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**Economic Crisis and China's 2009
Health Reform Plan:
Rebuilding Social Protections for
Stability and Growth?**

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Abstract

Economists analyzing the 2008-09 international economic crisis have argued that if China is to emerge successfully and build a more stable economic growth model for the future, it needs to develop its systems of social risk protection so as to encourage its people to spend rather than save. China's new health reform plan, announced in April 2009, appears to be geared to tackling this issue. It is aimed in part at extending health risk protection and delivering universal access to health care, and is an attempt to reverse the decline in health risk protection that has taken place since 1978. This paper discusses the plan, its origins and likelihood of success. It argues that the plan's social protection goals are relatively modest and may not be sufficient to dramatically shift the saving and patterns of the Chinese population. They are also likely to be difficult to implement evenly and will in the medium term leave significant pockets of insecurity. Meanwhile China's health reform strategy will remain highly contested and shaped by established interests in the health system.

1. Economic Crisis and Social Protections

Economists analyzing the 2008-09 world economic crisis have argued that if China is to emerge successfully and build a more stable economic growth model for the future, it needs to develop its systems of social risk protection. They argue that China's dependence on exports has been the reason that it has suffered during a crisis that saw international demand for the goods it produces decline precipitously. Their logic is that if China had better systems of social risk protection, people would not feel it necessary to save for their old age, or in case of ill-health or unemployment, and would spend more, boosting domestic demand for goods and reducing the dependence of Chinese manufacturing on exports. Stephen Roach, Asia Chairman of Morgan Stanley, is for example reported to have urged the Chinese government to make "massive and sustained investment in social safety nets, and build social security, state pensions and insurance for medical and unemployment needs" (DiBasio, 2009; see also Lakshamanan 2009).

The background to such analysis is the significant erosion in social safety nets and protections during the first 20-25 years of the reform period. Particularly in health, the focus of this paper, reforms from 1978 until at least 2003 saw the state retreat from its role in financing the health care system and backing public systems of health risk protection. Declining budgetary commitment and the commercialization and marketization of the health system left the vast majority of the Chinese population exposed to the risk of impoverishment through ill health and many of the poor unable to afford medical treatment.

Since 2002-3, however, and particularly since 2005, there have been some efforts to reverse these trends and perhaps to rebuild health risk protection systems. Notably, in April 2009 the Chinese Communist Party and PRC government announced a new health reform plan with the stated goals of ensuring at least a minimum of public provision (Party Central Committee and State Council 2009). Alongside the plan, the government has stated that it plans to invest 850 billion yuan (US\$124 billion) over the next three years to achieve ambitious goals that include guaranteeing every urban and rural resident access to basic health care services (Xinhua, 6 April 2009).

This paper argues that the 2009 plan appears to signal a turn toward focussing on health risk protection and away from the previous emphasis on market-oriented, pro-private health reforms since the 1980s. The plan is not directly a product of the economic crisis, because the decision to review health system reform was taken well before the crisis began. In fact, the reorientation in health embodied in it was catalyzed by the 2003 SARS crisis but also, importantly, by CCP General Secretary Hu Jintao's orientation toward rural issues and *social* as well as economic development. And this in turn appears to be a response to the political problems created by marketizing and commercializing reforms across the economy and in other social policy arenas, including health. In health, the market-oriented reforms, particularly since the mid-1990s produced widespread dissatisfaction. Although problems with the health system have not resulted in street protests in China, they have led to an increase in violence against medical professionals and a great deal of discussion in the media. As a result, it seems that the Hu/Wen leadership has been concerned about its detrimental impact on 'social harmony'. For this reason, the pro-market and pro-private direction of health reform began to be questioned in late 2004, and a review culminating in the 2009 plan was initiated in 2005.

The reform initiative's political impetus may, however, have been bolstered by the arguments of international economic analysts in 2008-09 on the importance of social protections for economic growth less reliant on exports, and the health reforms may have remained a leadership priority despite the potential distractions of the economic downturn. While, the government's economic stimulus package may have taken resources that would otherwise have been invested in the health system, those reforms have remained high on the central government agenda, and the stimulus package is sometimes reported as including health investment (*China Daily*, 29 October 2009).

But while high on the agenda, the reform plan was highly contested by influential interests in the health policy arena. As a result, its goals are relatively modest and may not be sufficient to dramatically shift the saving and patterns of the Chinese population. They are also likely to be difficult implement evenly and will in the medium term leave significant pockets of insecurity. Meanwhile China's health reform strategy will remain highly contested and shaped by established beneficiaries of the previous market-oriented reforms in health.

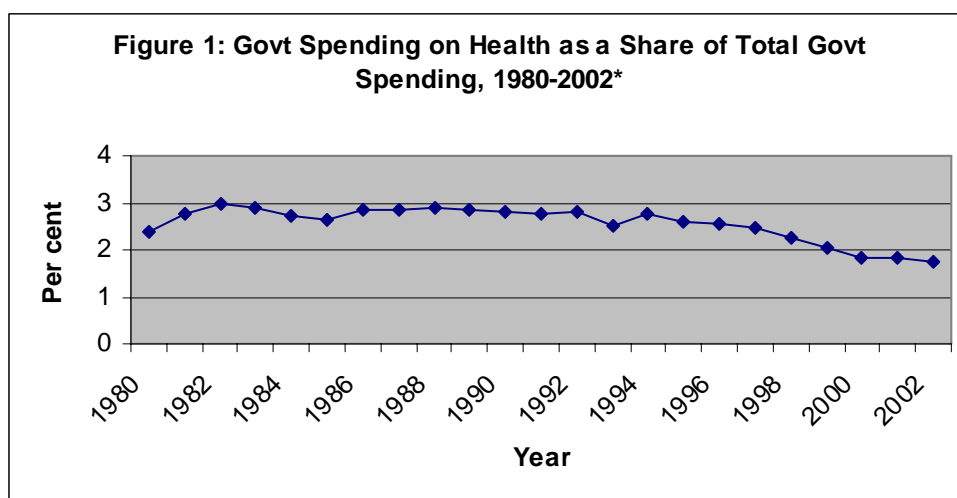
The paper begins by setting out the pattern of decline in health risk protection over the reform period. It then examines the content and goals of the 2009 health reform plan and looks at the reasons—including the impact of the economic crisis—for the apparent reorientation that the plan appears to signify. Finally, the paper considers the obstacles to implementing the plan and delivering on its promises to rebuild social health risk protection.

2. The Erosion of Health Risk Protection Since 1978

China's market-oriented health reforms are conventionally dated back to 1985, when the State Council issued a notice approving and distributing a Ministry of Health 1984 'Report Concerning Some Policy Problems in the Reform of Health Work' (Cao and Fu 2005).¹ This document permitted increases in the fees charged to patients, something which raised costs and undermined the accessibility of health care, particularly to poorer segments of the population. But pro-private policies and the seeds of a pro-market stance can be traced back to the late 1970s, when the Ministry of Health began to promote 'economic management' in hospitals: giving them greater financial responsibilities and autonomy—and thus the incentives to try and

¹ The State Council Notice was document Guofa (1985), No. 62.

generate income from providing care. The Ministry also in 1980 sought permission for small scale private health practices that in many rural areas soon replaced collectively-funded clinics. And in 1981, the Ministry abandoned its commitment to rural cooperative medical schemes that had provided farmers some assistance with the costs of their health care.²



Source: Ministry of Health, *China Health Yearbook* (Beijing: renmin weisheng chubanshe, various years).

* Data is for recurrent health spending (*weisheng shiye fei*), but capital spending also followed a similar trend.

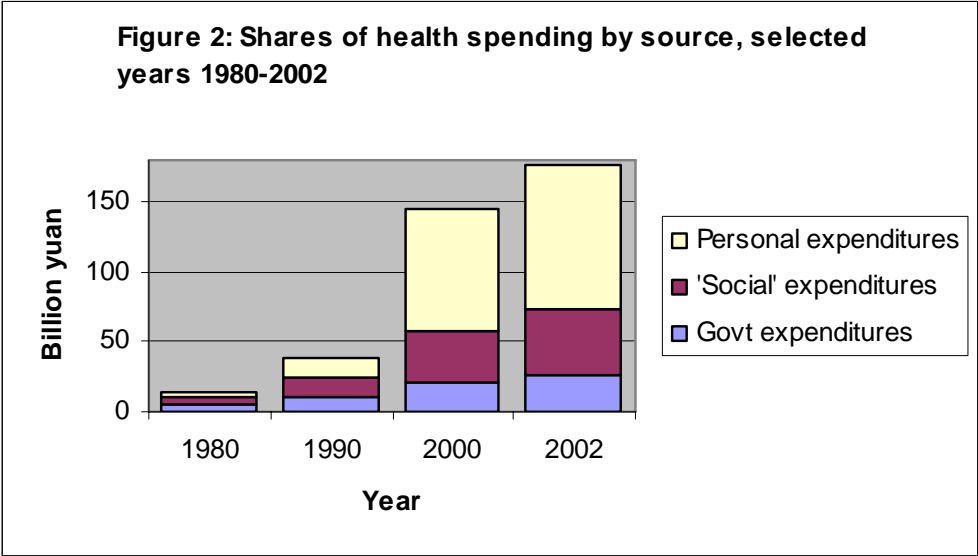
These policies from the late 1970s in the 1990s began to produce real problems in the context of declining government shares of spending on health, both in relation to total government spending (see Figure 1) and in relation to total health spending (see Figure 2).³ With little investment, hospitals relied increasingly on revenues from medicines and certain diagnostic tests and treatments. This pushed up health costs, making it difficult for farmers, now usually with no insurance at all, to afford treatment. But it also began to impact on the cities, where state-backed insurance schemes for government employees and those in state enterprises (and some urban collectives) were put under pressure. Failing state enterprises in particular found it difficult to continue paying for their employees' treatment, and began to renege on their commitments. Meanwhile the growing numbers of people working in the non-state sector usually had no insurance at all. And for these people, too, the costs were often prohibitively high.⁴ Overall, the share of the urban and rural populations with social health insurance of some

² The government documents permitting these developments include: A Ministry of Health, Ministry of Finance and Ministry of Labour 'Notice Concerning strengthening hospital economic management trial work', issued in April 1979, according to *Caijing*, 15 November 2007. Then in June 1979, the Ministry of Health issued 'Implementing Measures Concerning Strengthening directly subordinate and dual leadership non-profit institutions financial management work', which allowed hospitals to keep surplus revenues. A key document relating to private practice in health was the Ministry of Health, 'Weisheng bu guanyu yunxu geti kaiye xingyi wenti de qingshi baogao' (Ministry of Health Report Asking for Instructions Concerning the Question of Permission for Individual Health Practices), 20 August 1980', in Ministry of Health, ed. (1982). For a discussion, see Duckett (forthcoming). On September 23, 1992 the State Council issued 'Some Opinions Concerning Deepening Health Reform'. This document instructed hospitals to earn their own income, according to *Caijing*, 15 November 2007. It started a new wave of health reform and it was after this that a debate started within the Ministry of Health over state versus market. See Cao and Fu (2005).

³ On September 23, 1992 the State Council issued 'Some Opinions Concerning Deepening Health Reform'. This document instructed hospitals to earn their own income, according to *Caijing*, 15 November 2007. It started a new wave of health reform and it was after this that a debate started within the Ministry of Health over state versus market. See Cao and Fu (2005).

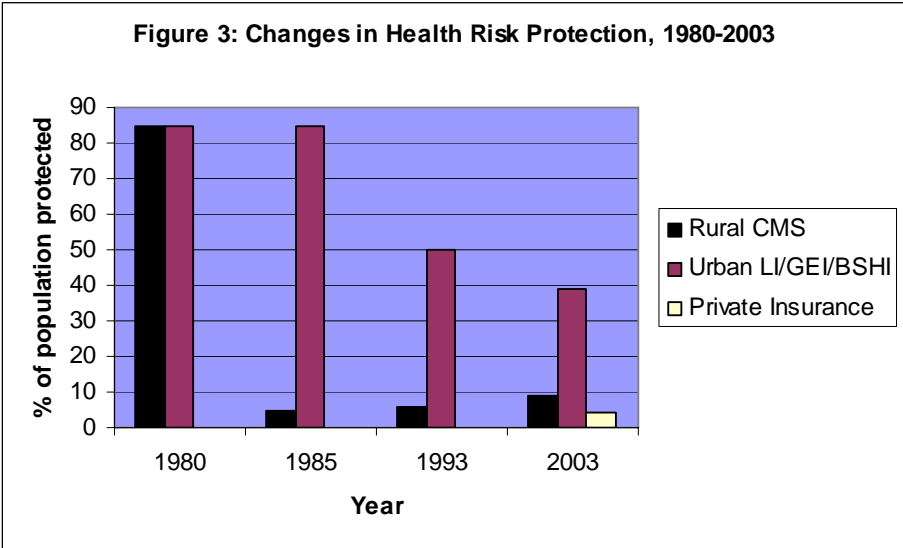
⁴ For a fuller discussion of these issues, see Duckett (forthcoming). Note that a key health reform document in 1997, a Party Centre and State Council 'Decision Concerning Health Reform and Development', advocated a two-tier health system, with economically more advanced areas developing systems at the level of middle-income countries and less developed regions developing systems at level of developing countries.

kind (either cooperative medical schemes (CMS) in rural areas or in the cities labour insurance, government employee health insurance or employee basic social health insurance) declined from the early 1980s until at least 2003 (see Figure 3).



Source: Ministry of Health, *China Health Yearbook* (Beijing: renmin weisheng chubanshe, various years).

At the turn of the 21st century, however, the pro-market, pro-private voices in the Ministry of Health remained influential, as they argued that the problems in health were due not to marketization but to the damaging residual influence of overweening state intervention. In February 2000, the State Council issued its ‘Guiding Opinions Concerning Urban Medical and Health System Reform’, which encouraged medical institutions to combine or cooperate and set up groups (*jituan*) and profit-type medical institutions, liberalization of medical treatment prices, and business autonomy in accordance with the law and paying taxes in accordance with the regulations. This document is said to have paved the way for the first public hospital sale later in the year in Jiangsu (Suqian city) (Cao and Fu 2005). It is from this point that the privatization of public hospitals began.



Sources: various (details available from author on request). Note that percentages are of the rural population for rural CMS, and of the urban population for labour insurance (LI), government employee insurance (GEI), basic social health insurance for employees (BSHI) and private insurance.

3. The 2009 Health Reform Plan

But during April 2009, in the midst of the economic crisis, the Chinese party-state produced its health reform plan. The Party Central Committee and State Council ‘Opinions on Deepening Medical and Health System Reform’ (hereafter ‘The Opinions’), though not themselves detailing spending plans, set out the goals, principles and key elements of the reform plan and established broad goals for both 2011 and 2020 (Party Central Committee and State Council 2009).⁵ The Opinions identified nine problems with the health system: urban-rural and regional inequalities in health work development; irrational resource allocation; weak public and community health work; incomplete medical insurance systems; irregularities in medicines production and distribution systems; imperfect hospital management systems; inadequate government spending on health; health spending rising too quickly; and too large a health (spending) burden on individuals.

The Opinions set out strongly the need to keep the public medicine and health’s public welfare nature’ (*gongyi xingzhi*), preventive health as the mainstay, rural areas as the focus (*zhongdian*), profit and not-for-profit provision, strengthen government responsibilities and investment, and establishing a basic medical and health system that covers but urban and rural residents. And the reform plan’s principles were clearly stated as ‘people-centred, putting maintenance of people’s health rights first’, so that all people enjoy basic health services. Again the public welfare (*gongyixing*) nature of the system was emphasized, so that all the people are provided with a basic health system that is a public product (*gonggong chanpin*). Indeed, the document uses the term ‘public welfare’ seven times, fairness (*gongping*)—another key principle—four times, public health (*gonggong weisheng*) 59 times, and public hospitals (*gonggong yiyuan*) 28 times. Overall, there was a strong ‘public’ (*gong*) focus to the plan. In contrast ‘market’ (*shichang*) was used only four times. Similarly, the word ‘non-profit’ (*fei yinglixing*) was used five times while ‘for-profit’ (*yinglixing*) was used only twice. Note, though, that there was a clear statement of the need to use a combination of government guidance and market mechanisms.

Overall the reform plan aimed to make improvements right across the health system, conceiving this as the reform of the ‘four big sub-systems’ relating to public health services (preventive care, education, maternal and child health, mental health, emergency treatment, blood transfusion, health supervision and birth planning), medical services (keeping non-profit providers as the core, and for-profit as supplementary with aim of reaching urban and rural areas), medical security (insurance), and medicines supply. It set initial basic goals for 2011 with further goals for developing a comprehensive system by 2020.⁶ Central to those goals was social health protection and ensuring access to basic health services for all the population so as to tackle the dual problems of ‘seeing a doctor being expensive, seeing a doctor being difficult’ (*kan bing gui, kan bing nan*).

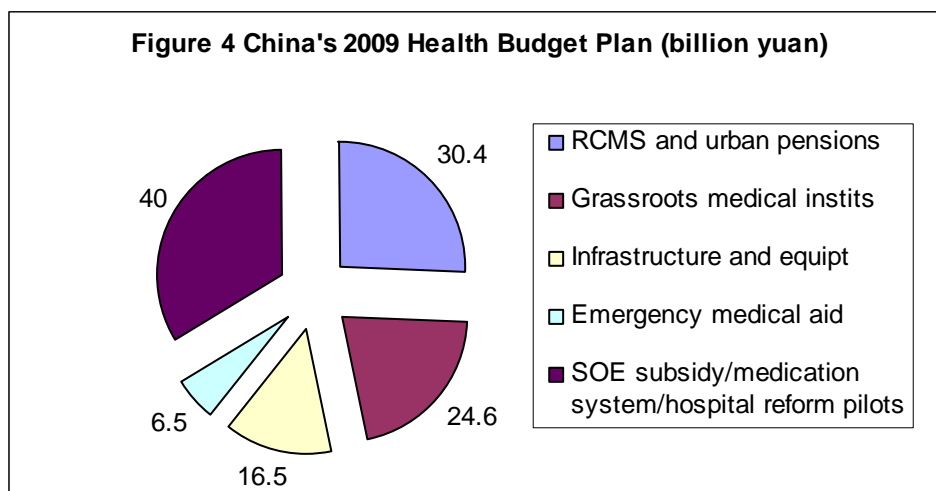
This plan was backed by a pledge of 850 billion yuan of investment in health over three years, of which around 331 billion yuan, around 110 billion yuan a year, would come from the central government (*Caijing*, 19 March 2009). In 2009, 118 billion yuan was budgeted for:

⁵ A second document, ‘Short term major implementation plans on medical and health care system reform’, was also issued in April 2009.

⁶ Other key elements of the plan: ‘a zero-profit system for medication sales’, to be implemented first on a pilot basis, to prevent hospitals making profits from medicines (*Caijing*, 19 March 2009).

‘The 2009 budget plan sets aside 30.4 billion yuan for building rural medical cooperatives across the country and subsidizing the old-age pensions for urban dwellers. Grassroots medical institutions would share a 24.6 billion yuan subsidy, and more than 16.5 billion yuan would be used for infrastructure and equipment at various levels of public hospitals and clinics, with special attention paid to 29,000 rural and township clinics and community medical service institutions. In addition, about 6.5 billion yuan would be poured into the emergency medical aid system. The remaining 40 billion yuan would be spent on helping money-losing state-owned enterprises pay social insurance for their employees and retirees, establishing a nationwide basic medication system, controlling major contagious diseases, subsidizing free public medical services, and supporting pilot reforms at public hospitals’.

As this breakdown indicates, much of the planned spending will go to health institutions rather than to social risk protection (see also Figure 4). Although building up primary care institutions is important to increasing people’s access to health services, and to the sustainability and impact of health risk protection systems (rural CMS and urban health insurance), and the investment in primary care is a shift away from policies that benefit elite city hospitals, it does indicate the continued influence of powerful interests within the health system as compared with those of patients and the rural population in particular.



4. Tracking the Health Reform Reorientation

4.1 Post-2003 Developments and the Impact of the SARS Crisis

The 2009 health reform plan had been almost four years in the making after the central government in late 2005 initiated a review of its two-decade approach to health reform. Although it is difficult to establish the precise decision that set in train the events leading to it, or the reasons for a break with the previous trajectory of health reforms, they can be traced back to changes within the Ministry of Health in late 2004, when critics of market-oriented, privatizing health system reforms apparently began to prevail over the pro-market voices that had dominated since at least the mid-1990s. These changes are in turn connected with a shift in the party-state leadership’s overall development strategy in 2003-04 and the growing ‘new left’ voices challenging the neoliberals who had dominated in the 1990s.

The 2003 SARS crisis also may have contributed to questioning of the previous health system reform trajectory. That crisis, in which a highly infectious disease spread rapidly, demonstrated (while China was in the international spotlight) not only that health reporting systems were poor but also that many people were not seeking treatment because they could not afford it. This meant in the immediate context of the crisis that it was difficult to trace the spread of SARS, so that the government was forced to declare that people would be exempted from the costs of treating it. In the aftermath, however, with the Minister of Health sacked and replaced by Vice-Premier Wu Yi, the health system and recent health policies came under scrutiny. In the summer of 2003, once the crisis had abated, the Ministry of Health sent a team to Suqian to look at their privatization plans and the local health bureau chief was reportedly criticized. Plans announced in 2002 to promote a new rural cooperative medical system that assist farmers with the costs of medical treatment, were given renewed impetus.

But a more thorough review of the health system was not announced until after a report published in a March 2005 supplementary edition of State Council's Development Research Centre's journal, *China Development Review* (2005). This report was highly critical of the health system reforms to date, and its conclusion that they had 'basically failed' received much attention in the national media. The media furor was preceded however by changes in the stance of the Ministry of Health itself. Just before the DRC report hit the headlines in July, Health Minister Gao Qiang (on 1 July) made a lengthy speech that was very critical of the previous health reforms (Gao 2005). Previous to this, on 20 June 2005, Liu Xinming, Policy, Law and Regulation Department Chief within the Ministry of Health, had also said that marketization was not the way forward (Cao and Fu 2005). Indeed discussions among officials within the Ministry of Health challenging the marketization direction in health reform reportedly date back to late 2004 (*Zhongguo qingnian bao*, 3 August 2005).

The health system review, although begun in late 2005, took some time to organize.⁷ In September 2006 a Health Reform Coordination Group was established, and in 2007, opinions were sought from domestic and international researchers. In September 2007, the State Development Reform Commission announced health reform programme had been drawn up and sent to the State Council for approval and would be published soon to get public opinion. In November 2008, a consultation draft was finally published.⁸ The Opinions were finally published in April 2009.

Meanwhile, however, new health policies did advance. First, in February 2006 the State Council issued 'Opinions on Developing Urban Community Health Services', seen by many health system specialists as essential to a more efficient and cost-effective and accessible health system. Second, on 3 July 2007, the State Council issued its 'Guiding opinions concerning developing urban residents' basic medical insurance trials', which ordered trials in 79 cities (*Caijing*, 15 November 2007). This initiative, too, was important to improving people's access to health services: urban health insurance reforms as developed in the 1990s had provided insurance only for people in work, and the urban residents' health insurance (URHI) targeted the non-working population. By 2008, 12.5 per cent of the urban population was reported to be participating in URHI. Third, throughout this period, but especially from 2005, there was a strong push to promote new rural cooperative medical schemes (NCMS) across the countryside. The result was a dramatic increase in the numbers of villages reported to be implementing such schemes, and by 2009 as many as 80 per cent were said to have

⁷ The discussion in this paragraph draws in part on an account in *Caijing*, 15 November 2007.

⁸ The consultation draft was published online and in *Renmin ribao* (People's Daily).

some kind of scheme in place.⁹ The 2009 plan seeks to expand these programmes: URHI in the cities and NCMS in the countryside. In addition, medical financial assistance for the poor continues to develop in many localities as does urban employee basic health insurance (BSHI), in which participation had increased from 30 per cent of the urban population in 2003 to 44 per cent by 2008.¹⁰

4.2 Leadership Effects: Hu Jintao and a More Balanced Development Strategy

Important to the reorientation in health that is signified by the 2009 plan has been Hu Jintao's apparent shift toward a development strategy that encompasses not only economic but also social progress. According to Joseph Fewsmith, Hu succeeded in establishing a distinctive approach to reform within a year of becoming General Secretary of the Chinese Communist Party in November 2002. While not criticizing Jiang Zemin and indeed claiming to be building on Jiang's 'Three Represents' and developing their populist element, he began making a shift from an economic growth-centred development to one that emphasize also social or 'people-centred' development (*yiren weiben*), rural areas and poor regions, and environmental issues.¹¹ Key changes took place at the Third Plenum of the 16th Central Committee in October 2003 and the 5th Plenum in 2005, which set out the principles behind the 11th Five Year Plan. In November 2003 the Politburo formally endorsed his 'scientific development concept' (SDC) (Fewsmith 2004) first articulated in September that year, and 'by early spring 2004, mobilization around [it] had reached a new level', with the Central Party School holding a special study course for provincial and national as well as military leaders, and the March National People's Congress enhancing the SDC's prominence. According to Joseph Fewsmith (2004), the SDC aimed at correcting the overemphasis on economic growth, measured simply in terms of gross domestic product (GDP) that characterized the national development particularly in the 1990s. It places the focus on social as well as economic development and on more balanced growth across regions in China that contrasts with the 1990s strategy of encouraging coastal development and assuming that it would 'trickle down' to other regions in the interior.¹² And as articulated by Wang Mengkui, head of the DRC, the SDC corrected the problems of both state planning and market economy and the gaps and unfairness they had created (Fewsmith, 2004).

The SDC is closely related to Hu's notion of a 'Harmonious Society' (*hexie shehui*), which first appeared in late 2004 and was developed particularly from late 2006. It appeared to be the culmination of several themes developed by Hu Jintao since he had become General Secretary, particularly the notion of 'people at the centre', the SDC and social justice (Fewsmith, 2008). But discussion of the need to promote social harmony is also underpinned by concerns over unrest, protest and dissatisfaction in Chinese society with the government and party-state.

⁹ In late 2006 the Ministry of Health articulated the two key features of health reform as NCMS and urban community health services and said that the aim was to guarantee ordinary people (*laobaixing*) basic medical security. It then state that the NCMS goal was widespread implementation by 2010 so as to prevent impoverishment (*yinbing zhipin, yinbing fanping*). Also this article in discussing the urban community health services development clearly says that the problem is that the big hospitals have been getting too large a share of the investment. So all this rather different from Mao's criticism of urban bias – it does not go that far; but it is taking a very different approach from health reform in the 1990s, which was dominated by efficiency etc issues rather than poverty and 'basic medical security' (Xinhua, 18 Oct 2006).

¹⁰ The source for 2003 is Xu et al (2007); the source for 2008, it is the Ministry of Health (2009).

¹¹ Joseph Fewsmith (2004) reports that 'people-centred' development was 'endorsed' by the 16th Party Congress in autumn 2002.

¹² The SDC also articulates quite prominently a prioritization of environmental and ecological issues that are not directly relevant to the health policies discussed in this paper.

4.3 Health, Balanced Growth and Social Harmony

The SARS crisis may not only have contributed to a rethink on health; it may also have affected the shift to a broader approach to development, or at least to Hu's ability to promote it. According to Joseph Fewsmith: '... perhaps the SARS crisis had allowed Hu to better make the case for comprehensive planning as the crisis showed that jolts to economic development could come just as easily from society as from the economy, and "such unfavourable factors cannot be eliminated by seeking growth alone"' (Fewsmith 2008, p 252). Certainly, the 2009 Opinions linked the health system reform plans to the wider Hu/Wen development strategy and ideology by making references to both the SDC and a harmonious society:

'Deepening health system reform, speeding up the development of health work ... is a necessary requirement for grasping and implementing the scientific development concept, promoting economy and society and fully coordinating sustainable development. It is an important means of maintaining (*weihu*) social fairness (*gongpingzhuyi*), raising the quality of people's lives, and it is an important task in building a well-off society and constructing a socialist harmonious society.'

The Opinions also note that deepening health system reform 'will help to promote social harmony' (section 2(1)). Similarly, Gao Qiang's 1 July 2005 speech argued the need for 'health work to contribute to the building of a socialist harmonious society' (Gao 2005). And the February 2006 State Council 'Opinions on Developing Urban Community Health Services' mentioned the Scientific Development Concept and 'harmony'. It seems, then that the health system reform review and its new orientation toward increasing government investment and access for all to basic health services, are the result of this shift in the priorities of the central leadership. It is likely that it is this that bolstered the critics of health marketization and privatization within the Ministry of Health.¹³

The Opinions were also in line with the Hu/Wen attention to rural issues. The Opinions stressed the need for a system that provided in both urban and rural areas and specifically mentioned the urban-rural imbalance in allocation of health resources. They also clearly aspired to extending access to basic health services to rural as well as urban residents – in line with the promotion of rural cooperative medical schemes since 2005 (see above).

But why was health reform so important to social harmony? The marketizing and (latterly) privatizing health reforms had created widespread dissatisfaction because they had widened the rural-urban divide in both quality of health services and in people's access to them because insurance systems in the countryside were virtually non-existent from the early 1980s. Although urban health insurance declined in its coverage of the population in the 1990s and into the 21st century, it still provided significantly better coverage (at least for those who had it). But people had other concerns, too, over the apparently unfettered circulation of fake medicines; poor quality health services in poor areas, the high cost of much treatment. The perception that medical professionals' diagnoses and prescriptions were based more on the revenues they could generate than on professional medical opinion led to widespread suspicion and deterred people from seeking care. It also led to an increase in attacks on doctors, widely reported in the media, so that even they became dissatisfied with the direction of health reform. Gradually discussion and debate over the health system were fuelled by growing media attention to these issues.

¹³ The shift within the Ministry of Health may have been relatively late – Fewsmith indicates that leaders began to use the term SDC as early as 2003 and early 2004 but Gao Qiang appears to have first begun to speak in these terms publicly at least only in mid-2005 (see above).

In addition, the PRC, lauded in the 1970s for its health system and the achievements it had made in extending life expectancy and reducing infectious diseases, was now criticized for contributing to impoverishing people and for a resurgence in some diseases. Opinion polls suggest it is a source of concern for people and public dissatisfaction (see *Zhongguo Qingnian Bao* 28 October, 1996, for example). According to *Caijing* (19 March 2009), quoting the Chinese National Health Economic Institute, patients in 2009 still paid about half their medical costs out of pocket. ‘Although that’s down from 60 per cent in the 1990s, it’s still much higher than patient shares in many developed countries. And high costs, along with substandard services, have stirred public complaints’. With the CCP interpreting social unrest as the outcome of people’s concerns over poverty and inequality,¹⁴ health began to receive greater attention from the top leadership than it had in the 1990s.

4.4 The Impact of the 2008-09 Economic Crisis

As we have seen, plans and consultations for the 2009 health reform plan began in mid-late 2005 and were probably set in train earlier that year. That the plan was announced in 2009, in the midst of a wider economic crisis probably had more to do with the heated debates over health reform and contestation and bargaining among its key stakeholders, notably the Ministry of Health and the hospitals it runs, and the Ministry of Finance. It is also likely that pharmaceutical businesses and the local governments dependent on local such local businesses. Other bureaucratic stakeholders will have included the bureau charged with overseeing the pharmaceutical industry and the Price Bureau. Whether or not (and how) discussions among the national leadership on the economic crisis and its stimulus package affected health, we do not know. It is likely, however, that some aspects of the health reforms have been less well-funded than they might otherwise have been, as the central government concentrated resources on infrastructure aimed at preventing too severe a slow down in economic growth and too high a rise in unemployment. Certainly the central government channelled massive spending into to a stimulus package that was heavily oriented toward infrastructural investment. The overall stimulus plan involved investing 4 trillion yuan (\$586 billion), and was supported by increased bank lending, tax cuts and subsidies (Lakshamanan 2009). And there have been accusations that the funding announced to finance the health reform plan is not all new investment, but in fact contained a lot of investment that had been announced or committed earlier (*Caijing*, 19 March 2009).

However, the economic crisis may also have galvanized the leadership to push forward the health reform initiative and particularly its social protection elements – in line with the widespread view that this would stimulate domestic demand and promote longer-term growth. But it may also have been driven by directly economic interests, too: the Chinese pharmaceutical industry has been widely touted as a major beneficiary of the reform plan. Certainly this sector’s profits seem barely dented by the crisis. Moreover, pharmaceutical NPOs on international stock markets since April have been highly successful.

Conclusion

Joseph Fewsmith has argued that in autumn 2004 the central leadership became concerned about the ‘colour revolutions’ in Eastern Europe and that this was linked to criticisms of marketization and neoliberalism as products of the US (and the Washington Consensus) that posed a threat to China. And this is when the concept of a harmonious society began to be

¹⁴ Fewsmith refers to a 2001 CCP Organization Department publication that traced the rise in ‘mass disturbances’ to people’s concerns with poverty and inequality.

articulated as well as the time when the Ministry of Health began to question a development strategy focussed almost exclusively on promoting growth through marketization. It is also in this intellectual context, with anti-neoliberal voices suddenly receiving greater attention, that the DRC's summer 2005 report on the health system should be seen.¹⁵

While we do not yet know the dynamics of the debate within the central party-state and precisely how a questioning of marketization and privatization in the health system emerged, it would seem to be linked to leadership perceptions of the need for more balanced development to reduce conflict and a threat to the PRC political system. That debate is ongoing, however, and the development strategy is still highly negotiated. And in the health sector at least (but likely also more widely), as we have seen, vested interests created over at least 20 years of market-oriented health reform are likely to obstruct efforts to significantly reverse the direction of reform.

But will the 2009 health reform plan establish social health risk protections and encourage people to spend rather than save in case of ill health? The Asian Development Bank's president, Haruhiko Kuroda, in late 2009 praised China's planned expansion of health risk protection, saying that "such measures reduce the need for 'precautionary savings' by the poor and increases money for consumption or more productive savings, which benefits the economy"(Agence France Press, 28 September 2009). And the plan's stated goals certainly indicate that it aims to extend health risk protection schemes to the whole population. But the goals are not radical ones: they only aim to ensure universal access to '*basic health services*', something that is not clearly defined. There are inter-local differences in the generosity of provisions, too, and a rural-urban divide remains, with RCMS (at around 100 yuan per person per year in premiums payments in 2009) less generously financed than urban insurance (8 per cent of annual wage for those in work—around 800 yuan on average).¹⁶ In any case, the plan will not be easy to implement. There are real state capacity problems in areas crucial to providing health risk protection. Notably, there is poor capacity to design and run sustainable localised rural cooperative medical schemes, and in the cities to ensure employer participation in the urban health insurance for the employed, particularly the many millions in informal work. At the same time poor localities will find it difficult to find investment to build up the primary care system that is crucial to providing low-cost care for those with only minimal CMS or health insurance protection.

The schemes now being put in place extend participation broadly across the population, but they are still not generous enough to provide most people with real protection from the risks of ill-health. Changing spending and saving patterns widely across the population therefore remains a long-term goal. While the economic crisis may have added some impetus to initiatives for building social protection, the challenge will be to retain that impetus beyond the crisis and tackle the state capacity problems and established interests that threaten to undermine it. Only then, if we accept the logic of the economic analysts, can China reduce the impact of future economic shocks from collapsing international demand for its goods.

¹⁵ Fewsmith (2008) discusses the late 2004 intellectual debates and criticisms of neoliberalism (that followed on a rumbling debate since 2003) that began to slow SOE reforms because of accusations of corruption in management buyouts.

¹⁶ There is much local variation and so these figures are indicative.

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