible for the bulk of healthcare costs, with only 22 percent saying that the government should be responsible. By contrast, the majority of villagers in Jiangsu and Hubei stated that the government should be responsible for healthcare costs, 57 and 54 percent respectively. Among village leaders, the view that healthcare is the responsibility of the individual is negatively associated with living in a wealthier province; small proportions of village leaders in Jiangsu and Hubei held this view (14 percent and 27 percent respectively), while 59 percent of village leaders in Yunnan expressed this opinion. These results suggest possible differences across provinces, but would require further research as the survey was only conducted in three provinces.

limited. When we further specify certain healthcare services, many survey respondents agree that it is reasonable for the individual to bear the cost of those services, such as specialty services and even, for some, emergency room visits or prescribed medicines. Figure 5.4 depicts the proportions of villagers and village leaders that thought that it would be “definitely reasonable” or “reasonable” to pay out-of-pocket for the specific medical services posed in the question.

Figure 5.4: Percent of Respondents that Replied “Reasonable” or “Definitely Reasonable” to the Question: “Is it reasonable to pay out-of-pocket for the following medical services?”



Source: Author's survey.

Observations : villagers = 766; village leaders = 283

Villagers are willing to pay out-of-pocket for many different kinds of services, but they are most concerned about services that are considered basic healthcare, such as children's vaccinations and routine annual medical exams. Despite recent reforms aimed at addressing the costs of catastrophic illness, many villagers are still accustomed to forgoing medical treatment,

sometimes even when treatment is absolutely necessary. Most villagers are also willing to pay for at least some part of medical expenditures, although they are probably envisioning a very small contribution, considering that the annual premium for rural health insurance is usually around 20 RMB (US\$ 3). For example, the vast majority of villagers think that it is reasonable to pay out-of-pocket for diagnostic tests (76 percent), adults' vaccinations (67 percent), special services such as a special diet to improve a patient's quality of life (88 percent), and treatments from specialists that the patient has chosen (90 percent). In addition, 67 percent of villagers thought that it would be reasonable to pay out-of-pocket for an emergency room visit. By contrast, only 33 percent of villagers thought that it would be reasonable to pay out-of-pocket for children's vaccinations and less than half of villagers thought that it would be reasonable to pay out-of-pocket for treatments for migrant workers when they are away from their place of residence, annual check-ups, and prescribed medicines (43 percent, 44 percent, and 43 percent respectively).

Village leaders have similar expectations as villagers regarding which health services should be the responsibility of the individual. One area of divergence between villagers and village leaders merits further discussion: out-of-town healthcare for migrant workers. First, villagers often feel strongly that they should not have to pay out-of-pocket for healthcare out of their local area when engaging in migrant labor. This is a contentious issue in large part because the current rural health insurance program, the NCMS, is linked to one's residence status (*hukou* 户口), and reimbursement rates at medical facilities outside of one's local area are significantly lower. Moreover, the reimbursement process is often prohibitively onerous for migrant workers. Although policies vary across counties, it is common for the county to require paperwork for

reimbursement for out-of-town health expenses to be filed within 30 days of the expense at an office that holds very limited business hours. This often effectively precludes migrants from filing for reimbursement, as many migrants only return to their home village once a year to celebrate Lunar New Year. The majority of villagers (57 percent) do not think that it is reasonable to pay out-of-pocket for healthcare utilized while conducting migrant labor out of one's local area, whereas only 32 percent of village leaders shared the same view. As it is unlikely that village leaders are currently engaged in migrant labor, this may explain why they are less exigent in this regard.

Three important and seemingly contradictory themes emerge when considering how villagers and village leaders view the state in rural China: a Mencian view of the state as responsible for the welfare of the people; minimal expectations for healthcare provision in rural areas; and an individualistic resilience. These perspectives reflect both historical state–society interactions and current policy, including central government rhetoric regarding social policy provision and promotion of a “harmonious society” coupled with a lack of comprehensive health systems in rural areas. However, upon further examination, villagers' expectations for healthcare provision are rather minimal; many villagers consider it reasonable to pay out-of-pocket for several different kinds of health services. This may explain why, despite an incomplete and uneven health reform coupled with state legitimacy linked to social policy provision, healthcare provision has not provoked mass social unrest.

Determinants of Villagers' Expectations

While villagers' expectations for state healthcare provision may be relatively low, there is variation among the expectations of villagers and village leaders. Identifying the factors associated with higher expectations furthers our understanding of who is likely to place demands on the state. My survey results suggest that villagers who have greater knowledge of life beyond the village demand more from the state in terms of healthcare provision.

To measure expectations for state healthcare provision, I averaged villagers' responses to the question depicted in Figure 5.4: "Do you think that it is reasonable to pay out-of-pocket for the following services?" Responses were coded for each service as follows: definitely unreasonable = 4; unreasonable = 3; reasonable = 2; and definitely reasonable = 1. Therefore, a higher score indicates a greater expectation of state provision of health services. I then examine the association between villagers' expectations and individual characteristics in a linear model with county fixed effects summarized in Table 5.2.⁸⁸ Broadly understood, villagers with greater knowledge of life beyond the village are more likely to expect more robust state provision of healthcare. Specifically, villagers with a higher level of education, those who have engaged in migrant labor, and those who report having close friends or family in a large city or abroad (*Knows migrants*) tend to expect more in terms of state healthcare provision.

⁸⁸ These results are robust in additional specifications of the model. For example, I also used polychoric principal component analysis (PCA) to produce a weighted average of this measure. The results of the linear model produced with PCA were similar, insofar as coefficients retained the same sign and similar magnitude. The weights that were used, descriptive statistics for villagers and village leaders, and the PCA model are reported in Appendix C.

Table 5.2: OLS Model of Expectations of State Healthcare Provision with County Fixed Effects

Expectations (Unweighted)	Villagers (1)		Village Leaders (2)		Villagers and Village Leaders (3)	
	Coef.	P>t	Coef.	P>t	Coef.	P>t
Woman	-0.023 (0.030)	0.446	-0.053 (0.068)	0.430	-0.091 (0.036)	0.012
Age	0.009 (0.006)	0.106	0.006 (0.014)	0.650	0.024 (0.007)	0.000
Age ²	0.000 (0.000)	0.156	0.000 (0.000)	0.535	0.000 (0.000)	0.000
Education	0.029 (0.017)	0.075	-0.020 (0.039)	0.613	0.089 (0.020)	0.000
Ethnic minority	-0.047 (0.055)	0.391	0.179 (0.101)	0.077	0.018 (0.063)	0.774
CCP	-0.066 (0.055)	0.173	-0.026 (0.078)	0.736	0.602 (0.040)	0.000
Insurance	-0.111 (0.087)	0.201	-0.066 (0.244)	0.788	0.025 (0.106)	0.814
Healthcare use	0.012 (0.034)	0.731	-0.016 (0.056)	0.774	-0.007 (0.037)	0.858
Health status	-0.011 (0.017)	0.518	-0.057 (0.032)	0.072	0.002 (0.019)	0.916
Willingness to criticize gov't	0.039 (0.021)	0.063	0.018 (0.039)	0.649	0.038 (0.024)	0.123
Migrant	0.049 (0.032)	0.132	0.009 (0.066)	0.890	-0.022 (0.038)	0.559
Knows migrants	0.053 (0.031)	0.086	0.068 (0.057)	0.236	0.034 (0.035)	0.338
Observations	567		215		782	
R-squared	0.212		0.265		0.437	

Source: Author's survey.

NB: Village leaders are not a probability sample.

Also, villagers were asked if they agree or disagree with the statement: “Everyone should support their government” (*renhe ren dou yinggai zhichi ziji de zhengfu* 任何人都应该支持自己的政府). This question seeks to capture whether an individual is willing to express critical views of the government or whether s/he emphasizes supporting the government. Villagers who more strongly disagreed with this statement (*Willingness to criticize gov't*) also tend to have higher expectations for state healthcare provision. Although this is essentially control variable, it is particularly important to include in an authoritarian context, where respondents may not be willing to express views that could be perceived as critical of the government.

These results are fairly consistent across villager, village leader, and the combined samples, although there is some variation in which variables have a statistically significant association with expectations. For example, the coefficient for women is positive, indicating that women have higher expectations for healthcare provision, but only statistically significant with the combined villager and village-leader sample. Also, in the village-leader model only, respondents who are members of an ethnic minority have higher expectations for healthcare. There is some evidence that suggests that minority regions receive greater subsidies from higher levels of government for healthcare, which may help explain this result (see Chapter 4). Finally, communist party members have lower expectations for state healthcare provision when the villager and village-leader samples are combined, but this variable is not statistically significant at the 0.10 level in the separate models for villagers and village leaders. The strength of the association of communist party membership with expectations may be depressed because of collinearity with education; party members tend to be more educated than non-members (correlation coefficient of 0.34).

Overall, my finding that villagers with more knowledge about life beyond the village have higher expectations for healthcare provision is also supported by some of the comments provided by respondents in a previous question. As discussed in the previous section of this chapter, one question asked who should be responsible for the bulk of healthcare costs: the individual, the government, your employer, or other. In their justification for replying that the government should be responsible, several villagers (and village leaders) mentioned that the state is responsible for healthcare in other countries and, therefore, the Chinese government should also provide this service. For example, one villager said: “abroad, the government takes care of most of it [healthcare expenses]; China should imitate other countries” (#1205, *guowai dabufen shi zhengfu fuze, zhongguo yinggai xiaofang guowai* 国外大部分是政府负责，中国应效仿国外). Several other villagers and village leaders justified their response by referencing the health policies of other countries, which is surprising because villagers generally have a relatively low level of education.⁸⁹ The inclusion of references to health systems abroad demonstrates how information about life beyond the village is increasingly available to villagers through the mass media as well as through communication with migrants. Although rural China may be relatively more isolated from outside influences, these results indicate that villagers are learning more about the outside world than we might expect. Moreover, those villagers who have more information about urban life tend to expect more services from the state.

⁸⁹ Respondents were asked about the highest level of education completed. In our sample, the mean level of education is between primary school and middle school for villagers and between middle school and high school for villager leaders. See Table C.2 of descriptive statistics in Appendix C.

Conclusion

Research on welfare state expansion and retrenchment often examines the institutional context coupled with the various political and social groups that may serve as veto players or new constituencies to court with social policy expansion.⁹⁰ Previous research has successfully analyzed social policy reform using these approaches. However, the majority of this research has focused on democracies or democratizing states. In the context of an authoritarian regime such as China, the channels for ordinary citizens to communicate their demands to government leaders are distinct and far more limited. Nonetheless, government leaders in China are preoccupied with maintaining social stability and the longevity of the regime. Therefore, they seek information about what policies can be implemented to ensure that citizens are minimally happy, or at least happy enough to preempt revolt. Throughout the 1980s and 1990s, this was achieved by giving primacy to economic growth. However, economic growth was achieved at the expense of other social goods, such as environmental protection, social and economic equality, and other social services. Therefore, by the early 2000s, it was clear that social policy, including healthcare, should once again be placed on the national agenda. But how do we understand the pressure from below in the Chinese case? Without autonomous civil society groups or elections, how do we understand the expectations of the people? Moreover, in the context of an incomplete reform of the healthcare system, why do we not observe more social unrest provoked by healthcare?

By examining villagers' and village leaders' expectations regarding state provision of healthcare, I argue that the government is pursuing an objectively minimal, but subjectively sufficient course of action for healthcare provision. Despite popularly-held beliefs about villagers

⁹⁰ For an institutional perspective see, for example, Pierson (1996, 1994). For research on the role of democracy and new constituencies facilitating healthcare expansion, see Wong (2004). For research that examines the interaction between institutions and veto players in Latin America, see Castiglioni (2005).

as lacking the cognitive tools to think critically about policy, many Chinese villagers do think about healthcare and about whether the government has the responsibility to provide some minimal level of wellbeing. Their expectations, however, are typically quite low. Moreover, these views are often affected by past experiences and sometimes even current policies. But as education levels increase and villagers have more access to the media and information about the world beyond the village, their demands are likely to increase. In addition, village leaders, who serve as a link between the village community and higher levels of government, tend to have higher expectations for healthcare provision than villagers themselves. While village leaders have higher expectations, they also report higher satisfaction with healthcare in the village, as discussed in the previous chapter. Therefore, their effectiveness as a channel for higher levels to gather information about the village is mixed.

I also find that individual characteristics explain some of the variation in villagers' expectations for healthcare provision. In particular, more educated villagers and those who have contact with people outside the village are more likely to expect more state provision of healthcare. This finding suggests that, as the rural population becomes more aware of life beyond the village through education and the media, their demands for social policy are likely to increase. Moreover, as some villagers' expectations are influenced by past and current policy, and satisfaction with the current NCMS insurance program is relatively high, retrenchment of this program would be difficult. Retrenchment of the current NCMS would be met with a very different reaction from the dismantling of the CMS in the 1980s, which reflects significant differences in current health policy and state–society relations as compared to the early reform period. Today's Chinese villagers hold divergent views about the role of the state: while some

emphasize the importance of social welfare as part and parcel of state legitimacy, others do not expect the state to provide these services or expect only very minimal provision.

Conclusions and Implications for Future Research

This dissertation was motivated by the puzzling phenomenon of welfare state expansion in the context of authoritarianism. China's recent healthcare reform has significantly expanded state funding of healthcare and created new programs that seek to ameliorate some of the problems caused by rising healthcare prices and a lack of basic health systems. Cross-national research on social policy provision suggests that rural populations tend to be marginalized in welfare expansion (e.g., Ewig 2010). Yet a significant aspect of China's reform targets rural areas, including rolling out a complex, state-supported rural health insurance program. What explains this state reengagement with healthcare at the national level? Similar to other policy areas in China, much of policy implementation relies on local levels of government, but scholarship in Chinese politics has focused on the effects of decentralization on economic growth. How does decentralization operate in the realm of social policy and are there discernible effects on health policy implementation? In addition to addressing these questions, my analysis of health policy adoption and implementation also reveals important state–society dynamics in China. While social welfare provision is linked to state legitimacy, villagers' expectations for health policy provision are minimal.

Summary of Findings

Health reform in China was precipitated by a leadership transition and a public health crisis of international proportions (SARS), but it was more subtle domestic and international factors in the late-1990s and early-2000s that determined the content of new policies and the health reform as a policy process. After 1978, revenue constraints caused Chinese state retrenchment in social

policy, while healthcare costs began to rise. This confluence left the healthcare system in crisis, with challenges such as a spike in out-of-pocket expenditures and the withering of community clinics. By the early 1990s, tax reforms alleviated the central government's revenue crisis and the increasing influence of think tanks in policymaking created new potential pathways for the state's role in social policy. Concurrently, the international community began to advocate state re-engagement with social policy provision. As a result of pressure from below, shifts in governance style, and encouragement from domestic and international organizations and think tanks, the Chinese government initiated a strikingly public dialogue on healthcare reform that culminated in the 2009 plan to overhaul the system. Thus far, the health reform has expanded health insurance to the majority of the rural population and increased government investment in medical facilities. However, the central government continues to engage in incremental reforms at the national level while local governments have varied in their implementation of current guidelines.

However, like most other policy areas in China, health policy implementation depends on local officials and varies significantly both across and within provinces. In fact, social policy spending and priorities across Chinese provinces varies as widely as we observe across developed and developing countries. Through my cluster analysis of provincial-level social policy spending, I demonstrate that Chinese provinces differ systematically in their approach to social policy; some provinces place a relative emphasis on productive spending, such as education, while others focus on protective spending, such as pensions, social insurance, and housing. Tests of significance indicate that these differences are statistically significant. Therefore, this analysis of provincial-level divergence in welfare priorities indicates that

classifying China as a mixed or dual welfare state has limitations. Rather, subnational analysis is necessary because it reveals important and systematic variation, which has both social and political implications.

Economic development strategies are not the only factor producing subnational variation in health policy implementation, however. I argue that, because of distinct relationships between the central and provincial governments across provinces, wealthier provinces tend to further decentralize health policy funding and implementation while poorer provinces tend to standardize health policy within the province. Central government transfers for healthcare tend to be progressive. Thus, wealthier provinces have more autonomy to implement health policy, but are also responsible for funding a greater proportion of rural health insurance. Meanwhile, poorer, inland provinces receive more targeted subsidies for healthcare but are also more constrained in policy implementation.

This differentiated decentralization has two important implications for state–society relations. First, local officials in decentralized regions have more opportunities to act as policy makers, rather than merely bureaucrats. Therefore, they can potentially build local state capacity and work with other local officials to improve local governance. Local officials in less decentralized regions lack this opportunity. Second, local officials that rely on higher levels of government for fiscal transfers may perceive new policies as opportunities for corruption. For example, cases of fraudulent healthcare bills (*jia bingli* 假病历) are a greater problem in poor regions that rely on funding from higher levels of government. Third, should the central government seek to re-centralize or concentrate power in higher levels of government, such an initiative would be significantly more difficult in a decentralized province where local officials

have become accustomed to a greater degree of autonomy (such as Jiangsu), compared to a province that relies on a more top-down approach to governing.

In the case of rural health policy, decentralization does not have a clear impact on policy effectiveness. On the one hand, health insurance reimbursement rates are more variable and, sometimes, lower in decentralized Jiangsu, despite the greater availability of local resources, than in comparable counties in poorer provinces. On the other hand, healthcare provision confronts additional challenges in impoverished regions, resulting in worse evaluations of healthcare provision by villagers in poor provinces. Particularly in poor regions, villagers have significant healthcare challenges, but no longer raise those grievances with local government officials, as they did prior to the rural health insurance program.

Although healthcare has been a significant grievance and many of the problems of cost and quality remain unresolved, incidents of social instability precipitated by health have diminished over the past decade. How have recent reforms, however imperfect, managed to quell dissent in this area? By examining villagers' and village leaders' expectations regarding state provision of healthcare, I argue that the government is pursuing an objectively minimal, but subjectively sufficient course of action for healthcare provision. Despite popularly-held beliefs about villagers as lacking the cognitive tools to think critically about policy, many Chinese villagers do think about healthcare and about whether the government has the responsibility to provide some minimal level of wellbeing. Their expectations, however, are typically quite low. Moreover, these views are often affected by past experiences and sometimes even current policies. But as education levels increase and villagers have more access to the media and information about the world beyond the village, their demands are likely to increase. In addition,

village leaders, who serve as a link between the village community and higher levels of government, tend to have higher expectations for healthcare provision than villagers themselves. While village leaders have higher expectations, they also report higher satisfaction with healthcare in the village.

I also find that individual characteristics explain some of the variation in villagers' expectations for healthcare provision. In particular, more educated villagers and those who have contact with people outside the village are more likely to expect more state provision of healthcare. This finding may indicate that, as the rural population becomes more aware of life beyond the village through education and the media, their demands for social policy are likely to increase. Moreover, since some villagers' expectations are influenced by past and current policy, and satisfaction with the current rural health insurance program is relatively high, retrenchment of this program would be difficult. Retrenchment of the current program would be met with a very different reaction from the dismantling of the Maoist-era system in the 1980s, which reflects significant differences in current health policy and state–society relations as compared to the early reform period. Today's Chinese villagers hold divergent views about the role of the state: while some emphasize the importance of social welfare as part and parcel of state legitimacy, others are skeptical that the state will provide these services. This suggests that future research should further examine the expectations of the citizenry and their links to state legitimacy, in a similar vein as Martin Whyte's research (Whyte and Im: unpublished; Whyte 2012, 2010).

Implications for Future Research and Good Governance

This analysis of the politics of health reform elucidates important dynamics between levels of government and state–society relations in China. First, at the national level, the healthcare reform process was more open and inclusive than previous policymaking processes in China, through media coverage and the opportunity for public comment on the health reform proposal. While this case does not portend an imminent political transition, this tangible change in the policymaking process in healthcare does suggest that central leadership may include more voices in the policy process and that policymaking may gradually become more transparent. Nonetheless, the health reform also reflects the pervasive impact of authoritarian institutions in China. For example, while there are indications of the political battles between government ministries over the health reform, debates that reveal dissensus among political elites are still muted and not publicly voiced. Moreover, the health reform also underscores the continued importance of political leadership in agenda setting at the national level; without Hu Jintao charting his own course and putting social policy back on the national agenda, health reform would have stalled.

This research raises further questions for research on decentralization and social policy implementation. How does the relationship between the national and subnational state affect policy adoption and implementation?⁹¹ In China, I find that poorer provinces have greater access to central government transfers and may pursue these as a form of pork. Therefore, this dynamic of relying on central government redistribution of revenue may create a vicious cycle where local leaders are incentivized to demonstrate to higher levels that their locality is sufficiently destitute

⁹¹ See, for example, Haeder & Weimer (2013) on the variable state implementation of insurance exchanges in the U.S.

to receive transfers, rather than promote economic development. The official poverty designation that determines the destinations of targeted development aid has been marred with sporadic cases of corruption. Future research should examine to what extent this type of targeted aid fosters development or fuels corruption among local officials.

While I examine social policy implementation in an authoritarian context, these findings are more broadly applicable to countries that are new democracies or have weak democratic institutions. For example, if local elections are fraught with clientelism (Stokes et al. 2013) or civil society's presence is weak, then societal expectations and conceptions of state legitimacy are crucial to understanding the intensity of grievances and how they may impact current and future social policy reform. While previous research has examined the role of social groups and lobbying organizations in social policy reform, future research should consider societal expectations for social policy provision and how these may (or may not) translate into salient grievances that are translated into demands on the state.

While the effects of recent health policies in rural areas have been mixed and reform is incomplete, the health reform has certainly created additional state institutions that further extend the reach of the state and strengthen the Ministry of Health in rural areas. The rural health insurance program, NCMS, established additional bureaucracy, particularly at the county level, to design and implement local NCMS plans under the auspices of the Ministry of Health. Moreover, despite recent reforms to the *hukou* or residence permit system, the NCMS and the Urban Resident Basic Medical Insurance program are generally linked to one's residence status. While some reports have suggested merging the two programs, the current healthcare system has, at least temporarily, reinforced the importance of the *hukou*.

This research also has implications for policy makers and the international community. The weakness of Chinese health systems, particularly at the community level, garnered international attention during the SARS crisis of 2003 and again during smaller spates of various strains of avian flu.⁹² To address future public health challenges in China, an understanding of local health systems and the key actors in health policy implementation is crucial. This research demonstrates the decentralized nature of health policy implementation in China. Therefore, gaining the support and cooperation of local officials is critical to ensure an effective response to public health crises. Additionally, local officials' willingness to cooperate and capacity to respond to health crises vary dramatically across provinces.

My analysis of healthcare reform reveals some of the ways in which the international community has impacted policy change in China. While the central government retains autonomy in its policy choices, the influence of international organizations and research on the healthcare is undeniable. Throughout the 1990s, as the role of research institutes in policymaking increased dramatically in China, international discourse shifted away from structural adjustment and international organizations began to recommend state reengagement with social policy provision. Since the 1990s, the impact of domestic and international researchers on Chinese social policy has been palpable. For example, the number of World Bank projects in China that experiment with various projects related to development and poverty alleviation increased

⁹² The World Health Organization reports a total of 45 confirmed human cases of H5N1 in China between 2003 and 2013 (WHO, Human-Animal Interface, http://www.who.int/influenza/human_animal_interface/EN_GIP_20130426CumulativeNumberH5N1cases.pdf, accessed May 31, 2013.) In early 2013, there were 132 confirmed human infections of H7N9 (WHO, "Overview of the emergence and characteristics of the avian influenza A(H7N9) virus," http://www.who.int/influenza/human_animal_interface/influenza_h7n9/WHO_H7N9_review_31May13.pdf, accessed May 31, 2013).

substantially at the end of the last century.⁹³ These projects and the research that resulted from them have then informed policymaking in China. The importance of research and evidence-based policy recommendations has only increased in China. Leading scholars at Chinese universities often seek to influence policy by providing sound, empirically-based analyses to effect change. Thus, as China continues to face new challenges, the international community and scholarship has a notable opportunity to affect the policy process.

Health reform in China reveals significant state–society dynamics regarding the politics of policy adoption and implementation. Future research should examine these processes in other salient issue-areas in China, such as environmental policy and education reform. Much of the dominant research in Chinese politics has focused on economic reform. Yet the state and society increasingly confront issues that have emerged as a result of economic development, including how to reform social policy institutions, rising economic inequality and poverty alleviation, and environmental degradation. Although these are now the salient challenges for China, the politics of these issues still remains relatively underexplored in scholarship on Chinese politics. My research suggests that important insights regarding policy processes, the nature and impact of decentralization, and state legitimacy can be gained from analyses of social policy and related issues.

⁹³ According to World Bank reports, both the amount of financing and the number of projects increased in China throughout the 1990s. For more details, see the World Bank, “Projects & Operations,” http://www.worldbank.org/projects/search?lang=en&searchTerm=&countryshortname_exact=China.

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Appendix A: June 26th Directive on Public Health

“Directive On Public Health”

Mao Zedong

June 26, 1965

Excerpted from: Schram, Stuart (ed.), translated by John Chinnery and Tieyun. (1974) *Chairman Mao Talks to the People, Talks and Letters: 1956-1971*, New York: Pantheon Books, pages 232-233.

Tell the Ministry of Public Health that it only works for fifteen per cent of the total population of the country and that this fifteen per cent is mainly composed of gentlemen,⁹⁴ while the broad masses of the peasants do not get any medical treatment. First they don't have any doctors; second they don't have any medicine. The Ministry of Public Health is not a Ministry of Public Health for the people, so why not change its name to the Ministry of Urban Health, the Ministry of Gentlemen's Health, or even to Ministry of Urban Gentlemen's Health?

Medical education should be reformed. There's no need to read so many books. How many years did Hua T'o⁹⁵ spend at college? How many years' education did Li Shih-chen of the Ming dynasty receive? In medical education there is no need to accept only higher middle school graduates or lower middle school graduates. It will be enough to give three years to graduates from higher primary schools. They would then study and raise their standards mainly through practice. If this kind of doctor is sent down to the countryside, even if they haven't much talent, they would be better than quacks and witch doctors and the villages would be better able to afford to keep them. The more books one reads the more stupid one gets. The methods of

⁹⁴ Here, and later in this paragraph, the term translated as 'gentlemen' is *lao-yeh*, which also means an official, in particular a district magistrate. Mao is using it ironically of the 'new class' of Party cadres, etc.

⁹⁵ Hua T'o (d. A.D. 220), a celebrated physician and surgeon who served as court physician to Ts'ao Ts'ao; the latter had him executed when he proposed to open his skull to cure him of headaches.

medical examination and treatment used by hospitals nowadays are not at all appropriate for the countryside, and the way doctors are trained is only for the benefit of the cities. And yet in China over 500 million of our population are peasants.

They work divorced from the masses, using a great deal of manpower and materials in the study of rare, profound and difficult diseases at the so-called pinnacle of science, yet they either ignore or make little effort to study how to prevent and improve the treatment of commonly seen, frequently occurring and widespread diseases. I am not saying that we should ignore the advanced problems, but only a small quantity of manpower and material should be expended on them, while a great deal of manpower and material should be spent on the problems to which the masses most need solutions.

There is another peculiar thing. Whenever a doctor makes an examination, he always has to wear a mask no matter what the illness is. Is this because they are afraid they might catch a disease and thus transmit it to others? I am afraid that it is primarily because they are afraid of catching an illness themselves. Different diseases should be dealt with separately. If they wear masks no matter what the illness, this creates a distance between doctor and patient from the start.

We should leave behind in the city a few of the less able doctors who graduated one or two years ago, and the others should all go into the countryside. The 'four clean-ups' movement was wound up in the year xx and has been basically completed, but even though the 'four clean-ups' has been completed, medical and health work in the villages has not yet been completed!

In medical and health work put the emphasis on the countryside!

Appendix B: Villagers' Expectations of Local Health Facilities

Table B.1: Villagers' Ratings of Local Health Facilities, by Province

Village Clinic	Jiangsu		Hubei		Yunnan	
	Count	Percent	Count	Percent	Count	Percent
Very Bad	13	6%	23	9%	27	12%
Bad	49	21%	49	20%	60	26%
Middle	145	61%	138	56%	112	49%
Good	26	11%	33	13%	28	12%
Very Good	3	1%	4	2%	1	0%
	236	100%	247	100%	228	100%

Township Hospital	Jiangsu		Hubei		Yunnan	
	Count	Percent	Count	Percent	Count	Percent
Very Bad	1	0%	9	4%	7	3%
Bad	22	9%	43	17%	31	15%
Middle	110	47%	142	57%	115	56%
Good	88	37%	49	20%	51	25%
Very Good	14	6%	5	2%	3	1%
	235	100%	248	100%	207	100%

County Hospital	Jiangsu		Hubei		Yunnan	
	Count	Percent	Count	Percent	Count	Percent
Very Bad	2	1%	0	0%	0	0%
Bad	6	3%	4	2%	0	0%
Middle	8	3%	59	25%	44	21%
Good	126	54%	139	59%	136	66%
Very Good	90	39%	34	14%	27	13%
	232	100%	236	100%	207	100%

NB: Percentages may not sum to 100 due to rounding error.

Source: Author's survey of villagers.

Appendix C: Weighted Model of Villagers' Expectations

Table C.1: OLS of Expectations of State Healthcare Provision with County Fixed Effects with Weights from Principal Component Analysis

	Villagers (1)		Village Leaders (2)		Villagers and Village Leaders (3)	
	Coef.	P>t	Coef.	P>t	Coef.	P>t
Female	-0.142 (0.137)	0.302	-0.314 (0.364)	0.389	-0.195 (0.127)	0.126
Age	0.041 (0.025)	0.104	0.045 (0.071)	0.533	0.037 (0.023)	0.109
Age ²	0.000 (0.000)	0.171	-0.001 (0.001)	0.407	0.000 (0.000)	0.118
Education	0.114 (0.075)	0.129	-0.103 (0.204)	0.614	0.121 (0.069)	0.080
Ethnic minority	-0.155 (0.242)	0.522	1.001 (0.535)	0.063	0.100 (0.220)	0.650
CCP	-0.164 (0.216)	0.446	-0.150 (0.399)	0.708	-0.146 (0.140)	0.298
Insurance	-0.318 (0.382)	0.405	-0.346 (1.267)	0.785	-0.230 (0.364)	0.528
Healthcare use	0.042 (0.157)	0.789	-0.128 (0.287)	0.656	0.020 (0.131)	0.880
Health status	-0.039 (0.076)	0.611	-0.279 (0.165)	0.092	-0.079 (0.068)	0.240
Willingness to criticize gov't	0.148 (0.095)	0.118	0.053 (0.201)	0.791	0.189 (0.085)	0.027
Migrant	0.248 (0.148)	0.095	-0.105 (0.344)	0.761	0.183 (0.133)	0.170
Knows migrants	0.217 (0.140)	0.122	0.372 (0.296)	0.211	0.130 (0.124)	0.296
Observations	506		200		706	
R-squared	0.231		0.258		0.171	

NB: Village leaders are not a probability sample.

Source: Author's survey.

Table C.2: Descriptive Statistics for Villagers

Variable	Obs.	Mean	Std. Dev.	Min.	Max.
Expectations: unweighted	772	1.34	0.37	0.00	3.00
Expectations: PCA weights	684	9.77	1.57	4.14	16.55
Female	801	0.48	0.50	0.00	1.00
Age	792	46.79	14.99	17.00	93.00
Age ²	792	2414.02	1421.76	289.00	8649.00
Education	800	2.72	1.07	1.00	5.00
Ethnic minority	775	0.10	0.30	0.00	1.00
CCP	744	0.10	0.29	0.00	1.00
Insurance	784	0.97	0.17	0.00	1.00
Healthcare use	786	0.73	0.45	0.00	1.00
Health status	775	3.58	1.03	1.00	5.00
Willingness to criticize gov't	709	1.53	0.70	1.00	4.00
Migrant	755	0.33	0.47	0.00	1.00
Knows migrants	705	0.46	0.50	0.00	1.00

Table C.3: Descriptive Statistics for Village Leaders

Variable	Obs.	Mean	Std. Dev.	Min.	Max.
Expectations: unweighted	282	2.35	0.38	1.11	4.00
Expectations: PCA weights	257	11.34	1.86	5.39	19.29
Female	290	0.20	0.40	0.00	1.00
Age	289	45.38	10.87	21.00	86.00
Age ²	290	2169.86	1029.93	0.00	7396.00
Education	285	3.68	0.88	1.00	5.00
Ethnic minority	282	0.09	0.28	0.00	1.00
CCP	277	0.86	0.35	0.00	1.00
Insurance	287	0.99	0.10	0.00	1.00
Healthcare use	285	0.62	0.49	0.00	1.00
Health status	276	3.93	0.85	1.00	5.00
Willingness to criticize gov't	274	1.49	0.68	0.00	4.00
Migrant	272	0.24	0.43	0.00	1.00
Knows migrants	259	0.50	0.50	0.00	1.00

Table C.4: PCA Weights for Model of Village Leaders

Variable	Factor	Uniqueness
Children's vaccinations	0.4277	0.4440
Adult's vaccinations	0.6982	0.3338
Annual check-up	0.5682	0.5817
Emergency room visit	0.5443	0.5772
Non-local healthcare for migrant workers	0.5237	0.7102
Doctor-prescribed medicine	0.5456	0.6505
Special accommodations to speed recovery (private room, special food, etc.)	0.4519	0.4943
Diagnostic tests	0.6151	0.5675
Special treatments when patient has chosen specialist doctor	0.4483	0.5645

Table C.5: PCA Weights for Model of Villagers and Village Leaders

Variable	Factor	Uniqueness
Children's vaccinations	0.4619	0.6200
Adult's vaccinations	0.6188	0.5529
Annual check-up	0.5488	0.6430
Emergency room visit	0.4472	0.7460
Non-local healthcare for migrant workers	0.4868	0.7085
Doctor-prescribed medicine	0.4058	0.7381
Special accommodations to speed recovery (private room, special food, etc.)	0.3559	0.6040
Diagnostic tests	0.5660	0.6145
Special treatments when patient has chosen specialist doctor	0.3924	0.5903

Appendix D: Research Methods *with Leah Larson-Rabin*

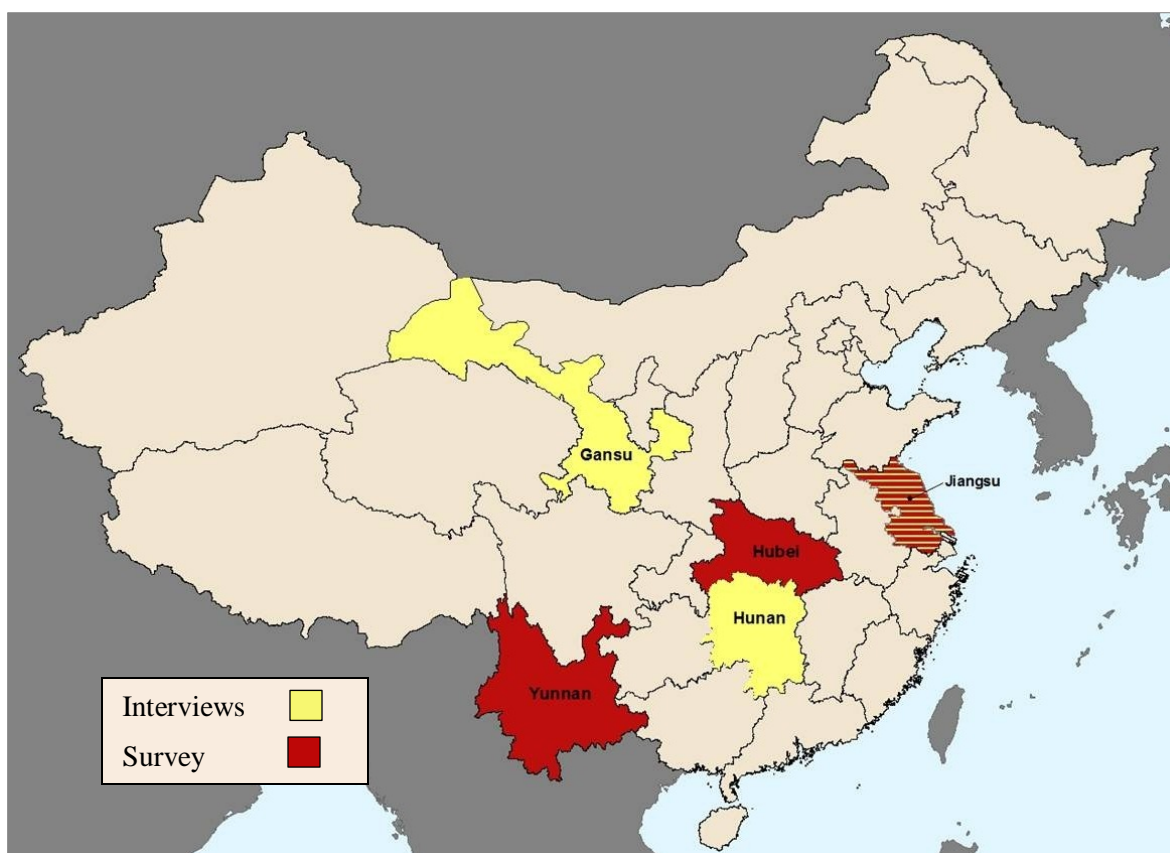
I. Introduction

The project relies on both qualitative and quantitative evidence, including semi-structured interviews conducted with county-level officials, hospital personnel, and villagers as well as an original survey of over 1,000 villagers and village officials. I also gathered information from statistical yearbooks, national and local laws and regulations, newspapers, provincial websites, and other government websites. By triangulating information collected from various sources, I examine the politics of healthcare despite the limitations on data collection in China.

I conducted semi-structured interviews in three provinces from 2009 to 2010 with the support of a Foreign Language and Area Studies Fellowship from the U.S. Department of Education. Respondents for these interviews included local government officials (particularly county-level health officials), hospital personnel, and villagers in three provinces: Jiangsu, Hunan, and Gansu. I visited seven counties in Jiangsu and four counties each in Hunan and Gansu. I purposefully chose three provinces that vary in the levels of economic development, given the importance of economic conditions in social policy implementation. I also selected counties within each province to reflect salient intra-provincial cleavages, including wealth and degree of urbanization. The provinces selected for fieldwork are depicted in Figure D.1. In addition, archival research was conducted between 2009 and 2012. I gathered information on healthcare reform and health policy implementation from local provincial libraries, the Universities Service Centre at the Chinese University of Hong Kong, national and regional statistical yearbooks, laws and regulations, provincial websites, and the media.

Finally, I conducted a survey of villagers and village officials in collaboration with Leah Larson-Rabin (Ph.D. candidate, University of Wisconsin–Madison) in 2012 in three provinces: Jiangsu, Hubei, and Yunnan (Figure D.1). The survey was funded by the National Science Foundation’s Doctoral Dissertation Research Improvement Grant (awarded to the author) and by the Southwest China IGERT program at the University of Wisconsin–Madison (awarded to Larson-Rabin), as well as additional support from the Summer Initiative Fund of the University of Wisconsin–Madison’s Department of Political Science and the Vilas Research Travel Grant from the Graduate School at the University of Wisconsin–Madison.

Figure D.1: Map of Fieldwork Provinces



This appendix is organized as follows. First, I discuss the impact of the political and social context on conducting research on healthcare reform in China. Second, I detail the process of conducting semi-structured interviews. Third, I describe the survey, including sampling, development of the survey instrument, enumerator training, and the resulting data.

II. Mixed Methods in a Challenging Research Environment

Social science research in China remains challenging, despite increased openness to policy evaluation research and greater dissemination of social scientific research methods in Chinese universities. Because China's political system is authoritarian and economic development is uneven,⁹⁶ access to information is highly contingent on local politics and the reliability of official statistics is dubious.⁹⁷ The logistical challenges of conducting research in a developing country can be significant but can be resolved with proper planning. The lack of political freedom, however, generates two major obstacles to research. First, interviewees are less likely to give honest and complete answers because of the potential for pressure and retribution from local officials; in poorer populations, among which I conducted the majority of my research,

⁹⁶ Official estimates place the Gini coefficient at around 0.47 in 2012. See Kevin Yao & Aileen Wang (2013).

⁹⁷ One of the difficulties in analyzing official statistics in China is that there are competing incentives for local leaders. On the one hand, some officials seek to demonstrate their success in promoting economic growth by inflating gross regional product figures. On the other hand, officials in impoverished areas may deflate economic indicators in order to elicit the coveted official "poverty designation" from the central government (see discussion of the official poverty designation in Chapter 4), which makes the locality eligible for additional subsidies from the central government. In terms of social indicators, local officials face severe repercussions if they are unsuccessful at implementing family planning policies or if there are significant incidents of social unrest in their locality. These incentives can lead to misreporting of crucial data by local officials. For a few examples, see Thomas Orlik, (2012) *Understanding China's Economic Indicators*, Upper Saddle River, New Jersey: FT Press or the excerpt "China's Puzzling Numbers," *The Wall Street Journal*, September 15, 2011, <http://online.wsj.com/article/SB10001424053111904353504576565893924294066.html>, accessed April 25, 2013. See, also, William Wan, "China's economic data drew sharp scrutiny from experts analyzing global trends," *The Washington Post*, February 4, 2013, http://articles.washingtonpost.com/2013-02-04/world/36744280_1_trade-data-chinese-government-wei-yao, accessed April 25, 2013. Regarding discrepancies in official environmental statistics, see Brad Plumer, "China could be hiding an entire Japan's worth of carbon emissions," *The Washington Post*, June 12, 2012, http://www.washingtonpost.com/blogs/wonkblog/post/china-could-be-hiding-an-entire-japans-worth-of-carbon-emissions/2012/06/12/gJQA3zuTXV_blog.html, accessed April 25, 2013. Regarding village statistics, see Tsai (2008).

individuals are even more vulnerable as they are dependent on the benevolence of local officials. Second, while all scholars, Chinese and foreign, are limited in what is permissible research, foreign scholars are subject to greater suspicion and even more limits, both *de facto* and *de jure*. Between 1999 and 2004, the Measures for the Administration of Foreign-Affiliated Surveys (National Bureau of Statistics) generated increasingly restrictive requirements to meet to obtain survey permits. Moreover, there are specific regulations that prohibit non-Chinese scholars from certain types of independent research within China: survey research by foreign scholars without direct oversight by Chinese researchers is not officially authorized and may be considered “gathering sensitive information.”⁹⁸ Even in those cases where research proposals have earned proper clearance, the lack of strong legal institutions results in ad hoc decision-making by local officials who may prohibit research that could be considered sensitive.

Perceptions of whether health policy is a politically sensitive topic are also germane to whether respondents were willing to speak with me and what type of information they were willing to divulge. In general, health policy is not a politically sensitive topic in China at the time of research and writing. Scholars, officials, the media, and the public at large can have relatively frank and open discussions about the need to invest more in health infrastructure or the ways in which current policy could be improved. As discussed in Chapter 2, the central government posted the proposal for the 2009 health reform on an internet forum for public commentary. This method of soliciting public comment on policy proposals has been utilized in other policy arenas as well. In fact, as evident in the sources cited throughout the dissertation, Chinese scholars also

⁹⁸ Recent attention on “illegal surveys” generally pertains to geographic mapping of national resources with commercial or national security implications. See, for example, Wang, Qian, “Tougher penalties mapped out to fight illegal surveys,” *China Daily*, October 23, 2012, http://europe.chinadaily.com.cn/china/2012-10/23/content_15837733.htm, accessed March 28, 2013. Nonetheless, in the context of a “rule by law” (Peerenboom 2002) legal system, the Chinese government has been known to apply the law selectively and instrumentally.

conduct research on the effectiveness of health policy. Health policy design and implementation is generally not considered politically sensitive as long as one does not suggest that the party-state is implicated in existing problems or that regime change would be necessary for effective policy reform. Within these parameters, relatively open discussion of the healthcare system can occur and, thus, the details of policymaking can be accessible for research.

Although health policy is generally not considered a politically sensitive topic, conducting interviews with officials, as a foreigner, was nevertheless far more challenging than approaching villagers. When I had a direct introduction to an official, such as through the official's former university professor, we often engaged in relatively frank conversations about local affairs. On the other hand, when I arrived without an introduction or through a more tenuous connection (a friend of a friend), officials would withhold ostensibly public information or would prevaricate in response to straightforward questions by saying "hard to say," "not sure," "[let's] talk about it later," (*bu hao shuo* 不好说/*hen nan shuo* 很难说, *bu qingchu* 不清楚, *yihou zai shuo* 以后再说) or similarly oblique responses. In a couple of cases, a county-level official assured me that he would send me requested information via e-mail, which I correctly interpreted as yet another form of evasion. In all cases, I made notes of the conditions of the interview and attitude of the interviewee and considered the implications for the likely veracity of the information obtained. Furthermore, local officials in some regions were more forthcoming with information than others; local officials in less wealthy counties were more reticent in general. Given the uneven quality of information collected from interviews and official documents and the difficulty in obtaining information from less wealthy counties, I also conducted a survey of over 1,000 villagers and village leaders in three provinces to further

examine the effect of local state–society relations on health policy implementation. The survey enabled me to test the generalizability of key hypotheses as well as create a controlled environment where the same questions were asked of everyone. The item nonresponse rate was very low for most questions (often less than 10 percent, even among politically sensitive questions) and I was able to gather information about health policy, villagers’ expectations, and perceptions of government that would not have been possible through interviews. As the survey was conducted with help from a local university in each province, local officials were more consistently forthcoming with our enumerators than when I approached them independently as a foreign researcher. We also encouraged enumerators to provide as much supplementary, qualitative information as they could, including, for example, whether there were other individuals present (an issue that has emerged as a source of reliability problems in politically restrictive environments). Therefore, we were able to gather a more complete picture of respondents’ views and any extenuating circumstances that may have affected responses.

The issue of protecting informants, respondents, and field assistants is of utmost importance for a social scientist. And being identified as foreign researcher can matter in the perceived risk calculation, as well as have additional bias effects, which will be discussed in the following section on semi-structured interviews. To protect those who participated in my research, I did not record our conversations, but rather my field assistant and I took copious notes on the conversation and general demeanor of the interviewee. I present the list of interviews with officials in Table D.1, but without the names of individuals or counties to protect informants.

Because of the challenges of conducting social science research in an authoritarian, developing country, social scientists must rely on multiple sources of information and aim to

triangulate to generate a more accurate and complete picture of political dynamics (Carlson et al. 2010). Incorporating semi-structured interviews and survey data in addition to official statistics and media reports has enabled me to examine the politics of health policy adoption and implementation. In the next two sections, I will detail the process of conducting field research.

II. Qualitative Evidence

Having gathered archival data and official statistics, I utilized face-to-face, semi-structured interviews with local officials (policy implementers) and villagers. The main goal of these interviews was to make a qualitative assessment: how were the reforms functioning in practice, what challenges had arisen, what was the response, and what were the factors that affected implementation across different regions and different socio-economic levels. The latter was particularly significant because previous research has shown that there is a major divergence between coastal and interior regions in China, largely resulting from variation in socio-economic development. Because the information I was seeking was related to processes and people's experiences with health systems, the method for gathering the data necessitated a flexible and open-ended approach to interviews (Rubin and Rubin 2012; Read 2010).

In 2009 and 2010, I conducted 38 semi-structured interviews with county-level officials and hospital personnel. I conducted less formal interviews and focus groups with villagers in each county. I also had conversations with local scholars in each province and Beijing regarding healthcare reform; these scholars have researched health policy and some of them have served as government advisers for healthcare reform. The respondents chosen for interviews were mainly a convenience sample developed through introductions from local scholars. I conducted interviews in a total of 15 counties in three provinces: seven counties in Jiangsu, and four counties each in

Gansu and Hunan. In Gansu, I gained permission from the provincial Health Bureau to approach local officials in nearby counties. Official permission facilitated access in some cases, but also may have influenced local officials' responses, because they might have perceived official permission as a signal that what they shared would then be reported back to their superiors.

Given that my interview targets were local officials, formal introductions were crucial to gaining access to potential respondents. Therefore, I utilized contacts established through my colleagues at the University of Wisconsin–Madison and during research in China. I developed an interview protocol for county-level officials, hospital personnel, and villagers based on previous research. However, I also allowed the conversation to flow naturally, when appropriate, and gained important insights about local officials through informal interactions.

In Hunan province, I chose localities to visit based on variation in socio-economic conditions and was able to obtain informal introductions in some cases. In other cases, interviewees were essentially “cold-called,” that is, I visited local officials without a formal or informal introduction. In these cases, a research assistant and I would approach local officials, explain our purpose as academic researchers, and obtain whatever information officials were willing to proffer. Without a formal introduction, whether I had an informal introduction or no introduction, however, the quantity and quality of information gathered was inconsistent. In general, local officials were more forthcoming if I had an introduction from a close friend or former professor. These interviews were, in general, the most successful and informative.

Respondents' willingness to be forthcoming varied substantially. In some localities, officials would say that information related to health policy implementation was “[politically] sensitive” (*min'gan* 敏感) or “classified,” (*baomi* 保密) whereas in other areas officials would

say, “this is not sensitive” or “this is public” (*gongkai* 公开) information. Officials were undoubtedly more reticent with a foreign researcher because of the potential to be perceived as revealing “state secrets” (which has an ambiguous and constantly shifting definition and scope) to a foreigner. Nonetheless, officials’ reactions as respondents provided interesting insight into local political climate variation and into whether local officials felt empowered to take initiative and discuss policy with a foreigner. As previously stated, health policy is not generally considered particularly sensitive relative to other political topics.

In selecting local officials to interview, I sought respondents in county-level Health Bureaus and New Cooperative Medical System (NCMS) offices and, in some areas, other local officials, such as the village representative of the All-China Women’s Federation (often tasked with implementing village-level family planning policy). The county NCMS office is responsible for implementing the NCMS health insurance program. In addition, although ostensibly an insurance program, there is institutional overlap between the NCMS and local providers. Therefore, NCMS officials also tend to have knowledge of health policy implementation more broadly. Which official was interviewed often depended on officials’ availability and, sometimes, the strength of my connection to the target official through an introduction. In some counties, I spoke to several officials together, which was useful because they were able to corroborate information or assist each other in recalling specific details. Most officials were also able to corroborate their accounts with official party documents or reports of which they could provide copies to me.

Interviewing villagers was easier in most cases. Villagers were generally more forthcoming—willing to tell me about their lives and tribulations—and seemed less wary of my

identity as a foreigner. In the majority of cases, local officials were not present when I interviewed villagers. Thus, villagers could speak relatively freely. In a few villages, local officials insisted on accompanying me to interview villagers or organized an impromptu focus group with villagers of their selection. In these cases, villagers' comments were clearly influenced by the presences of local officials. For example, when I asked a question, villagers would look at the official for an answer or would respond, but then look to the official for confirmation that their answer was "correct." In these cases, I interpreted the information with extreme care and generally excluded responses that seemed to have been heavily influenced by the presence of local officials.

I chose which villages to visit randomly with some consideration for local connections when available (e.g., if my research assistant had relatives in a local village) and accessibility (e.g., some locations would have been dangerous to visit due to poor infrastructure), except in the few cases in which officials insisted that I visit a particular village. In general, I did not notice anything particularly unusual about the villages that I visited; I was not taken to conspicuously "model" villages, except perhaps in one case where I was taken to an urban district that was a special economic zone and had recently constructed a brand-new hospital and medical facility. This was also instructive, however, since the Chinese government has made a concerted effort to invest more in health infrastructure, particularly at the local level. Thus, while investment in new clinics and hospitals may not occur in a majority of villages, this does occur in the context of recent increased investment in healthcare.

In addition to interviewing local officials, I also spoke to available hospital personnel in the counties that I visited. In most cases, I was able to speak to doctors, nurses, and low level

administrators. In some cases, I was able to speak to the hospital director. Most hospital personnel were able to corroborate or provide greater nuance to the experiences that villagers had shared.

Over the course of qualitative work, I gained a plethora of fascinating information about health policy implementation at the local level, as well as information about villagers' perceptions of government. I also achieved "saturation"⁹⁹ on a number of different issues, but interview experiences varied across provinces. For example, in poorer provinces, villagers consistently complained of inadequate health infrastructure. Moreover, they often stated that the new rural health insurance policy constituted an improvement over the previous out-of-pocket payment system. However, many people complained that the medicines and treatments that they had been prescribed either were not covered by the new insurance policy or were not available in local pharmacies or local medical clinics. These were the most common complaints regarding rural health insurance. These problems, however, were not as salient in Jiangsu, the wealthiest province included in my fieldwork.

Villagers in most localities also indicated that recent policies, such as the new rural health insurance program, demonstrated that the central government cared about improving health policy, but that local governments were not implementing the policies correctly or adequately, or that local corruption interfered with proper implementation. This resilient trust in the central government in combination with criticism of local government is consistent with previous research on trust in government in China (Li 2004; Shi 2001).

⁹⁹ In social science research, "saturation" refers to when you hear similar accounts from various interviewees to the extent that the researcher is confident that these accounts represent a common or typical experience for many people.

In conducting this type of research, interviewer effects are inevitable. Certainly, the information that I gathered as a white, female, American differed from what a researcher of another race, gender, or nationality might have found. It is not clear, however, that the bias introduced by research effects in China is consistent across respondents. While some respondents were clearly reticent in the presence of a foreigner for fear that they might be divulging “classified information,” other respondents seemed to be more open with me given that I do not have formal ties to the Chinese government or communist party. More often than not, conversations with villagers transpired fluidly without noticeable reference or interest in the fact that I am a foreigner. That is not to assert that my identity and its implicit effect on responses should be discounted, but rather that my easily identifiable status as a foreigner had varying effects. Some interviewees even seemed more willing to talk to my research assistants¹⁰⁰ and me because we were outsiders, and not from the village or region. In cases when villagers have had conflicts with local officials, they may be more willing to talk to people whom they do not perceive as part of the local power structure. Had I been a known confidant of local officials, some villagers may have been more reticent to discuss their problems with health policy implementation or daily life in general. In all cases, I made note of the respondent’s demeanor and I take this into consideration in my analysis.

¹⁰⁰ I often enlisted a local graduate student to accompany me to conduct interviews. She (almost all of my field assistants were women) would take notes and translate local dialect into standard Mandarin when necessary.

Table D.1: Interviews with Local Officials and Hospital Personnel

Interview Code	County Code	Province	Date	Institution	Position
JSAW01	A	Jiangsu	11/30/09	County Health Bureau	Bureau Head
JSAH02	A	Jiangsu	11/30/09	County People's Hospital	Doctor
JSBW07	B	Jiangsu	12/01/09	County Health Bureau	Bureau Head
JSBH08	B	Jiangsu	12/01/09	County People's Hospital	Doctor
JSCW10	C	Jiangsu	12/02/09	County Health Bureau	Bureau Head
JSCH11	C	Jiangsu	12/02/09	Hospital	Administrator
HNDX14	D	Hunan	12/14/09	NCMS Office	Administrator
HNDH15	D	Hunan	12/14/09	People's Hospital 1	Doctor
HNDH18	D	Hunan	12/14/09	People's Hospital 2	Doctor
HNEW19	E	Hunan	12/15/09	County Health Bureau	Bureau Head
HNEV20	E	Hunan	12/15/09	Village Committee	Village Leader
HNEV21	E	Hunan	12/15/09	Village	Village Head
HNEH22	E	Hunan	12/15/09	County People's Hospital	Doctor
HNF23	F	Hunan	12/17/09	County Health Bureau	Administrator
HNFH24	F	Hunan	12/17/09	County People's Hospital	Hospital Director
HNG29	G	Hunan	01/14/09	Office of Letters and Visits	Administrator
HNGW30	G	Hunan	01/14/09	County Health Bureau	Bureau Head
HNGH31	G	Hunan	01/14/09	County People's Hospital	Doctor
JSHW34	H	Jiangsu	03/04/09	County Health Bureau	Administrator
JSHH35	H	Jiangsu	03/04/09	County People's Hospital	Doctor
JSHH37	H	Jiangsu	03/04/09	Village Clinic	Administrator
JSIW39	I	Jiangsu	03/05/09	County Health Bureau	Bureau Head
JSIH40	I	Jiangsu	03/05/09	County People's Hospital	Doctor
JSIH42	I	Jiangsu	03/05/09	Village clinic	Administrator
JSJW44	J	Jiangsu	03/08/09	County Health Bureau	Bureau Head
JSJW45	J	Jiangsu	03/08/09	County Health Bureau	Administrator
JSJH46	J	Jiangsu	03/08/09	County People's Hospital	Doctor
JSKW49a	K	Jiangsu	03/09/09	County Health Bureau	Deputy Head of Bureau
JSKW49b	K	Jiangsu	03/09/09	County Health Bureau	Administrator
JSKW49c	K	Jiangsu	03/09/09	County Health Bureau	Administrator
JSKH50	K	Jiangsu	03/09/09	County People's Hospital	Administrator
JSLW53	L	Jiangsu	03/10/09	NCMS Office	Administrator
GSW54	M	Gansu	6/24/10	County Health Bureau	Bureau Head
GSH55	M	Gansu	6/24/10	Township Hospital	Managing Director
GSH56	M	Gansu	6/24/10	Township Hospital	Hospital Director
GSW57	N	Gansu	6/24/10	County Health Bureau	Bureau Head
GSW58	O	Gansu	6/29/10	NCMS Office	Administrator
GSW59	P	Gansu	6/30/10	NCMS Office	Administrator

Conversations with Villagers:

In each county, I visited at least one village in which I spoke to villagers, individually and in small groups using a semi-structured interview format, but allowing for greater flexibility depending on the situation (Rubin and Rubin 2012). The conversations with villagers were generally more informal, but enabled me to better understand interactions with the healthcare system from villagers' perspectives.

Conversations with Scholars:

I also had numerous conversations, formal and informal, with scholars from Chinese universities whose research examines health policy, some of whom have advised the government on healthcare reform. These scholars are rarely directly quoted in the dissertation, but their views have informed both my fieldwork and my analysis.

III. Survey Data

In addition to semi-structured interviews and other qualitative research, I conducted a survey of over 1,000 villagers and village leaders in Jiangsu, Hubei, and Yunnan provinces in collaboration with Leah Larson-Rabin (Ph.D. Candidate, Department of Political Science, University of Wisconsin–Madison). By utilizing archival and qualitative research from our separate dissertation projects, we were able to design and implement the survey to maximize internal and external validity under challenging research conditions. By subsequently employing survey data to complement my archival and qualitative research, I was able to assess the relationship between state–society dynamics and health policy implementation. I analyzed survey data to test the generalizability of hypotheses generated in earlier stages of my research, and also was able to gather information from village officials that had been elusive during my semi-structured

interviews. We were also able to collect useful demographic and village-level information that is not publicly available: when enumerators interviewed village leaders they inquired about village-level characteristics, such as population and village health facilities.

A. Sample of Localities

For the results of a sample survey to be generalizable to a broader population, the sample must be representative of the target population. In this project, I sought to understand expectations and perceptions of healthcare provision in rural China. While limited resources precluded a nationally representative sample, we were able to sample villagers and village leaders from rural localities in three provinces that vary significantly across socio-economic conditions. In a large, developing country such as China, social policy implementation in general—and healthcare policy in particular—relies heavily on local government’s capacity to implement policy effectively. Additionally, local government often bears a significant responsibility in funding healthcare in China. Therefore, sampling localities with variation in wealth was fundamental to this study. In addition, the three provinces chosen also vary in their approaches to health policy implementation as a whole. Jiangsu has taken a more decentralized approach to health policy implementation, in comparison to Hubei and Yunnan. As discussed in Chapter 4, both funding and policy decisions for healthcare occur at lower levels of government in Jiangsu, generally the county or municipality, whereas the provincial government of Hubei and Yunnan have taken a more active role in standardizing how health policy implementation. Hubei and Yunnan also rely on central government funds for healthcare to a greater degree than Jiangsu.

Therefore, with key independent variables such as wealth and the degree of decentralization of health policy in mind, we purposefully chose a convenience sample of three

provinces: Jiangsu, Hubei, and Yunnan. We chose these provinces for three primary reasons. First, these provinces represent some of the salient socio-economic, demographic, and geographic diversity of the country. Jiangsu is the wealthiest, Hubei is middle-income, and Yunnan is the poorest and most agrarian. Jiangsu is located in the littoral region, while Hubei is in central China, and Yunnan is in southwestern China. Jiangsu and Hubei do not have significant populations of ethnic minorities, whereas Yunnan has a large, but varied ethnic minority population. Having ethnic minorities often changes the dynamics of local politics in Chinese provinces; therefore, we sought to include Yunnan to examine the extent to which the politics of ethnic minorities might impact social policy and local state–society relations, although a nuanced analysis of the politics of ethnic minorities in China is beyond the scope of this dissertation. The second motivation for choosing these three provinces was that Larson-Rabin and I had previously conducted extensive qualitative research in two of the three provinces and, thus, had an understanding of the local context regarding healthcare and environmental issues as well as which topics would be politically sensitive. Third, in each province, we secured a partnership with professors at a local university who agreed to facilitate any necessary local permission to conduct a survey as well as assist us in recruiting students as survey enumerators.¹⁰¹

We then utilized a multi-stage, nested sampling design. Within each province, we chose three municipalities¹⁰² to represent the socio-economic diversity of the province. Each province

¹⁰¹ For example, Yunnan has unusually stringent regulations related to survey research that required the official support of a local university.

¹⁰² Municipalities, also sometimes translated as prefectures or prefecture-level cities (地级市) constitute an administrative unit one level below the province that comprises counties, towns and townships, and villages, (or cities and districts in urban areas).

has between 13 and 16 municipalities. Initial conditions for effective healthcare infrastructure are highly associated with the wealth of the local government, so I therefore sought to ensure variation in this characteristic. Furthermore, since local government is often responsible for funding a substantial proportion of healthcare initiatives, and in some cases funding the majority as in wealthier provinces, capturing this variation was crucial to understanding how implementation varies when controlling for wealth. We measured wealth by using the most recent statistics available for the municipality's gross regional product per capita; these are published by the provincial government in statistical yearbooks. Below the municipality, localities were chosen in a nested, randomized fashion. Specifically, three counties were selected randomly within each municipality, and then three townships and two back-up townships within each county were selected. Finally three villages and two back-up villages were also selected within each township. We instructed teams to visit three townships per county and two villages per township, where possible. Some teams were able to visit additional villages and townships, which had been selected as back-up localities. We include data from those localities in the dataset since those villages were also selected according to the same nested, randomized sampling method.

Publicly available lists of counties and townships were reliable, but additional information that would have been required for a probability sample or for a stratified sample was not reliably and consistently available in all provinces. Therefore, we elected to select counties, townships, and villages within each municipality randomly. At the village level, sampling presented additional complications. Through publicly available sources, we were able to compile lists of village names within the townships selected and we then sought to identify and confirm

village names and locations through satellite mapping.¹⁰³ However, a fair amount of flux has occurred with village boundaries and villages may change names or be amalgamated when local authorities see fit. Therefore, occasionally, the names of villages in our sampling frame were inaccurate. Further information at the village level, even basic demographic information such as population, is not consistently publicly available without permission from local government (usually the township government). Obtaining this type of information from over 80 townships would not have been feasible given the resources available. Therefore, we selected villages randomly, rather than probabilistically. However, because lists of village names were not always updated and because some villages were so remote that they were inaccessible or dangerous to travel to, we sampled back-up villages. Teams of enumerators were instructed to attempt to visit the villages that were sampled first and then visit back-up villages in the event that sampled villages were not accessible or village officials refused to participate. In fact, no team encountered a village where all officials refused to participate nor did any officials express concern about official permission, thus, the latter was not a problem. The final sample visited by enumerators comprised three provinces, nine municipalities, 27 counties, 83 townships, and 170 villages, 299 village leaders and 801 villagers.

B. Sample of Individuals

We were not able to gain access to local registries of villages or households and, therefore, had to rely on limited, and sometimes outdated, public records to create the sampling frame of localities. For individual-level sampling, certain teams were designated as enumerators for officials and others were responsible for villagers. For officials, enumerator teams went to the village committee's office and spoke to at least one village leader. In most cases, enumerators

¹⁰³ We used Google Earth, which we found to be highly reliable and as current as possible.

were able to interview two or more village officials. In most villages, there are between 5 and 15 people on the village committee who are chosen through a combination of nomination and popular election by villagers. Previous research has examined the quality and consequences of village elections for local government accountability and democracy (e.g., Manion 2012; Luo et al. 2010). Enumerators were instructed to speak to whichever officials were available and could provide the basic village-level information that appears in the questionnaire. Thus, the sample of officials is not a probability sample. The other enumerator teams were instructed to find the main village intersection of roads, and fan out in different directions, seeking willing respondents at every fifth door until they had completed two interviews each or time was up. Our goal was two interviews with officials and four interviews with villagers per village. Sometimes the enumerator teams were unable to meet this target because of access to willing respondents or time constraints, and sometimes they were able to exceed the target.

Enumerators reported few difficulties with nonresponse. In fact, although we had been advised by local scholars to avoid some topics because they might be politically sensitive, villagers and officials were, by and large, more forthcoming than we and the enumerators expected. There were only a few regions where enumerators encountered significant problems with response. In Suzhou (Jiangsu), the wealthiest municipality in the sample, enumerators reported that residents were standoffish, unfriendly, and often unwilling to participate in the survey. According to enumerators, because they were relatively wealthy, they were not enticed by the small gifts offered for participation. In Zhaotong (昭通) in Yunnan, one of the poorest municipalities in China, enumerators were not always able to travel to the counties and villages in the sample and had to go to back-up localities instead, because of lack of infrastructure, bad

weather, and precarious travel conditions, such as landslides. In Yuxi municipality (Yunnan), some interviews were cut short because farmers were in the midst of a harvest and had to return to their crops after about 20 to 30 minutes. In general, the completion rate was very high, even for questions that may be deemed political sensitive or personal, and the instrument typically took about 50 minutes to complete.

C. Implementation

We collaborated with local universities in each of the three provinces to implement the survey. In each province, at least one local professor assisted us in recruiting appropriate students to apply to be enumerators. In Jiangsu, all students were graduate students and students from one university had previous experience conducting health-related surveys in local hospitals. In Hubei, students were advanced undergraduates from a variety of majors without previous survey experience. In Yunnan, students were a mix of advanced undergraduates and graduates and approximately one-third had experience conducting surveys on health policy in rural areas. The majority of students were from the provinces in which the survey was being conducted, and many students were local to the prefectures and counties that contained the target villages, which improved communication and comprehension in those villages where villagers only spoke a local dialect. In addition, there were almost always two students—one male and one female—who conducted each questionnaire together.¹⁰⁴ This allowed the enumerators greater flexibility and improved accuracy in communication and note-taking. It also helped to neutralize potential bias introduced in those communities where gender roles affected villagers' willingness to participate and/or share honestly about more sensitive issues. The questionnaire took an average of about 50 minutes to complete. In some cases, because the interview might occur during daily chores, such

¹⁰⁴ In a few cases, a team member fell ill and some questionnaires were administered by only one enumerator.

as washing clothes, preparing dinner, or returning from work in the fields, an interview may have taken longer.

In each province, we conducted a three-day training for enumerators, which included an exam to test students' knowledge and a pre-test in a local village. In addition, we reserved the right to dismiss students who did not meet our criteria. The three-day training included an introduction to survey methods, sensitivity training for conducting research in rural China, and practice administering the survey instrument to each other. The training culminated in a pre-test in a local village, which enabled us both to refine the survey instrument to local conditions and to evaluate the enumerators' performance. For students without previous experience conducting a survey, the pre-test was essential to dispel some of the trepidation that they felt in asking questions of strangers, and reassured many who were concerned about whether respondents might perceive the questions as personally or politically sensitive.

When beginning the questionnaire, enumerators would record the village name, sex of the interviewee, descriptive notes about the appearance of the household, date of the interview, the time the interview started, any concerns about the interviewee's attitude (were there any questions about the perceived enthusiasm of the interviewee to participate), apparent language barriers, and whether there were any other people (including children) present. Respondents were compensated with a small gift as a gesture of appreciation for participation. Gifts were chosen to be appropriate to the income level of the locality, such as a bar of soap, high-quality winter socks, or a thermos for tea. In the wealthiest municipality sampled, villagers declined gifts.

Surveys in China often suffer from low quality responses and there have been incidents reported of fraudulent data where enumerators fill in the questionnaires themselves. In addition,

since enumerators were travelling to areas with which they were not familiar, we felt that it was important for enumerators to conduct each interview as a pair and to travel in small groups of three to five pairs (six to ten students). The safety of our enumerators was of utmost importance and we wanted to ensure that they would not be put in difficult or dangerous situations alone, particularly in the case of young women. Therefore, to ensure safety and improve reliability of the data collected, enumerators conducted interviews in pairs, generally a man and a woman. In rare cases, gender parity was not possible. In addition, most pairs included one person who could speak the local dialect to facilitate communication. We then grouped three or four pairs into a small team and each small team was responsible for the villages sampled in a particular municipality. The team travelled together and visited each village together.

The target of the survey was both village leaders¹⁰⁵ (officials) and villagers. However, we were concerned that if village officials learned of the survey, they would either accompany enumerators to conduct the interview or would suggest villagers to interview, as had occurred at times during my qualitative research. In order to avoid this problem, we instructed each small group of enumerators to travel to villages together and interview village officials and villagers simultaneously. One pair interviewed village officials while the other three or four pairs interviewed villagers. By conducting the interviews simultaneously, we were able to prevent officials from influencing villagers' responses.

In consultation with local collaborators, we determined that the most appropriate time to conduct the survey would be towards the end of the university winter vacation during Lunar New Year or Spring Festival, as it is generally known in China. This timing had two principal

¹⁰⁵ As mentioned in the Introduction, I use the term "village leader" to denote an individual who is serving on the village committee or a village "cadre" (*ganbu* 干部).

advantages. First, since enumerators were university students, they could participate in the project without disrupting their studies. Second, rural areas are generally in a state of festivities during this period. Therefore, villagers and officials have fewer work or farming-related demands. In addition, some migrant workers return home, allowing us to gain a fuller understanding of the dynamics of the village. While migrant workers were not the target of this project, those who were in the village at the time of the survey could also have been chosen as respondents. In accordance with the university schedules of our local collaborators, the survey was administered during Spring Festival of 2012.

D. Measurement and the Process of Drafting the Survey Instrument

The questionnaire, sampling, and preparation for the survey were likewise informed by data accumulated through archival research and the semi-structured interviews from my own research and Larson-Rabin's independent research on environmental, political, and social dynamics in rural China. The majority of questions in the instrument are closed-ended questions. However, the instrument does include some open-ended questions and we encouraged enumerators to provide supplemental information. Enumerators then had a full page to write additional notes and or anecdotes that interviewees shared with them, as well as any concerns, such as interruptions by the interviewee's superior or other people who may have joined the interview or influenced the interviewee's responses.

The survey instrument is divided into eight sections: personal characteristics and demographic information; local environmental conditions; healthcare usage and perceptions; the legal system; trust and relationships with others; sources of news and information; attitudes about social issues and the government; salary, political participation, and other sensitive

questions. We chose this order to ensure that the data of particular relevance to our two projects would be more likely to be completed along with demographic information, and also so that if the respondent's attitude was affected by the more politically sensitive questions, any resulting discomfort would not increase item nonresponse on the other sections, or cause the respondent to end the interview prematurely.

A pre-test in each province, for a total of three pre-tests, also enabled us to adapt the survey instrument in both form and content. First, the questionnaire needed to be revised to reflect local conditions and to ensure that questions were worded as clearly as possible in plain language that villagers could readily understand. Through discussions with our local collaborators and local enumerators, we were also provided with additional perspectives regarding which questions might be considered politically sensitive in addition to our own experiences conducting qualitative fieldwork. Generally, we excluded questions that were deemed highly politically sensitive by our local collaborators. Moreover, multiple pre-tests allowed us to revise the questionnaire and reduce its length so that the average time for completion was under an hour.¹⁰⁶ The questionnaire needed to be a reasonable length so that the time for participation would not be unduly onerous for villagers and officials; this improved the survey response rate and facilitated the work of the enumerators.

Most of the survey instrument was administered to both villagers and village officials. However, a few questions related to the village, such as village population, were asked only of village officials. Opinion questions related to perceptions of government and local leaders were

¹⁰⁶ The mean time for completion was 55 minutes with a standard deviation of 15 minutes, a minimum of 15 minutes (an incomplete questionnaire) and a maximum of 128 minutes.

modified to reflect the position of a villager or village leader. Thus, we have been able to conduct analysis related to the differences in perspectives between villagers and village officials.

By conducting extensive training of enumerators, communicating with enumerators while they administered the survey, and utilizing three pre-tests to revise the instrument, we sought to ensure that the data collected were as reliable as possible.

E. Limitations and Potential Sources of Bias

To the extent that there is non-response, whether item non-response or selected individuals refusing to participate in the survey, one may argue that villagers who are more satisfied with the regime would be more likely to participate. On the one hand, this is possible. But on the other hand, enumerators consistently found that villagers who had a problem with government (local or national) would try to complain to them and try to get enumerators to intervene or inform the media on their behalf. On several occasions, enumerators had to explain that they were there in only a research capacity and not to lobby on behalf of villagers. It is possible, however, that people in communities that have suffered extreme political repression may be reticent to respond openly to a survey. Despite having taken precautionary measures to reduce bias introduced by, for example, the presence of local officials during interviews with villagers, we could not completely eliminate this possibility. The survey was conducted in an authoritarian country. Therefore, I interpret the results with caution, and assume that there may be some bias in favor of the government. Another way in which we sought to reduce this was to ensure that the majority of questions in the survey instrument were not generally considered politically sensitive. Those questions that may be considered politically sensitive were relegated to the final section of the instrument. Although bias from political pressure is not completely unavoidable (much as

pressure to deceive enumerators for social, psychological, or political reasons would be present in a democratic setting), we sought to reduce this as much as possible. Significant proportions of respondents were willing to rate the government (local and national) unfavorably in different categories, suggesting that many respondents were willing and able to express their views, including negative opinions of the government.

Overall, our sample of villagers roughly reflects the demographic composition of rural China (Tables D.2, D.3, and D.4). There is one noticeable discrepancy, however, that could have implications for our analysis: our enumerators disproportionately interviewed communist party members. Communist party members comprise about 6 percent of the population in China (and much less in rural areas), but 9 percent in our sample of villagers. This slight over-representation of relatively “elite” villagers certainly affects inference drawn from our survey data. However, given that my main research questions are related to state legitimacy and state–society relations, the over-representation of CCP members does not preclude useful analysis of these data. CCP members tend to be more politically active, more educated, but also more critical of state policies. In addition, as CCP members are leaders in their communities, I expect that their views have a greater effect on other villagers and the potential for anti-government action than non-CCP members. Therefore, by including a slightly higher proportion of CCP members than is representative, our survey data are more closely reflect the positions of those villagers who play a leadership role in their communities. Also, party membership is always used as a control variable in my analysis, thus, I do not anticipate that this would preclude inference from our data.

Table D.2: Demographic Characteristics of Respondents

Villagers	Jiangsu		Hubei		Yunnan		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Women	118	46%	134	46%	129	51%	381	48%
CCP	22	9%	32	11%	17	7%	71	9%
Ethnic minorities	0	0%	28	10%	47	19%	75	9%
Total	258	100%	292	100%	251	100%	801	100%

Village Leaders	Jiangsu		Hubei		Yunnan		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Women	20	19%	27	28%	10	11%	57	20%
CCP	85	80%	80	82%	68	78%	233	80%
Ethnic minorities	0	0%	8	8%	16	18%	24	8%
Total	106	100%	97	100%	87	100%	290	100%

Source: Author's original survey.

Table D.3: Age of Respondents

	Obs.	Mean	Std. Dev.	Min.	Max.
Jiangsu					
Villagers	257	48.03	14.19	19	93
Village Leaders	105	44.69	11.75	21	81
Hubei					
Villagers	290	48.26	13.81	17	87
Village Leaders	97	46.46	11.79	24	86
Yunnan					
Villagers	243	43.57	16.63	17	81
Village Leaders	87	45.02	8.43	25	67

Source: Author's original survey.

Table D.4: Education Level of Respondents

Jiangsu				
	Villagers		Village Leaders	
	Count	Percent	Count	Percent
1: No schooling	40	16%	2	2%
2: Primary school	64	25%	5	5%
3: Junior high school	90	35%	20	20%
4: High school	48	19%	41	41%
5: College and above	12	5%	32	32%
6: Other*	3	1%	0	0%
Total	257	100%	100	100%
Hubei				
	Villagers		Village Leaders	
	Count	Percent	Count	Percent
1: No schooling	22	9%	1	1%
2: Primary school	77	30%	5	5%
3: Junior high school	117	46%	35	35%
4: High school	59	23%	39	39%
5: College and above	12	5%	16	16%
6: Other*	4	2%	0	0%
Total	291	113%	96	96%
Yunnan				
	Villagers		Village Leaders	
	Count	Percent	Count	Percent
1: No schooling	47	18%	0	0%
2: Primary school	82	32%	7	7%
3: Junior high school	79	31%	42	42%
4: High school	28	11%	34	34%
5: College and above	15	6%	4	4%
6: Other*	2	1%	0	0%
Total	253	98%	87	87%

*Responses to Option 6 included three graduate or professional school responses, five descriptions that were unclear, and one “self-educated” response.

Source: Author’s original survey.