Health Privatisation in China:

from the Perspective of Subnational Governments

By

FENG Qian

Submitted to

Central European University

Department of Political Science

In partial fulfilment of the requirements for the degree of

Master of Arts in Political Science

Supervisor: Anil Duman

Budapest, Hungary

2020

CEU eTD Collection

Abstract

From 2009, the Chinese government started to promote the policy *She Hui Ban Yi/SHBY* that encourages private investment in hospitals. This strategy of promoting private investment in hospitals represents the overall privatisation trend in Chinese health policymaking. Building on the national level health policymaking, the thesis focuses on the subnational governments in China and explains why are this national initiative has been implemented differently at the subnational level. Most existing studies in this topic focus either on the national level policymaking, discussing the relations between welfare policies and regime type or ideologies; or on the efficiency of public versus private hospitals in health sector by evaluating the outcomes. The thesis aims to understand SHBY and privatisation in health mainly from the local governments' perspective, analysing how the fiscal survival pressure and political incentives affect the actual health policymaking in local governments in China.

Drawing on official statistics, government policies and existing studies, the thesis mainly consider two types of influencing factors, and categorises three types of responses at the subnational levels. While the implementation of this policy requires a lot of resources and efforts, the thesis emphasises that, firstly, for the local governments, the fiscal impact, especially the hard budget constraint from the central government and soft budget constraint to the local public sector, plays the key role in health privatisation policies in China. Secondly, the political incentives, such as the the possibility of promotion by proving the governance performance might also motivate the local governments to promote this policy, however, the effects are not very clear.

Keywords: welfare policies, central-local relations in China, health privatisation, fiscal federalism

CEU eTD Collection

Acknowledgement

My deepest gratitude goes to my supervisor prof. Anil Duman. I have been a terrible supervisee, but she is the best supervisor I can imagine, giving me persistent feedback and helping me improve my very raw and vague ideas with enormous patience. She has also been a huge inspiration for me both in and out of our classes. I feel very lucky and grateful to have her support. All the potential errors and omissions are my own responsibility.

Many thanks to Minyan for his constructive suggestions; to Zsuzsanna from academic writing centre and my amazing friends Alsu, Ali, Chitrangi and Tilak for their important editing and support. Thanks to people in CEU, especially our political science department, for their kind help.

During my thesis writing, Covid-19 occurred. I feel angry and sad for all the sufferings and difficulties people have gone through, and it also confirmed my belief that health policy is a vital topic to work on. Thanks to Prof. Jeffery Moe who inspired and guided me at the beginning.

In the past two years, my journey in three places - CEU, UNODC Taunggyi and the Hebrew University of Jerusalem - has profoundly reconstructed me. I feel very grateful for the things I learnt and the warmth I received from many wonderful people, especially to prof. Daniel Large, prof. Louise Bethlehem and señor Jaime; to my dear friends Antonia, Ayda, Alex, Anton, Akyl, Faruk, Jinyuan, Manran, Noemi, Qiuye and Ruichuan. Děkuji, vítku.

I am eternally grateful to my family, especially to my parents, for their love and support.

谢谢爸妈，非常感谢你们的爱与支持。

CEU eTD Collection

Table of Contents

Introduction 1

1. Background: SHBY Policy and China's Health System 8

2. Literature Review 15

3. Theoretical Framework 20

4. Analysis I: Health Policymaking and Central-Local Relations 28

   4.1 Government's Involvement in Health 28

   4.2 Explaining Health Policymaking in China 30

   4.3 Central-Local Dynamics 35

5. Analysis II: SHBY and Subnational Government Rationale 37

   5.1 Regions in China 38

   5.2 Fiscal Sustainability as Priority 42

      5.2.1 Hard Budget Constraints, Debt and Social Expenditure Patterns 42

      5.2.2 Soft Budget Constraints and Low Efficiency in Public Hospitals 44

   5.3 Political Incentives and the Cost-benefit of Policy Implementation 47

      5.3.1 Cost: Public Hospitals as Interest Groups and Strategic Spending 48

      5.3.2 Benefit: Political Incentives from the Central Government 50

6. Provinces and Response Types 54

   6.1 Type A: Promoting Privatisation for Fiscal Pressure 56

   6.2 Type B: Promoting Privatisation for Better Performance 59

   6.3 Type C: Not Promoting: Tacit Incompliance 61

Conclusion and Discussion 63

References 65

Appendix: Provincial Data 70

CEU eTD Collection

List of Figures

Figure 1: the proportion of private hospital number and hospital beds in China 9

Figure 2: Different Types of Provincial Social Spending...21

Figure 3 Theoretical Response Model...25

Figure 4 health payment by sources in China from 1980s to 2017..30

Figure 5: the whole health sector in % of the provincial GDP...38

Figure 6 Government Health Expenditure as % Total health Expenditure 40

Figure 7: Government Health Expenditure (GHE) per capita (CNY) 2017. 41

Figure 8: provincial debt as % of provincial GDP..44

Figure 9: Local Implementations to SHBY...54

Figure 10: Response Types...55

Figure 11: Response Type A provinces...56

Figure 12: Response Type B Provinces...59

CEU eTD Collection

List of Abbreviations

CCP: Chinese Communist Party

GHE: Government Health Expenditure

NHC: National Health Council

OOP: Out of Pocket Payment

PRC: People's Republic of China

SHBY: *She Hui Ban Yi*

THE: Total Health Expenditure

WHO: World Health Organisation

CEU eTD Collection

Introduction

China's health system has gone through several rounds of drastic reforms, especially regarding the degree and scope of the state's involvement. Since the most recent health reform initiated in 2009, the government has been promoting privatisation in health, with a focus on private insurance and private hospitals. The promotion of private hospitals has especially raised concerns and prompted debates.

The thesis focuses on the policy *She Hui Ban Yi* [1](SHBY), which is one of the primary national initiatives that has drawn considerable attention. It aims to encourage private investment[2] to build hospitals[3]. There are two puzzles regarding the implementation of this policy. One is that although the national policy paper[4] claims it is a response to the rising health service demand, in some regions, there is also simultaneously rigid restrictions on public hospitals to expand any further[5]. The other is that whereas at the national level SHBY is promoted by ten major ministries, the implementation varies significantly from region[6] to region at the subnational level.

[1] 社会办医. The literal translation is "social force building health sector". Here the terminology "social force" refers to private investments. In China, with Communism being the claimed official ideology, the government has been avoiding using the term "private" in every possible way. The examples are, the privatisation of State-Owned Enterprises (SOEs) in the 1990s was called "changing ownership of SOEs" (国企改制), and private companies are called "people's economy" (民营经济).
[2] It refers to non-government actors such as companies and foreign investment.
[3] The original words refer to medical institutions. According to China Health Yearbooks, medical institutions are grouped into four types: hospitals (general hospitals, Chinese medicine hospitals; Primary medical health centres); clinics in townships; specialised public health institutions (prevention centres, paternal care centres); and others (research centres). Among the four types, private investment engages predominantly with hospitals. Therefore, in the following text, the thesis will refer to this policy as one that encourages building private hospitals.
[4] The State Council of China, "China to increase support for private hospitals to improve medical services". http://english.www.gov.cn/premier/news/2019/05/23/content_281476676388590.htm.
[5] National Health Council of China, "several opinions on controlling the unreasonable increase of medical expenses in public hospitals". The policy paper issued order in restricting public hospitals to expand (in Chinese). http://www.nhc.gov.cn/tigs/s9660/201511/0038da2bf8fe43d69511fb675e205d37.shtml
[6] The thesis focuses on the 31 provinces, province level cities and ethnic autonomous regions, in the following text refers to them as provinces for convenience, also they are all provincial level. It does not include Hong Kong Special Administrative Region (SAR), Macao SAR, or Taiwan.

CEU eTD Collection

Together with other policies in the 2009 health reform, this policy shows that the central government in China attempts to control the overall cost of health. Although public health has gained more attention, the government does not attempt to improve public health through financial support, and it is not the priority on the government agenda. I argue that, since the top leadership has been unwilling to shift from relying largely on economic performance as legitimacy sources to further investing in health, the local governments' fiscal capacity is the key to understanding social policymaking.

SHBY: The National Policy Initiatives and Regional Responses

This section briefly introduces the policy and the relevant academic discussion on the same. At the central level, SHBY is comprised of two components: **limiting the expansion of public hospitals and encouraging private investment to build more private hospitals.** I identify the policy SHBY as an explicit move towards privatisation in health.

The academic definition of privatisation in health has been the subject of debate. Although according to the World Health Organisation definition, privatisation mainly centres on "the change of ownership and government functions from the public to private bodies", there are numerous ways to decrease the public engagement in health. Boorsma (1994) identifies the health sector as a production process from planning, financing, production to distribution. He suggests privatisation can happen in this whole process or some parts of it[7].

In many countries, with the ageing population and developing technology, both the health service demand and the overall cost in the health sector has been growing. Thus, expanding private

CEU eTD Collection

[7] Private organisations and privatisation processes can be linked very differently. Public financing pools can finance private hospitals; public authorities can sign contracts with private insurers; private clinic can provide services for public insurance; medical practitioners can join both public hospitals and private hospitals. Private investment can also take different forms. There are also callings for Public-private partnership (PPP) model, which attempts to combine the human resources in the public sector and the investment from the private sector.

provision is one of the less obvious ways to privatise the health sector (Maarse, 2006). For example, Janssen and Made (1990) have observed that since the early 1980s, many health systems across Western Europe have gradually shifted the financing and provision of health from the public to private sectors. In Israel, while the national health system covers the whole population, one of the policies is to limit the medical students' enrolment within its education system and restrict medical professionals to be employed with foreign education (Reis et al., 2017). In the Chinese case, although other factors such as the efficiencies of the public provision need to be considered, the financing structure is the direct cause for initiating this policy (Huang, 2019).

In the Chinese case, the first wave of privatisation in health is the direct withdrawal of public financing starting from 1980s. The 2009 health reform could be viewed as the second wave, since it is recognized as the beginning of the era with the most encouraging policies for private hospitals in China. In 2009, the National Health Commission[8] (NHC) emphasised the national commitment to private health and included SHBY as one of its main initiatives in the new round of health reform. The central government has continued to introduce further policies. The most recent major one is in 2019 when ten major ministries in the central government published a joint policy initiative to promote SHBY[9].

Since the onset of the 2009 reforms, policy directives affirming the role of private capital in developing health sector firmly sealed the place and position of private participation in the health sector. The importance of growth in the private health sector was highlighted by the Chinese

CEU eTD Collection

[8] In 2013, the Ministry of Health and National Population and Family Planning Commission combined as one agency National Health and Family Planning Commission (NHFPC); from 2018 the name changes to National Health Commission (NHC). Since the division of different ministries do not influence the analysis too much, also to avoid confusion the thesis refers to the national governing body as NHC.
NHC is responsible for drafting laws and regulations for health and family planning. It is also responsible for planning the resource allocation of medical care, public health and family planning services; establishing a basic medicine system to standardize drug prices; formulating China's family planning policy; and supervising and administering public health, medical care and family planning services.
[9] http://www.gov.cn/xinwen/2019-06/12/content_5399740.htm

government in the 13th Five-year Plan (2016-2020). It was also incorporated into one of president Xi's major initiatives known as "Healthy China 2030". The pace and scope of private investment in the health sector began increasing dramatically. The share of private hospitals in the total number of hospitals grew from 30.75% in 2009 to 63.55% in 2018 (China Statistical Health Yearbook, 2019).

Although the policies have been promoted across the whole country, but huge variances are also observed regarding the adaptation of SHBY among different regions, which will be the focus of this thesis.

Research Question and Objectives

By drawing upon these two observed phenomena, I attempt to address two questions in the thesis: Why is the central government promoting private hospitals? And why do subnational governments respond in different ways? It finds that, at the national level, this policy SHBY aims at raising the private provision in health to curb the growing government health expenditure. At the subnational level, however, the dynamics and motivation of selective implementation are more complex and under-discovered.

Level of Analysis

The thesis will first discuss health policymaking at the national level. Since the existing studies are mostly at the national level, and it is necessary to understand the policy SHBY with countrywide consideration, but it ignores the tremendous regional differences.

CEU eTD Collection

The focus of the thesis is on **provincial level subnational governments**[10], while some prefecture level cases are discussed too. Especially in the Chinese case, the subnational governments are the direct policymakers for exact implementations and shoulder the main part of the health expenditures. Thus, in studying social policymaking in China, some scholars suggest bringing the local governments back to the centre of the discussion. The thesis follows this trajectory by employing theoretical frameworks on fiscal federalism and bureaucrats' behaviours and explaining the local governments' responses to the national level imitative SHBY.

In policies or motivations promoted by the national government, like fiscal decentralisation and political tournaments which will be discussed in more details later, one phenomenon usually appears — the national initiatives often have an effect of **vertical magnification**[11] (Que, Zhang and Schulze, 2019)[12].So, in effect, different subnational levels of governments can also be considered similarly. The thesis mainly focuses on the provincial and prefecture level, since both levels are where SHBY related policies have been carried out, and most private hospitals are located in the cities.

Method and Data Sources

The World Health Organisation (WHO) and other international organisations' data on China's health financing is either largely missing or inaccurate. International journal articles do, however,

[10] Here the provincial level refers to provincial level in the Chinese administration system. It includes provinces and four provincial level cities. The division of Chinese subnational government has de jure three levels[10]: the province-level, prefecture-level (mostly cities); below there are counties, townships and villages. Studies about health policy making have been conducted at all levels.

[11] Although the A few studies have been done at the villages level (Luo et al., 2007). Studying the village level politician promotion and public goods investment. But it is not relevant to the private hospital investments. Also, Guo (2007) finds out that informal factors like social network are more likely to operate in the levels lower than the prefectures.

[12] For example, a task commanded by the central government will be carried on by the provincial level, that the provincial level will make a similar task to the prefecture level.

For instance, if at the country level the social policies are made to accommodate its industrial development and it is more or less the case with provinces in China, but the subnational governments have another layer which is the political consideration.

CEU eTD Collection

provide clearer data sources. Unless otherwise indicated, most of the data that I have referred to is sourced from various issues of China Health Yearbook and China Statistical Yearbook. In order to explain cross-regional variances, I take the regional policies as the main measurement for explaining the response types, while taking official data to demonstrate existing patterns.

Contributions and Broader Relevance

In the thesis, I attempt to fill the gap in the existing studies by: 1) bridging the cases of privatisation in health in other countries and that in China, 2) bringing the subnational governments into the centre of health policy studies; and 3) exploring the central-local government dynamics in Chinese welfare policies.

The broader relevance of this thesis is that it could provide a useful framework for understanding health policies and privatisation in health in other countries with similar developmental trajectories. It can provide insight into, for example, how many other low and middle-income countries with limited government health expenditure, such as India and South Africa, or other post-communist countries approach the public versus private share in health expenditure.

On the other hand, by studying the execution of health policy in China, we can better understand the manner in which a federal system of governance negotiates and regulates the central-local dynamics, thereby providing insight into the workings of other similar political setups in different contexts. Furthermore, struggling health systems during the COVID-19 crisis has highlighted the critical importance of understanding development of health policies and their impact on combating health crises.

Roadmap

The thesis is organised as follows: Chapter 1 introduces the policy SHBY and identify it as privatisation in health. Chapter 2 reviews the existing literature on the subject and chapter 3 builds

CEU eTD Collection

a theoretical model to explain the subnational governments' responses to central initiatives. Chapter 4 provides analysis on health policymaking at the central level. Chapter 5 recognises the phenomenon of welfare regionalism and offers two arguments to explain the subnational government health policymaking rationale. It also identifies the implementation cost of SHBY. Chapter 6 offers further illustration with more detailed studies.

CEU eTD Collection

1. Background: SHBY Policy and China's Health System

This chapter presents the details of the policy SHBY and explain it in relation to the hospitals' development with China's health system in the background.

Details of SHBY

In 2009, China initiated a new round of health reforms aimed at responding to widespread public discontent. One of the main initiatives[13] the State Council advocates is the policy *She Hui Ban Yi* – which encourages private investment to build hospitals. There are three major components of this policy:

1. Providing financial support to private investment in building hospitals, such as providing land and funding, tax deduction.
2. Offering administrative support and removing private investment entry barriers in hospital establishment regulation.
3. Limiting public hospitals' expansion. In regions where the hospital bed per thousand people have reached the national standard, the public hospitals will be prohibited to add more beds[14]. At the same time, the policy encourages private hospitals to share public hospitals' resources like sharing expensive equipment, allowing public hospital practitioners to work in private hospitals. It also encourages including private hospitals into the public insurance paying pool.

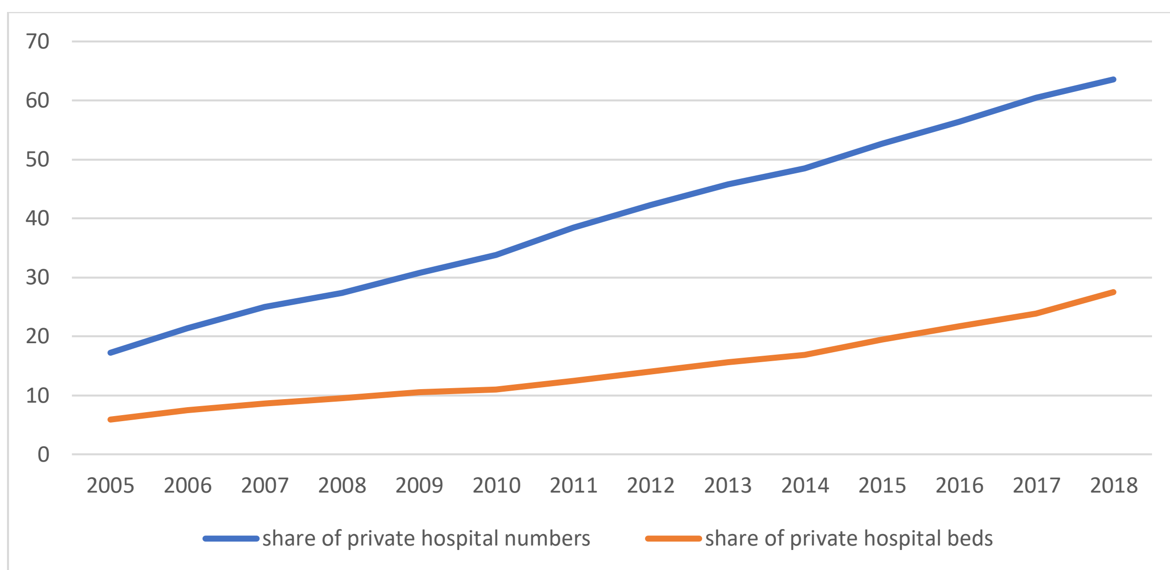
CEU eTD Collection

[13] At the same time, the Chinese government has been advocating other initiatives in the health sector. One is the payment method reform. With the establishment of national health insurance in the last decade, more and more cities have switched from the traditional pay for performance method (which incentives over-prescription and overtreatment) to retrospective payment methods such as prepay at the beginning of the year or DRG (Diagnose Related Groups) payment. Another one is drug price control, that the government regulate the prices of a list of fundamental drugs and set a limit profit proportion. Both initiatives attempt to lower the overall cost, but there is no significantly more amount of government financing to compensated the hospitals' loss. There is a saying in Chinese perfectly described the situation, which translates into "order the horse to ride without feeding it grasses".

The importance of growth in the private healthcare sector was outlined by the Chinese government in the 13th Five-year Plan (2016-2020), while the later "Hospital Construction Guidance," issued in July 2016, encourages investment in private health centres so they can grow in scale and improve the quality of their services. This marks a fundamental change from the previous Guidance issued back in 1994, which defined private hospitals as merely "supplementary" to public healthcare.

During the past decade (2009-2019), there have been a series of encouraging policies[15] following up. The most recent one was in 2019 where ten ministries at the central level issued a joint policy paper[16] to advocate this policy, and the same was also incorporated in one of President Xi's major national development strategy[17] "Healthy China 2030." There is also steady increase in the share of private hospitals both in numbers and hospital beds. See data from 2005-2016 in figure 1.

Figure 1: the proportion of private hospital number and hospital beds in China



CEU eTD Collection

[15]For example, in 2015, the State Council issued policy directives that further encourage private participation in the health sector by providing diagnostic, general and specialized health services, fostering "fair" competition with public facilities such as relaxing entry barriers, and facilitating investments in hospitals and other facilities. Directives also encouraged investment in and formation of non-profit health care organisations.

[16] http://www.gov.cn/zhengce/2019-06/12/content_5399589.htm

[17] President Xi Jinping gave a speech during the opening ceremony of the China International Import Expo in 2018, stating that China is steadily expanding the opening-up of the financial sector, and will loosen limitations on foreign investment in the medical field.

However, we see different levels of responses to this national initiative across regions. The majority of the provinces have followed the national policy and made local policies; some of them set exact goals, such as to level up the private hospital share to a certain proportion, or to change certain administrative procedures. Only a few provinces offered financial support for private hospital investors or set strict limitations on public hospital expansion.

Two questions emerge. The published policy papers claim this policy aims at addressing people's growing demands for health services[18]. Indeed, the health service demands in China are growing because of the changing demographic and socio-economic structure of the population. However, the first question that arises is why promote private hospitals specifically?

On one hand, numerous researches have pointed out the weakest chain in the Chinese health system is at the primary level, in the township and rural areas, while private hospitals are clustered in developed urban areas with the majority of the patients from the urban upper-middle class. For example, one of the main indicators for a country's medical resources related to hospital sizes is the number of hospital beds per thousand inhabitants. The number for China at the national level is 4.2[19], which is not very far from the average number in EU countries, 5.1[20]. In Hubei province, where covid-19 first gained the world's attention, the number is 5.5; and in Hubei's capital city Wuhan, it is 6.5. On the other hand, expanding public hospitals[21] can address the rising demands

[18] It is also promised that private hospitals will be included in the public health insurance paying pool to proof that the government does not attempt to withdraw from its financing responsibilities. This will be addressed later.
[19] WorldBank, https://data.worldbank.org/indicator/SH.MED.BEDS.ZS

[20] https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf

[21] In fact, experts have warned that in China's already highly fragmented health system, privatise health provision will increase administration cost (Hsiao, 2014).

too. However, on the contrary, the national policy has issued strict restriction for public hospitals to expand.

I argue that to answer this question, we need to understand the differences between public and private hospitals, especially from the viewpoint of the government. While factors such as the efficiencies of the public hospitals need to be considered, I identify the financing structures of public versus private hospitals as the key difference. This is contingent upon the fact that the two types of hospitals' funding sources differ. I discovered that when the details of the policy and the government financing channels for public versus private hospitals are examined, it becomes evident that long term cost control is the key to understanding this national policy initiative.

Public versus Private Hospitals

Public hospitals are the core in the Chinese health system. While a large part of the population lives in village or townships, China's medical resources are concentrated in large tertiary hospitals in major cities. The distrust of medical professionals made patients go to big hospitals for medical service regardless of the severity of the illness. As a result, it turned the developing strategy for public hospitals to keeping on expanding the scale to attract more patients; it also facilitates the big hospitals to become more powerful in

The roles of public and private hospitals in China have been controversial especially after its economic reform starting from the 1980s[22]. The division of public versus private hospitals can be very vague, and the additional factor of for-profit versus not-for-profit further complicates the picture. When the government retreated from financing public hospitals in the 1980s, public hospitals are widely recognised as profit-driven (Hsiao, 2014; Eggleston et al., 2017; Duckett,

[22] As mentioned in the previous footnote, while holding on to communism as the claimed official ideology, the economic reform starting from the 1980s have made twisted and confusing changes in each industry on the ownership, financing structure, and management and bureaucracy system. The health sector is no exception.

CEU eTD Collection

2020). Whereas private hospitals usually register as the not-for-profit type to pay fewer taxes. Since the research question focuses on the government's behaviours rather than hospitals'; I will emphasise on the financing structure. The following table illustrates the funding structure difference between public and private hospitals.

Table 1 financing structure differences between public and private hospitals in China

	Public Hospitals	**Private Hospitals**
Staff Salaries	local governments	private investment
Capital Investments	government subsidies; patients; borrowing from the banks	private investment
Operational costs	patients	patients

The major expenditures of hospitals in general can be divided into three parts: staff salaries, capital investments (infrastructures such as land, construction, and medical equipment) and operational costs (drugs, and medical consumables etc.) For public hospitals, the local governments pay for their staffs and fund some part of their capital investments. The funds for the other part of capital investment and daily operation usually comes from the hospitals' revenue, which is from patients eventually[23]. However, with the fiscal burden and expansion strategies, many public hospitals need to borrow from the local banks. For private hospitals, private investors pay for the staffs and the infrastructure; the service gets paid partially by the patients. It becomes clear after examining the differences between public and private hospitals that the governments have different levels of financing input.

CEU eTD Collection

[23] Here the patients' pay includes payment from public insurance, private insurance and out of pocket (OOP) payments. The public insurance is funded by the governments, employers and individuals, but there is no available data on the exact proportion of input.

Variation in Local Implementation of National Policies

According to the calculation in China Health Yearbooks, the total payment in health is categorised into three sections: the government expenditure (Government), social insurance including commercial and employers (Social) and individual out-of-pocket payment (Individual). For the governments, the government mainly funds the health sector by funding hospitals and the public insurance pool[24].

From the governmental side, the central government and the local governments both spend on health, but the central government pays for only around 1% of the total government expenditures. In 2018, the governmental expenditure on health was 27.74% of the total health expenses, and out of the governmental expenditure, only 1.3% came from the central government. Therefore, it is the local governments that primarily take financing responsibility and finance the health sector.

Although people might assume China to be a giant unitary autocratic machine, academic discussions have reached the common understanding that the People's Republic of China has been a political unitary country, but the financial structure adopted a federalism approach. (Cao, Qian and Weingast, 1999; Bahl, 1999; Wong and Bhattasali 2002; Jin and Zou, 2005; Feng et al, 2015).

While the central government maintains tight control over issues with high political sensitivity like propaganda and social protests, the central government permits the subnational governments to adopt the national initiatives differently for economic or fiscal policies with a high-level autonomy (Qian and Weingast, 1996). In some situations, it encourages the local government to experiment with different pilot programs or to carry out radical reforms to gain more policy innovations and

CEU eTD Collection

[24] the national health insurance system consists of three main schemes for different populations covering more than 95% of China's population.

experiences for policymaking (Heilmann, 2008; Zhu, 2016). The question remains, regarding SHBY, why there are variations across regions?

CEU eTD Collection

2. Literature Review

This chapter presents the existing discussion on the topic of privatising health in China. From the perspective of health policymaking, the discussion in welfare policies are highly relevant; from the angle of local implementation, the central-local government relations are also important.

Privatisation in Health

At the national level, the privatisation trend in health has been thoroughly discussed and remains an important agenda, mostly in the European context. The academic discussion on how to measure and what is the effect of the rising engagement of private sector is still ongoing and remains inconclusive, and the explanations on why countries privatise their health sectors have produced different responses.

The most popular argument is that governments, as collective decision-making bodies, privatise the health sector because they consider that private forces can provide health services with higher efficiency and better quality (Maarse, 2006). There is no doubt that public hospitals have a lot of flaws, however, there is also no clear evidence still that private hospitals will certainly lead to better efficiency. The market logic is more distorted in the health sector because of greater information asymmetry between the providers and consumers. The engagement of the government and insurers further complicates the simple competition principles (Arrow, 1963).

Literature has also developed explanations for why local public services are privatised. One major explanation is Public Choice theory. Niskanen's studies on bureaucrats' budgetary behaviour are seen by some as understanding the growth of privatisation as a strategy for the government to encourage competitions in public goods sectors. According to Niskanen (1971), after politicians and bureaucrats monopolise public service delivery, overproduction and inefficiency will happen. The popular Public Choice solution is market competition in public service supply. He builds a

CEU eTD Collection

theoretical model that bureaucracy agencies attempt to maximise revenue, which he later modifies as, what the agencies pursue the most is the flexibility in utilising public funds.

Niskanen's model faces several types of criticism. Downs (1957; 1967) argues that bureaucrats' behaviour complies with the basic economic person assumption, that under certain institutional setting, they attempt to maximise their personal interests. Another strong criticism from Kogan (1973) and Margolis (1975) suggest that the senior officials are different from the assumption of the bureaucrats in Niskanen's model.

Bring the Subnational Governments Back: Welfare Regionalism

While "scaling down" is not a new trend in politics, in welfare policies studies it is still an underexplored angle. Existing literature on social policy in China either focuses on the national level policies[25],. One of the main shortcomings in this approach while studying the Chinese case is that it ignores the vast regional variances and lacks viable explanations when confronted with the incoherence between the national discourse, initiatives and policy motivations vis-à-vis the actual subnational implementation.

In recent years, some scholars began to fill the gap and study the subnational level welfare policies patterns. In *China's Changing Welfare Mix: the Local Perspectives*, Duckett and Carrillo (2014) suggest that focusing on state policies in China was understandable since the state took a dominant role in its welfare system in the pre-reform era. But after the marketisation, "China's welfare mix" – the structure and dynamic among the state, the market, and individuals, has changed. They suggest that in the three decades after (the 1980s -2010s), China's welfare mix diverges for two main

[25] There are also many studies on the policy evaluation or ethnographic research at the communities' level. However they are less relevant for understanding policymaking.

CEU eTD Collection

reasons. One is the decentralisation in welfare delivery, the other is the regions diverged in their wealth, industries and investment.

SHBY and the variation of its local implementations can be discussed as a manifestation of the phenomenon of **welfare regionalism,** that different regions have their welfare policy and social expenditure patterns, which a relatively new trend in social policy study on China (Mok and Wu, 2013). The questions like how we understand the variations and what causes it, can be approached in different ways.

One intuitional explanation is that regions have their own economic development levels and demographical features, which lead to different demand and social welfare models. However, studies show that simply **wealth** and **demands** are not sufficient to explain the cross-region variances (Ratigan, 2014). De Mello (2014) suggests that various factors can influence subnational governments' engagement, including demography, technologies, as well as the **local development of market institutions**, and other factors that set different conditions for the private sector's engagement.

Bel and Fageda (2007) review four common hypotheses to explain local privatisation: 1. Fiscal constraint leads to privatisations; 2. Cost reduction may be an important objective; 3. The relative strength of the interest relevant groups is important; 4. Left-wing government will be more reluctant to privatise. Then they take four groups of variables to empirically test these four hypotheses: fiscal restriction, economic efficiency, political process and ideology. They conclude that **fiscal stress** and **interest group pressures** are important for local privatisation. They also identify the importance of the impact of political factors and political processes in the privatisation decision-making, but in interest group dynamics more than ideological affiliation.

Mok and Wu (2013) take three coastal provinces in China as examples, and argue that with similar socio-economic conditions, the three provinces adjust their welfare policies according to **the**

CEU eTD Collection

forms of capitals, governance style and industries varieties, instead of following the central policies. They suggest that welfare regionalism emerged especially due to the **welfare financing decentralisation** and **the political promotion system** in China.

While there is no common explanation of why the regions vary, there are also different debate on the incentives and restriction for sub-national governments while making policies. First, the relevance of the literature on fiscal federalism needs to be highlighted. SHBY can be closely associated with the literature on privatisation in China[26]. One of the most relevant bodies of literature stems from the relation between fiscal federalism and privatisation as well as regionalisation.

It is commonly recognised that the fiscal federalism in China lays the foundation of economic regionalism (Qian and Weingast, 1997). The fiscal decentralisation made **keeping fiscal survival and sustainability the priority for the local governments**. The fiscal decentralisation gave the local government more pressure to maintain its fiscal balance, and at the same time they acquired higher autonomy as well. The relation between fiscal federalism and public good supply can be debated[27]. While being apprised as contributing to rapid economic development, the fiscal decentralisation's effects on social welfare in China are less mentioned. Existing studies show mostly negative results. Qian, Martinez-Vazquez and Xu (2007) developed a model using panel data from the 1990s from China and concluded that fiscal decentralisation led to economic growth as well as drastic regional inequality. Chen (2010) also discovered that the public good supply significantly decreased after the Tax-Sharing System Reform in 1994. While reviewing the fiscal

CEU eTD Collection

[26] While the centre of the debate is on the normative roles of different levels of governments, the literature on fiscal federalism also provides a rich explanation for different levels of government and their behaviours under different fiscal structures. Groenendijk (2002) suggests that the theory of fiscal federalism can be applied in a wide range of countries regardless of whether they are unitary or federal in its legal structure.

[27] In the traditional fiscal federalism literature, many theories suggest fiscal decentralisation is at advantage for the public good supply. Tiebout (1956), Oates (1972, 2006) and other scholars argue that fiscal decentralisation can improve public good supply. But the Chinese case does not directly support this argument.

decentralisation's social impact in China, Martinez-Vazquez et al. (2017) find out it has mostly positive effects on education that the expenditures on education increased, but both positive and negative results are shown in health. In studying the impact, Qian et al. (2019) find out that fiscal decentralisation had a strong negative impact on local government's expenditure in the rural population insurance scheme.

The fiscal decentralisation literature and its application in China seem to have set the assumption that the regions make welfare policies predominately based on their regional context and neglected the national level politics dominance. As mentioned earlier, Mok and Wu (2013) suggest that the political factor also matters. Lacking the electoral system functioning as incentives as in its democratic counterparts, local governments in China are more strongly influenced by the **promotion criteria** from the central government than their counterparts in democracies. How do we consider the various factors in a more systematic way, especially in relation to health policymaking?

CEU eTD Collection

3. Theoretical Framework

This chapter discusses different viewpoints on social policymaking mechanism for the subnational governments in China, including an existing typology; it then proposes a theoretical model to capture the different types of response for the national initiative SHBY.

Existing Typologies

Studies on welfare regime typology provide insight into the key features that make different welfare policy patterns, and what influences the policymaking rationale. Esping-Andersen's foundational work (1990) lays on the countries where the majority of the workers are in the formal sector. Huber and Stephens (2005) identify two types of social spending patterns in Latin American countries: one type aims at developing human capitals so invest more in education and health, and the other focuses more on protecting workers from the market, so there is more spending in pensions and social insurance.

Rudra (2007, 2008) further develops spending patterns into three types: productive, protective and dual welfare states, based on the countries' economic development strategies. According to Rudra, the **productive** states are often export-oriented, and they tend to invest more in health and education to improve the human capitals, but health and education spending still are not significantly high. The **protective** countries focus on protecting the workers from market fluctuation and provide pensions or, and the Latin American countries adopting Import substitution industrialisation for their state-led strategies. The dual welfare states combine both types of spending.

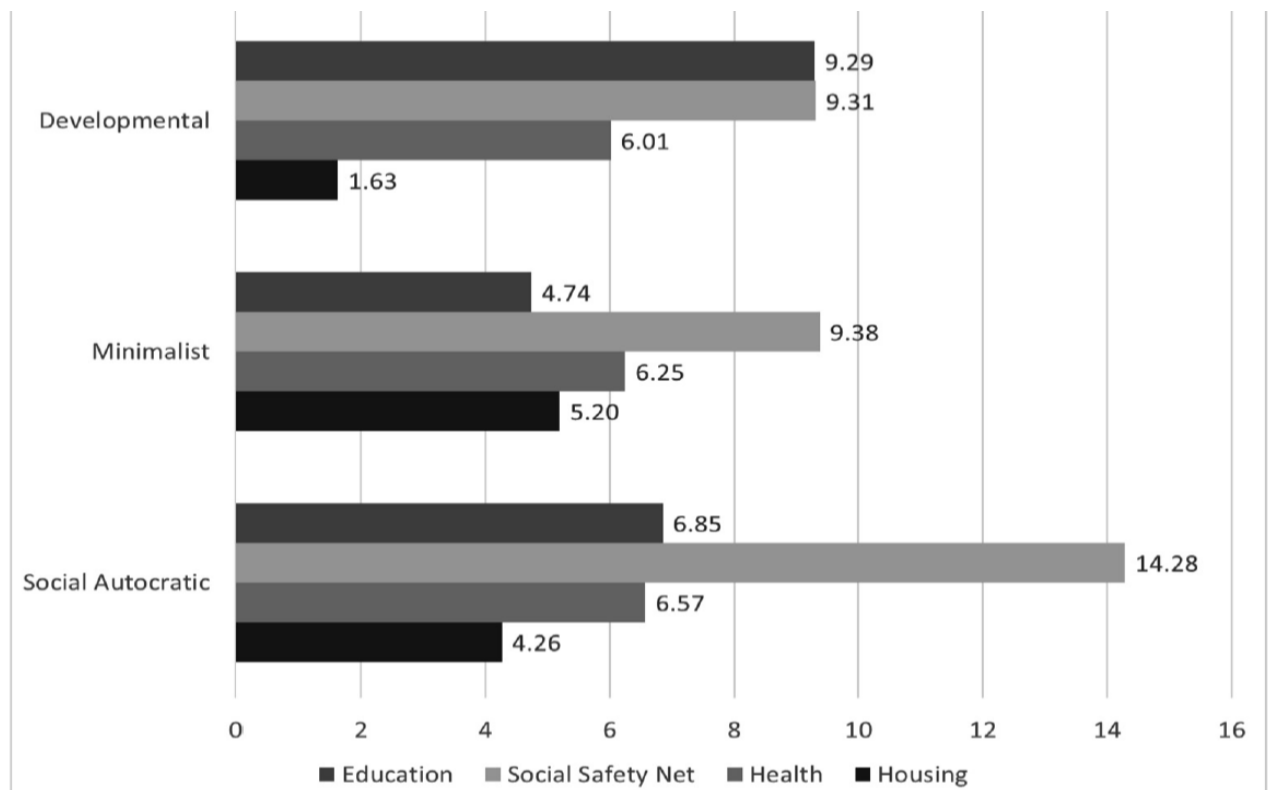
Ratigan (2012, 2014, 2017) has been one of the very few scholars focusing on the regional welfare regime variations in China. She developed different versions of provincial welfare regime typology in China. In the most recent version (2017), she makes a welfare regime typology for Chinese

CEU eTD Collection

provinces based on cluster analysis of government social spending data. With the relative proportion of spending on different types of social policies, she distinguishes three types: **developmental provinces, minimal provinces** and **social democrat provinces**, while **Qinghai** being an outliner outside of these three types.

She illustrates the cluster means of the proportion of provincial budget allocated to social policy in a graph, which I quote here as figure 2[28] below. Ratigan states that: the developmental provinces, which usually have export-oriented economies, emphasise on investing in human capital such as education, but are resistant to spend more on housing; the minimal provinces, usually the least developed provinces, comparatively spend the least on education, but invest more in housing for employ social spending more for poverty alleviation; the socio-autocratic invest more in the social safety net, and they tend to have more standardised policies at the provincial level.

Figure 2: Different Types of Provincial Social Spending



[28] Ratigan, 2017. Data are from 2008-2012,

CEU eTD Collection

She suggests that the economic development strategy, as well as social instability, can be associated with some distinct approaches to social welfare spending. She proposes that Chinese local governments design their social policies for two major purposes: **economic growth** and **social control**. For example, some provinces focus on poverty alleviation to maintain social stability. Some provinces invest more in education and health to promote the development of human capitals for the local industries and further facilitate economic growth.

While her explanation provides important insight to understand health policymaking at the local level, regarding the central research question of this thesis, there are three issues.

First, welfare policymaking is indeed strongly related to the local industries. The central government has imposed strict discipline for the local governments. It encouraged the local government to depend on itself on revenues generating and triggered industrial distributions across different regions (Park et al., 1996). However, she also notes that the industrial model is not the only major influence; the political consideration also accounts for the welfare making at the subnational level. For example, Ratigan singles out the one factor that the reliance on SOE is a national wide phenomenon, which makes the industrial focus in Rudra's model not applicable in explaining the cross-provincial differences. Pitifully, Ratigan does not explain this in-depth.

Second, Ratigan also notices the issue on the applicability of the national comparison being used at the subnational level. She suggests that difference provinces have different level of autonomy, and the local social policy priorities reveals the combination of local consideration and central government preference, but there is no further discussion on how this could be considered.

CEU eTD Collection

Third, the differences on health spending is not obvious among the three types[29], as the cluster means on health spending as in total government expenditure in the three groups are 6.01%, 6.25%, 6.57%. This then requires an adjusted and expanded explanation.

Response Type Model

To what extent can the existing literature be tailored and applicable to explain Chinese local governments' behaviour regarding policies on health privatisation? The literature on fiscal federalism, national level welfare policymaking and privatisation in the public good sphere provide a general understanding but cannot explain the exact regional variations in the case of SHBY. Studies around welfare regionalism in China explaining the existing overall welfare policy pattern. They emphasise the regional context but treat subnational governments as autonomous and ignore the central-local political dynamic, which is not the best for examining top-down policy implementations like SHBY either.

The thesis combines different approaches. In order to understand local government welfare policymaking rationales, we can apply the national level analysis to subnational level by adding one more facet of local government policymaking (which is absent in national level policymaking process): the central-local government dynamics; while referring to the international literature and theories, the country specific situation is also taken into account.

Using the national policy SHBY and its regional variances as an illustration, while taking the regional contexts such as the economic and demographic features into account, the thesis

CEU eTD Collection

[29] In the previous version of analysis where she made two groups of provinces (2014), Ratigan conducts student t-Test to test the differences between different types of provinces, she also notes that for the five types of social expenditure - education, health, science and technology, social insurance and pensions, housing, there is no significant statistical difference between the expenditure patterns of the two types on education or health. She explains that with the indicators she employs, the aggregate expenditure proportion might not be the best to capture the subnational variation. In the 2017 version, the differences on education expenditures is solved, but the differences on health is still not distinctive.

categorises two types of influencing factors - **fiscal** and **political factors** - for health policymaking at the subnational government level, conducts analysis based on examining two arguments.

Building on the general theories on local government policymaking, similarly like what has been assumed in fiscal federalism literature, the fiscal pressure is the major motivation for the regional governments to promote health privatisation progressively. I suggest that the central-local government fiscal relations, especially the fiscal structure and fiscal burden distribution, are the foundation of local government health policymaking. Thus, the first argument is:

If a region has high fiscal pressure, it will privatise its health sector.

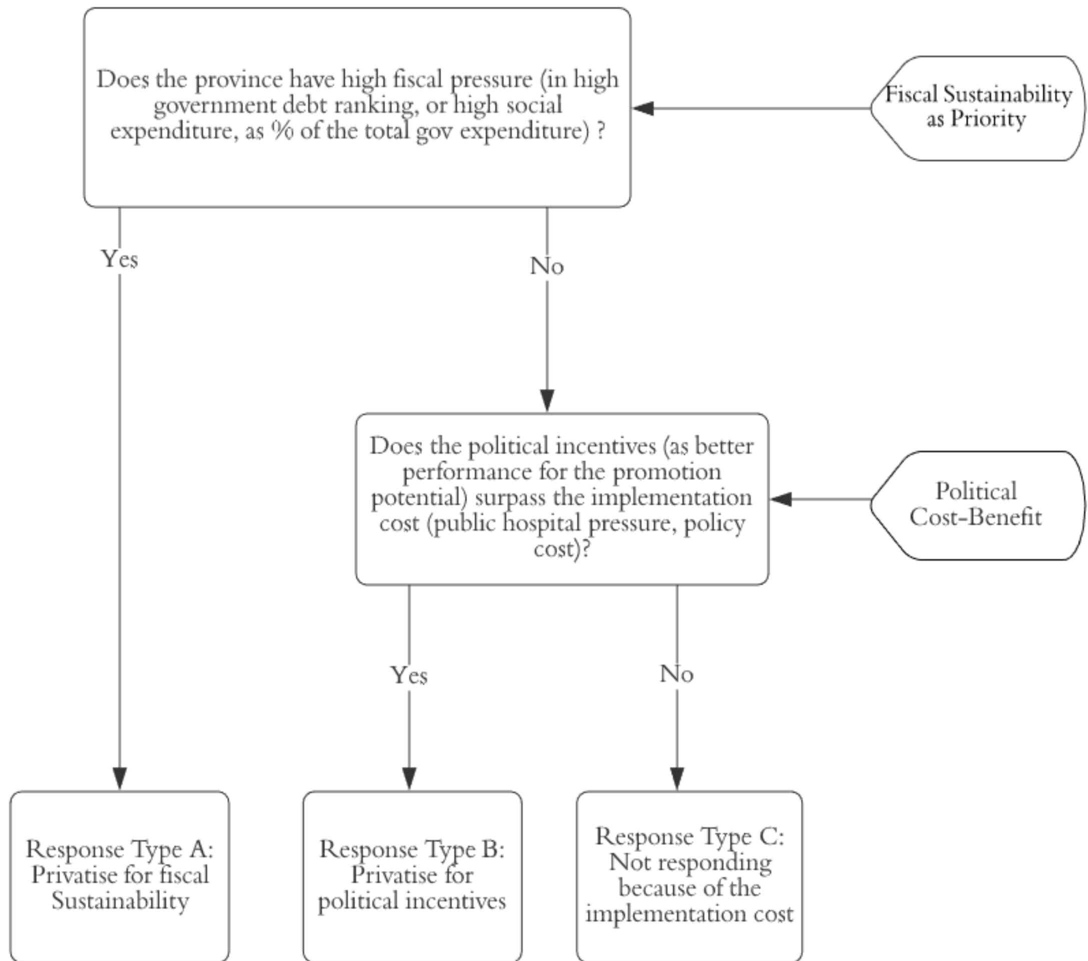
Also, the political system in China add another layer, that the regional government might promote health privatisation for the political incentives that they might be able to illustrate their performance by catching up with the national level policies. The second argument is:

If the political incentives surpass the policy implementation cost, the regional government will privatise its health sector progressively.

Based on these two arguments, I propose three types of regions based on a two-step response model regarding SHBY (see figure 3). proposed here agrees with the general international understanding and the mainstreaming welfare regime typology literature, that the fiscal capacity and consideration is the foundation of a region's health policymaking. However, considering the relatively low government attention in health policy, I argue that **if only a regional government faces high fiscal pressure, they will promote policy on health privatisation progressively**. High fiscal pressure is indicated either by high governmental debt, or high government health expenditure.

CEU eTD Collection

Figure 3 Theoretical Response Model



CEU eTD Collection

When the fiscal pressure is not so pressing, the political cost-benefit calculation will be the next step in considering the local implementation of a national initiative in health. **If the political incentives surpass the reform cost, the region will promote policy on health privatisation progressively**. Here the political incentives refer to the promotion potential for the local officials to show the local implementation of a national initiate as their performance, and the implementation cost refers to the efforts the local governments have to make in order to carry on

the policy. In this case, it can be the pressure from public hospitals, extra administrative work or the financial support they offer to private hospitals.

Put it in another way, take an abstract local government X in China for example. I argue that under the fiscal decentralisation, the priority for policymaking is to keep its fiscal survival and sustainability. If the region X has high government debt pressure or high social expenditure, to control the cost will be a more urgent issue, and it will respond to SHBY progressively, since privatising the health provision helps to control the government health expenditures.

If for X, this priority is satisfied, it then will consider the cost and benefit of the policy implementation. In implementing SHBY and to reform the public hospitals, the governments need fiscal or administrative cost as well as overcome the pressure from the local public hospitals. But the local government also faces the promotion incentives, that to implement SHBY can improve their governance performance thus get more chances to be promoted. So, if the political incentives surpass the reform cost, it will also choose to respond to SHBY. If not, then it will not respond.

To clarify, local governments in China faces a complex net of incentives and motives at the same time. Although the three types of responses are theoretically grounded and empirically observed as explained in later chapters, in the actual cases the model cannot capture the whole picture. Besides, from a theoretical perspective, I identify a two-step consideration model which are driven by fiscal factors first and then political ones. In real-life situations, these two are influencing at the same time and are hardly separable. The fiscal sustainability being prior tasks for the local governments contains the political pressure from the central government and is achieved with the absence of bottom-up electoral pressure; the political incentives manifest as and includes fiscal orders too. At the practical level, even within the regions that fall in the same type of response group, the regions have very different situations. Instead of providing a strict categorisation for

CEU eTD Collection

different regions, this model aims at examining the two factors-fiscal sustainability and political incentives, and how they influence the local government's health policymaking. The following chapters will discuss the mechanism in detail.

CEU eTD Collection

4. Analysis I: Health Policymaking and Central-Local Relations

The following three chapters will discuss 1)the national level policymaking motivation and the central-local government relations in China relating to SHBY; 2) analyse the subnational governments' response motivation - the working mechanism of two types of factors, the consideration for fiscal sustainability and the political incentives; and 3) identify three types of subnational governments' responses to SHBY.

This chapter proceeds as follow: section 4.1 reviews the Chinese government's involvement in health sector; section 4.2 provides various viewpoint on how to explain the policymaking at the national level; section 4.3 introduces the central-local dynamics in health policymaking.

4.1 Government's Involvement in Health

From the 1950s, the Chinese health system relied heavily on central government finance under the centrally planned economy. Public hospitals were largely established, and they focused on public health and preventive treatment and made significant progress. From the 1950s - 1970s, it was absolute public dominance that most hospitals are public-owned and predominately received government funding. One of the key indicators is that percentage of individual out-of-pocket (OOP) payment in total health expenditure is around **20% in the 1978**, while the public sector workers enjoy full and free health service.

The economic reform started in late 1970s set the national priority as developing the overall economy at all costs, it resulted in a rapid drop in government financing in health. It also led to hospitals relying on patients' payment mainly, which provided incentives for hospitals to ignore preventive health and make profit out of over-prescription and over-treatment (Yip 2007). The health system then was still dominated by public-owned hospitals, although they are predominately profit-driven (Hsiao, 1997, 2014). With the sudden withdrawing government financing, OOP

payment was around **60 % in 2000**. During this period, private hospitals started to appear, but they were mostly small clinic running by retired public hospital doctors and they remained as a neglectable in the country.

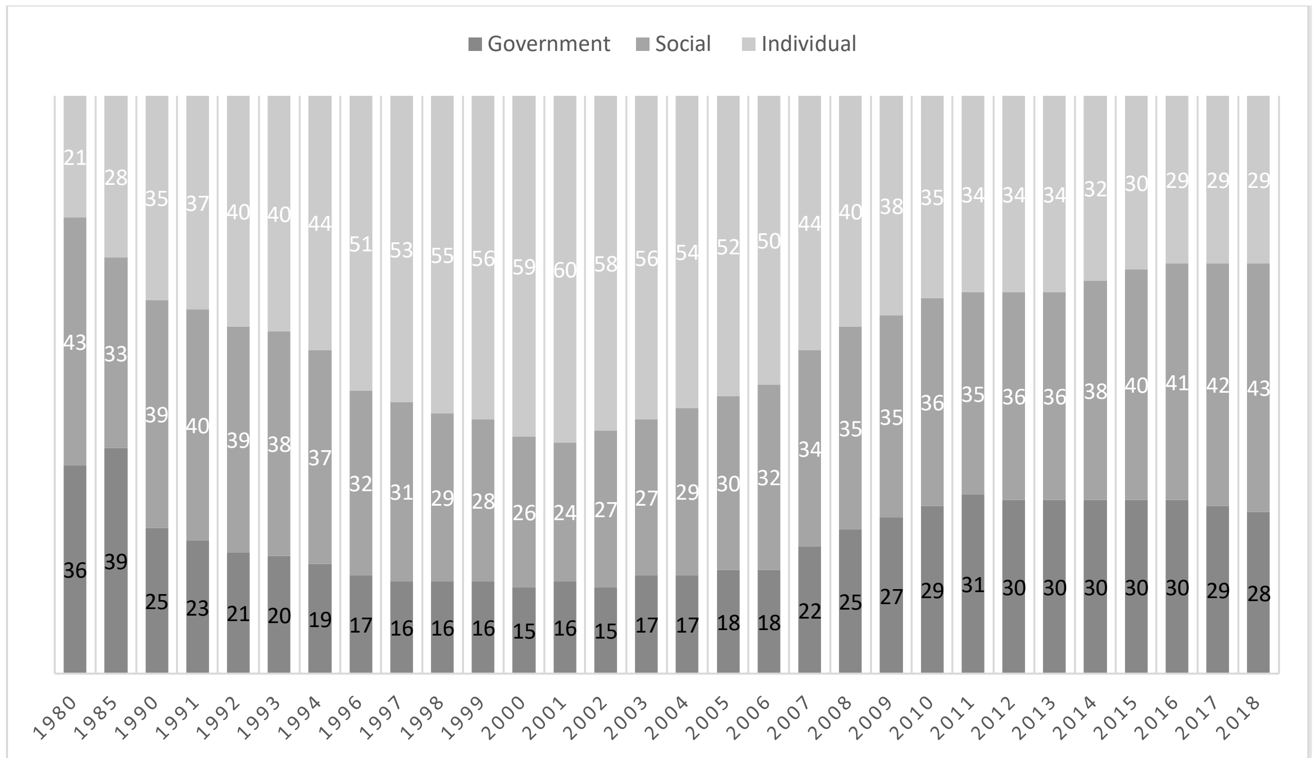
The outbreak of SARS[30] in 2003 brought back attention and resources to public health. In 2009, a new round of health reform was initiated. From 2009 to 2012, within three years China achieved almost universal health insurance coverage (Yip et al., 2012). However, the covered service ranges and financial protection depth are still insufficient (World Bank, 2013). The OOP payment was around **30% in 2018**.

There are debates on which direction the 2009 health reform has been heading. Qian (2016) argues that the government expenditures on social provision including the health sector have been increasing to a significant level. However, Duckett (2020) suggests that the privatisation trend in China is "neoliberal-looking" and insists that the government social expenditures are still very much limited and biased to the government officials and urban formal sector workers. From examining the data released by the government, I agree with the later view that, especially in the health sector, the government is very cautious in expanding the expenditure. Also, simultaneously as SHBY was initiated in 2010, the increasing tendency in government health expenditure from 2003 stopped (see figure 4[31]).

CEU eTD Collection

[30] Severe Acute Respiratory Syndrome, a communicable disease occurred to China and surrounding regions in 2003 which poses huge challenges for the government then.
[31] Data source: China Health yearbook, 2019.

Figure 4 health payment by sources in China from 1980s to 2017.



4.2 **Explaining Health Policymaking in China**

What drives the rounds of health reforms and health policy changes in China? In the literature studying privatisation in health in different countries, cost control and the assumed or claimed efficiency of the private sector are the two direct driving motivations (Maarse, 2006). Beyond these two simple answers, the thesis aims to investigate the political dynamics behind this policy, and to a broader sense, the logic of health policymaking in the Chinese system.

Some argue that the Chinese government makes health policies based on its dominating **ideology** (Hsiao, 2007); some suggest the **regime types** matter since health policymaking should be discussed, as the social policies being the instruments for legitimacy, social control and securing the loyalty of the support base in authoritarian regimes. some also mention that **leadership** has a

CEU eTD Collection

significant impact on health policymaking. Some claim that the Chinese case can be posited in the **East Asian context** as most of the countries in this region, regardless of their regime types, have practised the Productivist economic model in which social policies are subordinated to the economic growth.

Ideology

After started to endorse market economy[32], China also adopted neo-liberal ideas not only in reforming the economic sector but also in social policies (So, 2006). Regarding the health policymaking in China, Hsiao (2014) points out that, since the market reform in 1978, the main driving force for China's health reforms is the ideologies of the government, "especially how much priority it gives to the equity vis-à-vis economic growth." Other scholars (Huang 2014; Blumenthal and Hsiao, 2015; Duckett 2020) agree that the ideological shifts in the top leaderships in CCP have been the dominating force in the changes in public-private provision in China's welfare regime.

Authoritarian Welfare Regime

The regime type is the primary explanation. There is a rather limited amount of literature discussing social policies in authoritarian regimes. Forrat (2013) reviews that in authoritarian regimes, the welfare policymaking is subjected to the **legitimation strategies** the regime adopts and **the loyalty of its supporting base** (Svolik, 2012). China has a highly centralised and authoritarian government, controlled by the Chinese Communist Party (CCP). After Mao's death, CCP's legitimacy rests primarily on its performance in improving the population's welfare through economic growth and political stability.

CEU eTD Collection

[32] Maybe comparison post-communist welfare regimes. (similar: public to market and then back then privatise again); difference: electoral system+ mass mobilisation versus social control

China grounds its legitimacy mainly on its economic performance. In turn, the economic growth strengthened the regime's capacity and increased its social control, which then enabled it to sustain the low expenditure, until major events invoked mass discontent, like SARS in 2003 (Hsiao, 2007). CCP has strategically chosen the distribution mode of social welfare to secure the urban privileged population's support to maintain social stability, while distributing modest portions to the masses to prevent mass discontents (Huang, 2014). Some argue that the universal health insurance plan was initiated after 2003 because the political elites feared the mass unrest and huge challenges to its governance and survival coming with the epidemic (Zhu, 2016).

Changing Leadership

In authoritarian regimes, the proactive role of the elites also means that the preferences, mentality, and the personality of the rulers are important to understand the authoritarian welfare state and authoritarian politics in general. Wintrobe (1998) treats the dictator's preference for power or consumption as one of the most important variables in his analysis and as the basis to distinguish different types of dictatorships.

While back in 2003-2012, the leadership of the previous president Hu and prime minister Wen, the main goal and slogan for governance is the harmony of the society. There was discussion allowed. According to Duckett and Langer (2015), based on several media reports from 2005 and 2009, the party does not have a unified position on health policies.

However, the current president Xi seems to have his personalistic patterns in policies and strategies. Although propagating in a series of policy to strengthen the legitimacy of the Communist Party's leadership including anti-corruption campaign, advocating redistributive justice, but at least in health policies, it is not what has really happened.

CEU eTD Collection

The CCP's rule under Xi has been centralising the power (Erik 2018), restricting autonomies for local governments, from within the politburo, and from nongovernmental actors including but not restricted incorporates, SOE, academia, media. While, after president Xi came to power, CCP put more emphasis on the nationalistic discourse of rejuvenation of the Chines nation, global governance and the Belt and Road Initiate, and at the same extensively increase the social control and further limit social discussion[33]. The lack of electoral constraint made the leadership penetrate the political system easier.

East Asian Welfare Regimes

The literature on welfare states offers the foundation to explain a country's social policy approach. Although the origin of welfare regimes is mostly based on capitalist states in the democratic European context, the further development of East Asian welfare regimes offers more insights for the Chinese case. After Esping-Andersen (1990) came up with the three worlds of welfare states based on 18 European countries, many scholars have proposed their criticism and modification. Beside what Esping-Andersen defined as the three criteria: social rights, stratification effects and state-market-family relationship, drawing on the historical development of welfare policies in East Asia, Holliday (2000) extends the fourth type with a fourth comparison pillar: **the relative importance of welfare policies**. He argues that in liberal and conservative welfare states, social policies are neither privileges nor subordinate for the state's agenda; in the social democratic welfare states, social policies are privileged; and in the fourth type, as Holliday hinted by naming it Productivist welfare states, social policies are subordinated to economic policy.

CEU eTD Collection

[33] China Digital nr, an international news agency covering the censorship in Chinese domestic media, reported that the topic on health reform and a medical accident occurred in a private hospital has been banned. https://chinadigitaltimes.net/2016/05/minitrue-inner-workings-shady-medical-business/

In the East Asian context, when explaining the limited post-war welfare policies in Japan, Korea, Singapore, Hong Kong and Taiwan, the early popular argument about the cultural influence (Jones, 1993) has been criticised as unhelpful in explaining the evolution of the welfare policies in these economies, nor the different models they adopted. The state-centric argument (Ramesh, 1995) then became dominant, stating the welfare policies are mainly accommodating the economic development policies. Holliday (2000) also suggests that the state-centric argument is still too narrow, and the domestic bureaucratic politics, external threat and the demographic changes need to be considered.

Ian Holliday points out that these policies have been "fundamentally Productivist", that the basic welfare schemes provided were mainly aiming at improving human capital development aspect in production. In the Chinese case, after the market reform started in the late 1970s, the health policy in mainland China shared some similarities with the neighbouring economies: "growth at all cost", and also the feature that "social policy was perpetually subordinated to higher priorities in stimulating industrial transformation" (Wong and Feng, 2004).

However, in the 1990s welfare reforms, Japan, South Korea and Taiwan all took a much more progressive and universalist approach to promote redistribution and social justice, even when the overall economy was slowing down and the general world trend was to step back from social expenditures (Wong and Peng, 2004), which made them growing out of the Productivist definition. Wong and Peng suggest it was due to the domestic political, social and demographic changes, but the Chinese case stays at the Productivist approach, that its welfare scheme largely benefits the urban middle class and workforce while ignoring the rural population (Duckett, 2020).

Since the period when China published SHBY policy, it seems that the Productivist approach remained dominant in China, that the development of the overall economy is the priority. One of the major initiatives President Xi has advocated is "Health China 2030" from 2017, in which the

CEU eTD Collection

first sentence goes: healthy people are the symbol of a wealthy and strong country. As some argued, even the implementation of universal health insurance after 2003 followed a different trajectory: it is the authoritarian regime fearing of the mass unrest and huge challenges to governance coming with the epidemic (Zhao et al., 2018). This then guides us into another path of understanding the health policymaking process.

Different from the common democratic setting, there are different perspectives in studying welfare policies in authoritarian regimes, and that offers two main trajectories in understanding the policymaking motivation behind SHBY. Responsive authoritarianism is the term in authoritarian regime studies frequently associated with the Chinese case to suggest that authoritarianism can respond to changes both happening within the regime and from outside. After rounds of reforms, we can view the current trend of promoting a mixed system as an exploration to reach the balance point.

However, shifts in social policies still reflect the defining feature of authoritarian characteristics. SHBY leads redistribution through funding private hospitals and urban middle class who are their main customers, and Duckett (2020) argues this policy shows the neoliberal trends coming back to the health sector, and it is because of the authoritarian nature of the regime, that it can promote the social policies that mainly favour the urban elite without responding to the broader concerns.

4.3 Central-Local Dynamics

One question can be raised here, that to what extend are the regions autonomous welfare regimes?

On one hand, the central government in China has hold on tight to its control over the whole country, but the policies made by central government lack the adaptabilities to the complex

variations existing in different regions. Thus, for the central government, to allow and even to some extent to encourage some local governments to deviated from the central directed unified policies is necessary to keep the flexibility (Zhou 2010). On the other hand, the central government maintains its authority in various ways, including taking in charge of all the high-ranking official appointments. The promotion mechanism has changed throughout different historical stages. After the Open and Reform era in 1980s, governance performance has been one of the most important criteria when promoting officials, and the indicators are usually related with economy (Zhao and Zhou 2004).

Scholars explain the central-local relations and its impact on social policies from various angles, but it is commonly acknowledged that the turning point is the Tax-Sharing System Reform in 1994. After the cultural revolution ended, from the late 1970s to early 1990s, the central government in China had turbulent financial flow, since the economic reform brought great instability. The 1994 reform settled the fiscal revenue and responsibility division between the central government and subnational governments in China. In the decades afterwards, the subnational government expenditure in the proportion of total government expenditures rose from 45% in the 1980s to over 70% after the reform.

Zhao and Zhang (1999) suggest the overall economic decentralisation policies and the reforms in planning and fiscal systems from 1994 led to regionalism. In public goods financing, the central government sharply retreated from social financing (Duckett, 2012). In government expenditure on health, although the central government shouldered more than half of the listed fiscal responsibilities in the division[34], in effect, in recent decades the local governments take over 99% of the total government expenditure health.

CEU eTD Collection

[34] http://www.gov.cn/zhengce/content/2018-08/13/content_5313489.htm.

5. Analysis II: SHBY and Subnational Government Rationale

Chapter 4 explains why the policy SHBY is issued at the central government level, and it will help release the fiscal burden on subnational governments. However, at the subnational level, this national policy is responded differently. As presented earlier in theoretical framework (chapter 3), SHBY and its variation in local implementations can be discussed as a manifestation of the phenomenon welfare regionalism: that different regions have their welfare policy and social expenditure patterns. This chapter presents two arguments and the theoretical backgrounds.

Argument I: If a region has high fiscal pressure, the regional government will privatise its health sector progressively.

Argument II: If the political incentives surpass the policy implementation cost, the regional government will privatise its health sector progressively.

The first argument is based on the consideration of fiscal sustainability under fiscal decentralisation. In the context of fiscal decentralisation in social expenditure, between the hard budget constraint from the central government and the soft budget constraints they impose on the public hospitals, for the local government, their social expenditure patterns suggest that fiscal sustainability is the priority task before any other kinds of policy considerations. The second argument suggests that, if a region does not face high fiscal pressure, while recognising the costs of policy implementation, it is the political promotion incentives- that the officials can show better governance performance by implementing SHBY- that motivate these regions to react to SHBY.

The discussion in this chapter explains health policymaking rationale that are applicable for all subnational governments. The next chapter will show more detailed cross-regional variances.

CEU eTD Collection

5.1 Regions in China

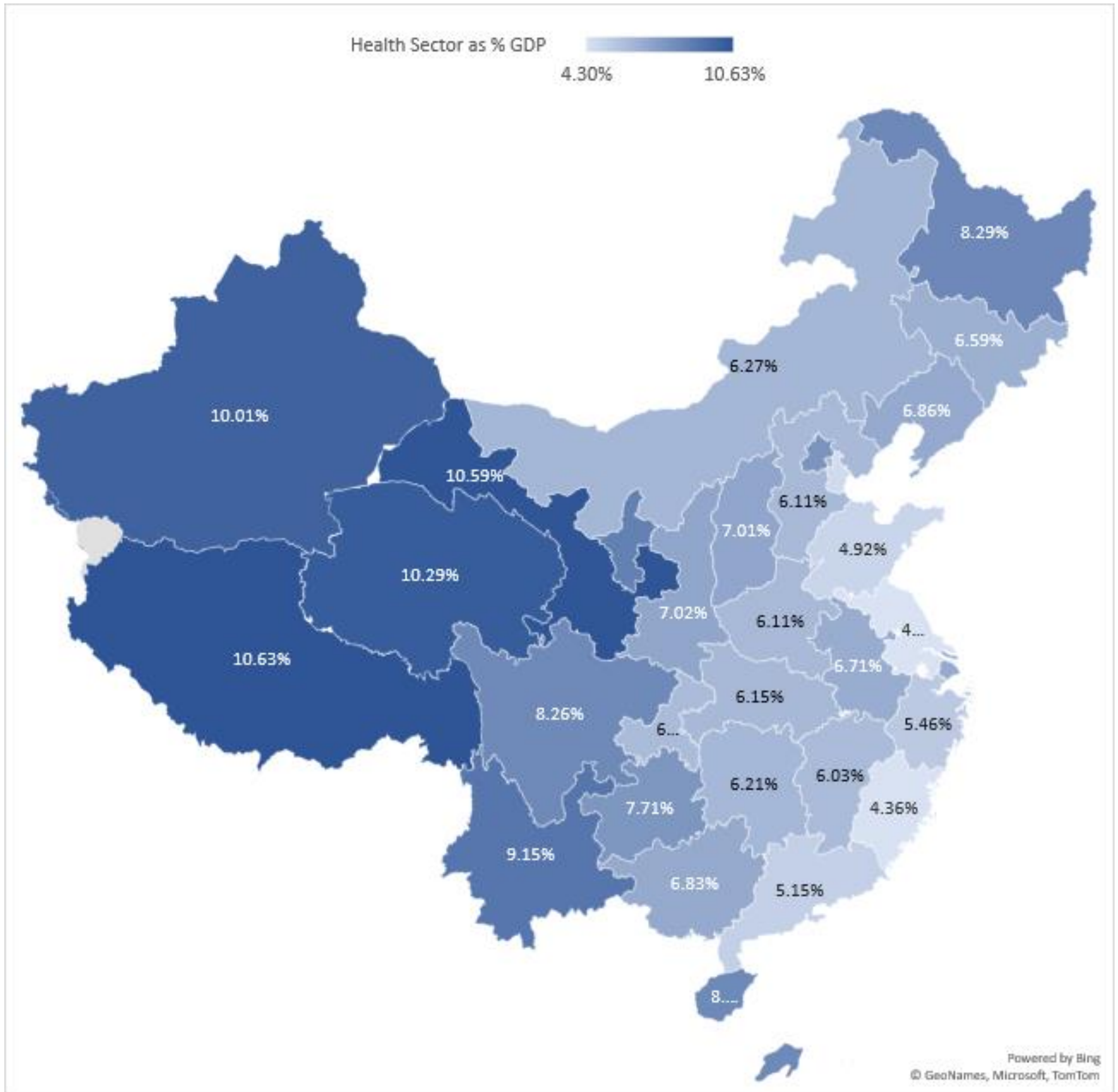
China can be divided into three areas generally according to its geographical locations. The Eastern coastal provinces like Zhejiang, Fujian, are economically more developed and have the highest level of human development and industrialisation. The Western provinces like Tibet, Xinjiang, Yunnan etc., have the lowest since the economic foundation is weak. The central provinces are mostly in the middle and vary to different local situations on a different standard. Wang (2017) compares the government health expenditure structure and finds out that, in China, the government health expenditures on health per capita are the highest in the western provinces, then the Eastern provinces; the central provinces have the lowest government health expenditures.

In numerical indicators, the total health expenditure as a proportion of the local GDP, which reveals the size of the whole health sector and its relative importance for the local economy, varies. In 2018, while the national proportion is 6.36%, in provincial level, it ranges from 4.3% to 10.63%. In Figure 5[35], we can see that in the Western regions, since the overall economy is not very developed, the relative size of the health sector is higher, and it is a bigger share in its overall economy.

Figure 5: the whole health sector in % of the provincial GDP

CEU eTD Collection

[35] The following figures shows different provinces in Mainland China which does not include Taiwan due to the data availability, but the borders on the map does not match with the Chinese official territories. They are only for showing regional variations in their health sector



While the health sector has higher proportion in the overall economy, in the western regions, the government health expenditure as in proportion of the total health expenditure, which shows the local governments' investment in health, is also higher. It ranges from 21.18% to 68.55%, with the national proportion is 29% (See figure 6).

CEU eTD Collection

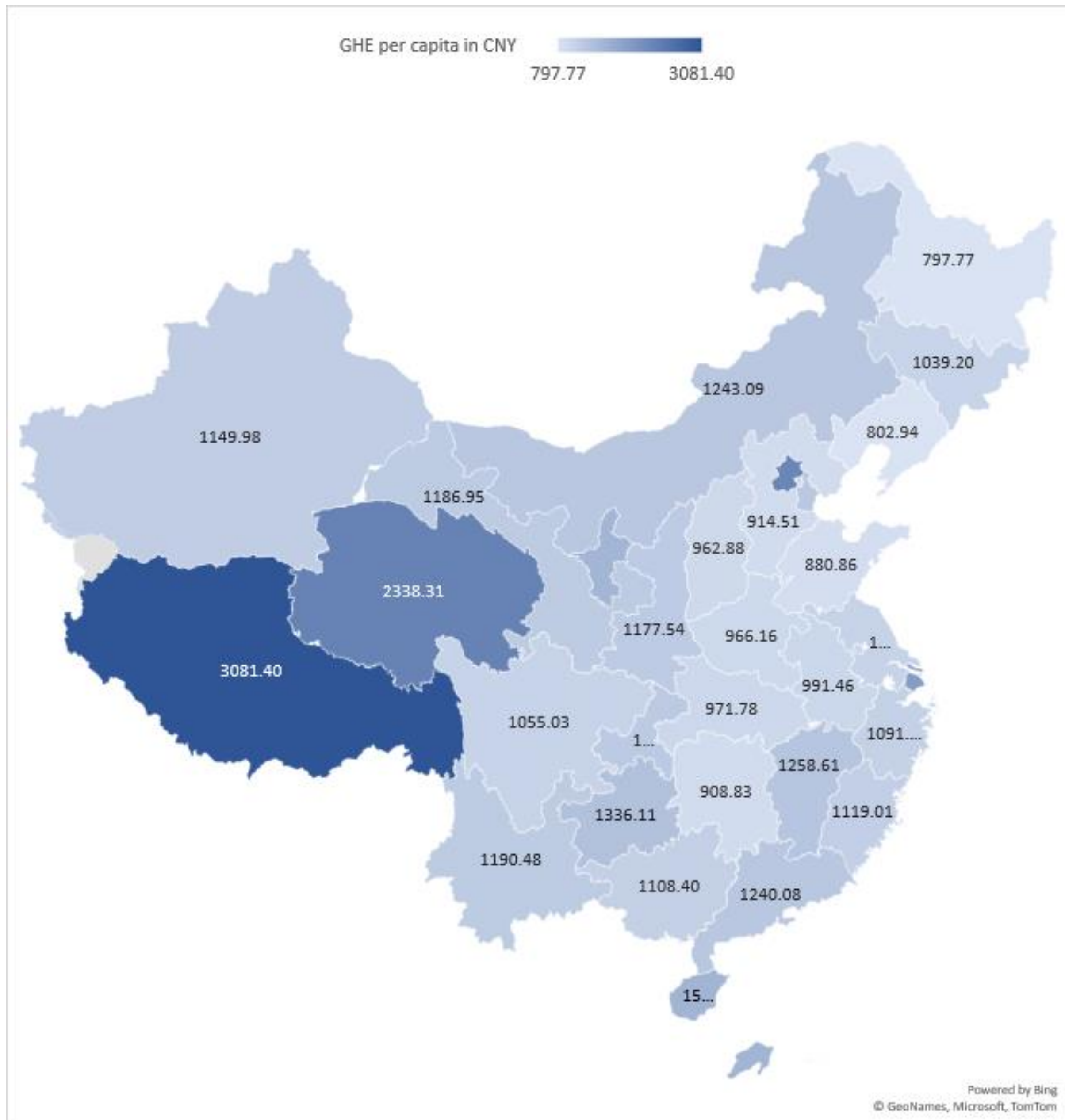
Figure 6 Government Health Expenditure as % Total health Expenditure

Some might expect that since the economy is less developed in the Western regions, so the government might spend less money but still shows a higher proportion. But as we can see in figure 7, GHE per capita across different regions does not follow this assumption. This is because, these least developed regions are mostly near the border and have largely ethnic minority

CEU eTD Collection

population, and the risks for social instability is also higher, hence the government invest more in social policies.

Figure 7: Government Health Expenditure (GHE) per capita (CNY) 2017.



With all of these different indicators and variations, on what ground do Chinese provinces differ in their welfare systems, and what are the rationale behind social policymaking, in this case, health policy, is puzzling.

CEU eTD Collection

5.2 Fiscal Sustainability as Priority

5.2.1 Hard Budget Constraints, Debt and Social Expenditure Patterns

In studying city and county level State-Owned Enterprises (SOE) reform in the 1990s, Wang, Qian and Weingast (1999) argue that the "federalism in Chinese style has induced privatisation in Chinese style". The central-local relations have provided incentives for local politicians to carry on privatising SOEs. They argue that the reforms carried out by the central government have **hardened the budget constraint** on local governments, which then changed the cost and benefits of keeping SOEs and incentive the local governments to opt for privatisation.

The central government in China imposes hard budget constraints on the local government, which is the key for the Chinese style fiscal federalism, and it has complex impacts on local government behaviours. While in other regions like Latin American countries, the hard budget constraints face serious challenges (Rodden, Eskeland and Litvack, 2003), China's central leadership has managed to maintain it at a rather manageable level since the tax reform in 1994 with its top down political control (Oates, 2005), that the revenue has been re-centralised to the central government and the expenditure decentralised to subnational governments.

The fiscal distribution in central and local government relations have significant impact in **social expenditures**. Fan (2015) describes the Chinese welfare financing model as "the central decides and the local pays", that the central government assigns mandates, while the fiscal burden for welfare expenditure including public health, is mostly on local governments. Thus, the pressure for fiscal sustainability is totally on the shoulder of the local government.

It has also induced **higher government debt**. From early 2000s to 2009, local government debt rose from 1.8% to 25% of the GDP within a decade. For the local governments, on one hand the financial support from the central government is less, on the other hand the expenditure has been

increasing. While the financial support from the central government decreased, the local governments still have been employing all kinds of fiscal tool to sustain its fiscal balance and promote economic growth.

The fiscal risks can be manifested in both the fiscal gap and the government debt. For example, the investment model in China is associated with the fiscal gap. While the global average investment rate is 25% according to the World Bank, the Chinese case is over 44% (Que, Zhang and Schulze, 2019). The formal government debt has been increasing to a historical high point in recent decade, and the informal debt, as estimated by business consultancies like KPMG, have been also raised as one the greatest risks for Chinese economy.

One phenomenon is that in the decade between 1980s to 2008, the local officials hide the high debt. Since 2008, the local debt skyrocketed as the local governments started to claim debt increasingly. While in the previous years, the government officials still managed to hide the debt situation, while the debt pressure got higher increasingly, recent years they began to claimed the debt (while pushing the responsibility to their predecessors), and they can ask for more fiscal resources since the central government special transfer have offered more opportunities. See figure 8 for provincial debt in ratio to their GDP.

CEU eTD Collection

Figure 8: provincial debt as % of provincial GDP

Studies have confirmed this connection and its relations with welfare financing. Fan (2015) finds that the local governments respond to the unfunded mandates with informal privatisation policies. Fan (2015) argues that both the formal and informal way need to be taken into consideration. It might lead the local governments to extensive borrowing (Jin and Zou, 2003; Wildason, 2004). Combes (2015) finds out that fiscal profligacy is a common feature at the provincial level.

5.2.2 Soft Budget Constraints and Low Efficiency in Public Hospitals

Comparing with the Budget constraint from the central government to the local government, the budget constraints from local governments to public sectors, like public hospitals, are much softer. In doing field work in public hospitals in China, Eggleston et al. (2009) conclude that controlling other factors, public hospitals' probability to get financial support from the government is

CEU eTD Collection

correlated with their previous net revenue. The empirical finding is supported by theories developed based on other countries' cases too. Kornai (2009) concludes that soft budget constraints often occur in public hospitals, and it is not restricted in Hungary, where he did the field work, or post-socialist countries, but rather prevalent in most modern states. The government does not want to bear the consequence of decreasing government credibility if the public sector goes bankrupt; also the public sector stakeholders often attempt to maximise their budget.

The government's retreat from financing left a huge and long-lasting impact on public hospitals behaviours (Duckett, 2012). It provided incentives for public hospitals to turn for profit-driven strategies. Scholars have noted that China witnessed rapid expansion in big hospitals and the fierce medical arms race, which is fast increases in purchasing expensive medical infrastructures (Qian et al., 2019).

For public hospitals in China, the debt asset ratio rose from 25% in 2005 to 42 % 2014. According to China Health Yearbook, in 2018, public hospitals in China have in total 4080 billion CNY assets (583 billion USD), and the debt is 1715 billion CNY, which equals to 42% of the total assets. Non-public hospitals have in total 728 billion CNY assets (104 billion USD), and the debt is 414 billion CNY, which equals 57% of the total assets.

It seems that in this regard public hospitals perform better than private hospitals, however, the reasons behind the debt in public and private hospitals are different. In general, investment in hospitals takes a long time to recover. For non-public hospitals, especially those with bigger scale, the encouragement and opening-up in policies only emerged in the recent decade, and many of those which are under huge debt are still in the initial establishment stages.

For public hospitals, the debt started much earlier and continued increasing until recently. Public hospitals in China receive funding through three main components: service charge, drug sales, and government financing. The local governments contribute partially to the staffs and the operations

CEU eTD Collection

of public hospitals and the payments of the professionals. The regulation department in the local government sets the price for drugs and basic services like diagnosis. Starting from the 1980s, the government withdrew large parts of the financial support, the public hospitals faced huge pressure and have been having financial difficulties in maintaining financial sustainability. In the decades after, public hospitals turned profit driven. The highly profitable services are those with high end technologies. The hospitals also turned to compete in scales to attract more patients, because the bigger the hospitals get, the more patients will hear about it and trust it more. Thus, many hospitals across the country have been in a fast pace to expand.

The heavy debt is also highly associated with the poor management and disorganised and fragmented bureaucratic administration and ownership structure. Barber et al (2014) find out that many public hospitals run on cash budget system, while the comparing with the private hospitals mostly set annual operation budget. The poor management led the public hospitals more prone to much less efficient investment decisions and led the public hospitals to borrow from local financial institutions.

The debts public hospitals borrow are mostly from local banks rather than from the hospitals' revenue nor governmental financing. But in the long run, if the hospital cannot repay the debt, the risks and burden will be shouldered by the local governments. Similar phenomenon occurs in education, especially in public universities[36].

The nationwide reform has turned to focus on the hospital financing aspect. It includes some other policy acts that will further lead to financial risks for the public hospitals. For example, the drug price regulation reform started in the 2009 health reform further raised the risks of underfunding for public hospitals (Chen et al. 2016).

CEU eTD Collection

[36] Wang and Chen, 2017.

5.3 Political Incentives and the Cost-benefit of Policy Implementation

The previous section analyses fiscal sustainability as the survival conditions for the subnational governments in China when deciding how to respond to SHBY, and it can also be examined from the perspective on local bureaucrats' behaviours, since a distinct feature the Chinese case possesses, that its political promotion system offers the local government officials different than their democratic counterparts.

With hard budget constraints in the decentralised fiscal system and heightening debt pressure in the recent decade, the subnational governments have a high-level autonomy and responsibility to maintain its fiscal sustainability. In this regard, it is reasonable that existing studies, both on fiscal federalism and on the Chinese provincial welfare patterns, lead to view subnational governments as separate welfare regimes which make health policies mostly based on the economic development pattern.

I agree that the fiscal consideration lays the foundation of health policymaking. What needs to be further addressed is, how the political system, specifically the top-down selection process, has shaped the policymaking rationale. If without the high pressure for fiscal sustainability that is fatal for the local governments, to carry on SHBY has both administrative and political cost. The **costs-benefits calculation** is another main consideration. While implementing SHBY at the local level faces several types of costs, the political incentives are the reason for some subnational governments to endorse this policy.

5.3.1 *Cost: Public Hospitals as Interest Groups and Strategic Spending*

Section 5.2.2 states that with the pressing fiscal risk, the low efficiency in utilising funds in the public hospitals made the local governments opts for promoting the private hospitals. However, if the fiscal risk does not pose enough pressure, if the government attempts to promote SHBY, they must overcome many policy costs.

First, the most direct and obvious policy cost is the increasing workload of the government staff. Nong and Yao (2019) conducted interview with 124 public hospital administrators provincial level hospitals and 105 government officials from three provinces, one in Eastern China, one in central, another in Western. All the interviewees perceive that if the reform is carried out, their workload in the short term will increase. And most of all the interviewees involved in the reform are not incentivised to collaborate.

Tiao-Kuai (network) relation is one of the key concepts in Chinese politic studies. It describes the quasi-federal feature of the Chinese governmental relations. *Tiao* refers to the vertical lines in the departments in different levels with similar policy or responsibility arena, for example, the relations between the Ministry of Health at the central level and the health department in a city. *Kuai* refers to a block of government departments within one region. A local department faces political control from both the local government leadership and the senior from one level above. The local health departments are subjected to the pressure from the upper level as well as the local leaders.

Embedded in the network, Like in many Low- and middle-income countries, the poor governance structure are embedded public hospitals in China (Eggleston et al, 2012; Yip et al, 2012). For example, several government bodies are managing the public hospitals' assets, and are direct the hospitals recruitment, especially in administrative positions. Due to the organisational structure in CCP and historical development, more than a dozen of local government departments are involved

CEU eTD Collection

in the operation of public hospitals[37]. Different departments have their own interests. The Finance Department attempts to improve the efficiency in public hospitals, but the Development and Reform Commission, which is one of the main economic departments, sets the prices for tests and drugs. The health department desires to improve the management by employing professional hospital directors, but the organisation department, the main branch in CCP that exist in all the government bodies and public sector, gives priority to political loyalty when selecting the hospitals leadership. Besides, the local health departments can be involved in blocking decreasing public hospitals' share (Hsiao, 2007). From the perspective of bureaucratic polities, the public hospitals are the different levels of health ministries' constituencies, and the health departments as an agency, aims at expanding the public hospitals for their own benefits.

Second, to promote private hospitals, especially to promote big and strong ones while grant private hospitals to share the resources with the public hospitals (especially the public insurance fund)[38] poses potential disadvantage for the public hospitals. Public hospitals are a hidden but strong interest group in China (Hsiao, 1997). Comparing with hospitals in the U.S in lobbying, they exert influence in a much less formal yet strong way. One of the common features but neglected the public hospitals have special section for officials. He (2010) also mentioned similar stories.

Third, there exist corruption and collision in the public hospitals and the local government[39]. That corruption happens between other local government departments, the local health ministries and

CEU eTD Collection

[37] the Department of Health determines the supply of health services and rate the clinical level and qualification; the Finance Department sets financial rule that governs hospitals; the Department of Social Insurance has the power to set payment policies for hospital services; the Development and Reform Commission has the power to set prices for drugs and health services; and the Organization Department has the power to hire and appoint hospital directors.

[38] See previous policy details in the Background section. The national policy includes to allow private hospitals to share human resources, equipment and to be included into the public health insurance paying pool.

[39] https://www.nytimes.com/2019/06/14/business/china-ge-siemens-bribery-medical-devices.html

public hospitals, also block the local governments to favour private hospitals[40]. One health reform act of separating the local government involvement in the public hospitals has been promoted at the central level for a long time but has nearly no effect. Like in all the other Chinese public sectors, at least part of the top leaders in public hospitals are appointed by the Organisation Department in the local governments. Numerous corruption cases happen in the public hospitals. For example, in 2016, two G.E. sales representatives bribed a hospital administrator more than 1 million USD for a sale of a CT scanner for 4 million USD.

5.3.2 Benefit: Political Incentives from the Central Government

Facing many obstacles in promoting SHBY, there are also political incentives for the local government officials in implementing the policy, which is closely related with their political prospects.

Promotion Mechanism and the PTG Model

In the Chinese system, the promotion of government officials is influenced by many factors. Some studies suggest **the network** and **factional struggles** of the officials matter greatly (Bo 1996; Lin, 2007; Choi 2012; Rochlitz et al, 2015; Dittmer and Wu, 1995; Guo, 2001; Keller, 2016). Some (Persson and Zhuravskaya, 2015; Wu, 2019) find out that the provincial leaders got promoted within the same province where they govern, they spend a higher share of education and health and invest less in constructions than those officials who rise from others. But these are difficult to collect information or uncommon to study.

CEU eTD Collection

[40] Private hospitals should not be the simple opt-out choice either. Unlike European countries which substantially strengthen their regulation after the privatisation wave in the 1980s, the Chinese governments did pay enough attention in regulating private hospitals (Tam, 2010). Medical accidents from underqualified private hospitals frequently occurred but not addressed nor reported.

The more commonly examined selection mechanism is a performance-based political promotion (Feng et al., 2013). Since the beginning of PRC, to control a big country like China, Mao has developed the strategy that CCP top leadership controls the promotion of officials. I suggest that, for local governments and officials, all of these factors matter, and my argument will focus on the political incentives from the central government, that what the central government encourages is one of the major incentives, and the encouragement and punishment mechanism plays an important role.

Various models have been developed to explain the Chinese local official promotion standard. Zhou (2007) suggests a Political Tournament Game (PTG) model and it has been widely accepted. The PTG model suggests that in China the local officials seek for political future as their top goal. The political promotion is like a tournament, the local officials compete on the criteria the central leadership set. During the reform era from the 1980s, **economic growth is the top criterion**. This argument sounds convincing intuitively, and it is supported by the many studies, for example, the phenomenon of set GDP growth as the only goal have been reported by the CCP official media. Li and Zhou (2005) find evidence emphasising the correlation between economic growth and the chance for officials to be promoted to provincial leaders.

The PTG model faces several challenges. One of the main issues is that the PTG model is it **ignores regional differences** in a sense that the central government have different measuring standards for different regions. Also, it ignores the local officials' interests at the local level. I propose the first modification here, to conform with the central shows the political loyalty and performance.

The second is that, in the time after Zhou (2005) builds the mode in the early 2000s, as leadership changes, the **Selection Criteria has also changed.** GDP as the most important criteria was the main driver for economic growth until the 2000s. From 2003, under Hu administration, the

CEU eTD Collection

promotions criteria started to change. In recent decades, China's economic growth has slowed down, the local governments also reported more government debt pressures, and the top leadership started to emphasise more in environmental governance and other issues. The fiscal survival is still the priority, but if the fiscal pressure is solved, the local government will try more to impress using different methods.

Political Promotion and SHBY

The performance criteria have also changed drastically. It went from the loyalty to Mao before 1970s, to the economic growth measured mainly by local GDP since the 1980s till the early 2000s. As the economic growth started to slow down, and especially after Xi came to power in 2013, the whole political atmosphere changed visibly. Without access to CCP's internal guideline or interview with the central level officials confirming the influence between health policymaking and government official promotion, the changing criteria can be detected from the state media discourse, politician movements and policy studies in other arenas.

The most important trend is that the political control and supervision over the subnational power got significantly tighten. This is the most obvious in environmental policies and its local implementation. The evaluation in this leadership weight more in the social control capacity, better governance and better implementation of central policies (Teets, 2018).

In the case of SHBY, the central leadership has shown the highest attention in recent decades. The policy has been issued by NHC together with other 9 ministries including National Commissions of Development and Reform (the key body within CCP carrying out economic planning and reforming), the Ministry of Finance. Second, SHBY can be closely linked with the Anti-Corruption Campaign Xi has been strongly pushing nationwide.

CEU eTD Collection

Government officials can implement SHBY both as a show for better governance capability as well as determination in fighting corruption within their administration and the public sectors. However, in general, not much attention is assigned to social policies (Que, Zhang and Schulze, 2019), and health policy has never been a policy priority.

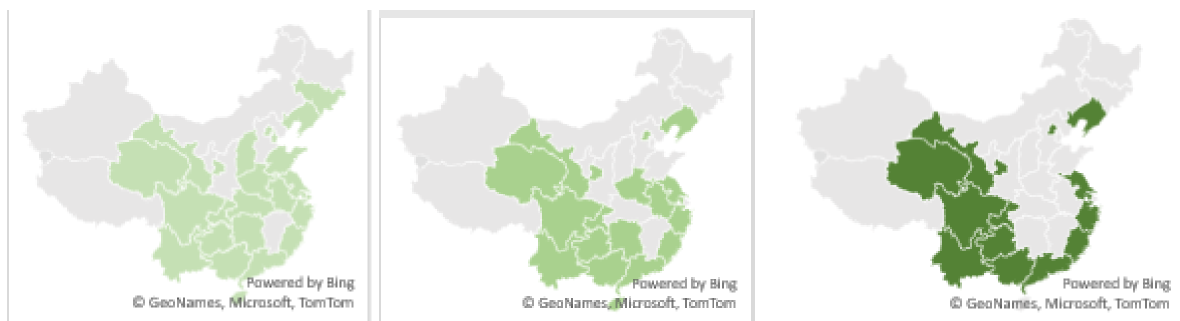
CEU eTD Collection

6. Provinces and Response Types

This chapter checks the provincial responses to SHBY to examine the previous arguments. When it comes to the provincial levels, we see different policy responses. I distinguished three level of intensities.

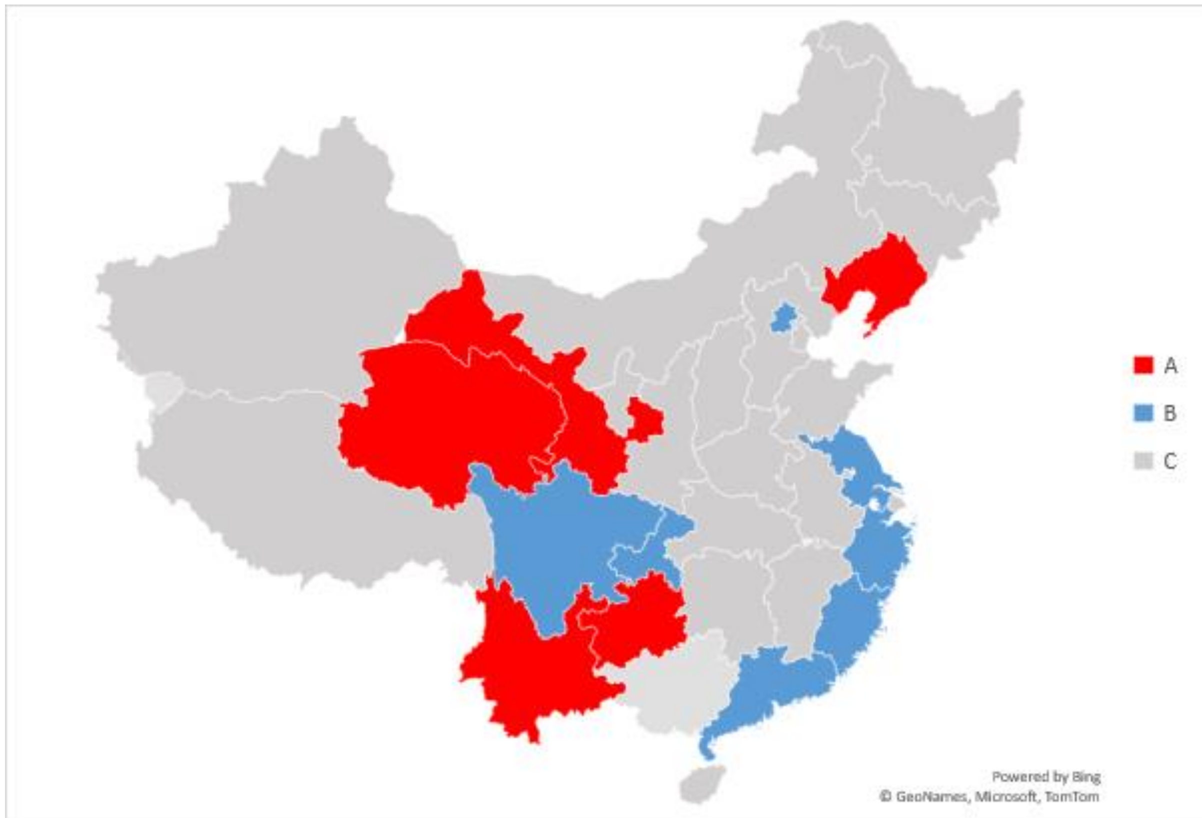
1. Among the 31 regions, 23 provinces have followed the national policy and made local policies (see the left map in figure 9);
2. then around 15 have set exact goals such as, to level up the private hospital share to a certain proportion, or to change certain administrative procedures (the middle map in figure 9);
3. around 10 provinces offered financial supports, or set strict limitation for public hospital expansion, which shows the most solid policy support, since the financial support utilises the most vital financial resources, and the restriction of public hospitals shows the determination to challenge the local interest group (the right map in figure 9).

Figure 9: Local Implementations to SHBY



CEU eTD Collection

Figure 10: Response Types



Then I categorise the following three types of responses (See figure 10):

A. Some regions in Western China, like Qinghai and Gansu, which have high social expenditure and low government fiscal capacity, are promoting SHBY progressively, that they followed all three components, with focusing on offering financial support;

B. Some regions with better governance, mostly wealthy coastal provinces like Guangdong and Fujian, also Sichuan and Chongqing in Central China, with more innovative and efficient governance styles. already have better governance, which set good foundations for private investment, also there are bigger markets and their demand to develop private health provision, they are also promotive SHBY proactively.

C. A majority of the provinces are less active in responding to SHBY since they have manageable fiscal situation and less political incentives, and that makes them more

CEU eTD Collection

reluctant to offer preferential land or tax policies to incentives for private investment; or to challenge the interest of the local public hospitals.

6.1 Type A: Promoting Privatisation for Fiscal Pressure

Provinces that falls in the Response Type A: Qinghai, Gansu, Guizhou, Yunnan, Guangxi, Liaoning (see figure 11). The following reasons mainly influence the Type A provinces to promote HSBY progressively. That the central government has imposed hard budget constraint and offers limited financial support and it causes the local governments to have high debt pressure; while the social expenditure is relatively high and the efficiency of fund utilisation in public hospitals is low due to the soft budget constraint.

Figure 11: Response Type A provinces

Regarding the development of SHBY, on the policy side, these regions have been promoting SHBY the most progressively. They have been utilising land and tax reduction and even financial

CEU eTD Collection

support to fund private hospitals[41]. On the outcomes, they are also the regions where the growth of private hospitals is the fastest[42]. These provinces mostly locate in Western China and share are mainly two features: high government debt pressure and high proportion of government social expenditure[43].

Pilot Program and Progressive Privatisation

The political structure, notably the central-local government relationship, has caused policy experiments to occur as a source of policy innovation in the party-state system (Heilmann 2008). Before SHBY becoming the national initiative, between late 1990s to 2009, in various places the public hospitals were sold by the local governments (He, 2010). **It is widely observed in the past decades, the most radical privatisation cases often happened in the economically lagged regions[44].** The main promoter in the previous local level reforms is the core leadership of the local governments, rather the health ministries. For example, in Henan province, the provincial level health minister published documents forbidden changing ownership of the public hospitals in a large scale, but it did not prevent the local governments to do so. For local government, the change the ownership of the public hospitals can cash out the previous years' fiscal support on public hospitals and to ease the financial pressure.

In the response type A regions, the policymaking process of privatising the hospitals resembles the privatisation of State-Owned-Enterprises (SOEs) in the 1990s. Different from the top-down privatisation approach in the Post-Soviet and Eastern European countries, the Chinese path of privatising SOEs followed the typical Chinese policymaking process. Heilmann (2008) concludes it as "from local experiments to national policy". Throughout China's economic development, the

CEU eTD Collection

[41] See further details in Annex I.
[42] Which is partially also because in these regions there were relatively less private hospital before 2009.
[43]The proportion of the total local government expenditure.
[44] https://www.huxiu.com/article/341150.html (in Chinese)

central leadership encourages the local governments to conduct different innovative policies and then utilises the local experiment for national policymaking. It has been a decisive feature for many economic policymaking, including the promotion of private business, state-sector restructuring and stock market regulation.

Before permitting privatising SOEs as a national policy in the CCP's Congress in 1997, the privatisation process already started in different provinces in the 1980s. Cao, Qian and Weingast (1999) state that it is the fiscal federalism that incentivised the privatisation process of the SOEs in China. For local governments in the 1990s, they faced with the rising subsidisation to the SOEs as well as hardening budget constraint from the central government after the tax reform.

The city Suqian, with 5 million population, conducted a radical reform of privatising all the public hospitals[45]. Suqian had similar features with the Type A regions. Although located in the wealthy Eastern province Jiangsu, Suqian had the lowest GDP per capita within the province, Suqian government had high debt, and the public hospitals had high debt that before the reform, two thirds of the workers in health institutions cannot receive wages[46] on time. From 1997 to 2001, the local government sold all the public hospitals for 1.7 billion RMB. While it reserved part of the revenue coming from the private investors for public health uses, it is still unclear where did all the fund go. What we do know, is that the key official[47] who initiated this reform also started a series of reforms to increase the government assets, including privatising schools and SOEs and contracting out collective owned lands etc.

CEU eTD Collection

[45] The impact on health service delivery and equity from the reform has been mixed. In 2019, Suqian started to build public hospitals again. The thesis does not attempt to evaluate the policy, but rather highlight the background features.

[46] The public hospitals employees' wages are from local government financing.

[47] Qiu He was a very controversial official. He was promoted to provincial level after his tenure in Suqian. and he was corruption in 2019.

Qinghai province locates in Northwest China. Comparing with surrounding provinces, it does not have abundant resources, it is also not one of the provinces near the border with separationist sentiments like Xinjiang or Tibet, which the central government has been paying extra attention in maintain the social order. At the same time, it has high government debt, ranked the lowest among the 31 provinces in credit rating by Moody's[48]. Health expenditure is also a large part of its government revenue. Comparing with the national average 5.6%, In Qinghai, government expenditure in health is 8.6% of the total government expenditure. Thus, Qinghai has been the most active province in promoting SHBY. It offers free land, financial subsidies for private investment to build hospitals. As a result, the growth rate of private hospitals.

6.2 Type B: Promoting Privatisation for Better Performance

Figure 12: Response Type B Provinces

[48] https://www.moodys.com/research/Moodys-Chinese-provinces-face-significant-fiscal-shortfalls-as-growth-slows--PR_414081

CEU eTD Collection

The following fit the Type B responses. Provinces like Jiangsu, Zhejiang, Fujian, Guangdong, mostly locate along the coastal line in Eastern China. They have higher economic development with developed mature industries, bigger health service market. Provinces like Sichuan and Hunan have low fiscal pressure, but they are not as well economically established. However, these provinces are politically more active, for example Hunan province is Mao's hometown, Sichuan is where Deng Xiaoping, the second national leader after Mao, was from. They have many encouraging policies for private hospitals, in some more developed regions like in Fujian, private hospitals are even a major tax source. What these provinces share in common is that there are more competition in governance and higher performance anxiety.

Better Governance Environment for Private Hospitals

In these regions, there is a virtuous cycle: good economy foundation / politically more active – politically more monitored by the central government – more performance based-promotion - better governance - better economy / politically more active (Guo, 2007).

Various factors can influence subnational governments' engagement regarding the provisions of public goods public including demographics, technologies, as well as the local development of market institutions, and other factors that set different conditions for the private sector's engagement (De Mello, 2014).

There is the historical heritage of promoting the development of the private sector in the Type B regions[49]. Fujian has been one of the most active provinces in responding to SHBY. Located in the southeast coast of China, Fujian has one of the best government credit ranking. It has the most developed private hospitals industries in the whole country.

CEU eTD Collection

[49] https://www.jfdaily.com/wx/detail.do?id=201217

In Fujian province, health reform has been one of the key policy arenas that enable the local officials to stand out. The health reform pilot program in Sanming county, Fujian province, has been a textbook example in the Chinese health system, since the government initiated an overall health reform, which basically carried out all the health reform initiatives the central government. It caught attention to the core leadership of CCP, president Xi endorsed this reform as its demonstrative success in reform public hospitals. The state council also include this as an example for improving the health sector in the overall reform[50]. The local official who imitated this reform was later promoted rapidly.

6.3 Type C: Not Promoting: Tacit Incompliance

Among 31 provinces, more than one-third of the provinces did not respond to SHBY in a substantial way, and they did not respond for various obstacles. On the contrary to Type B regions, this is the historical path of limiting the development of the private sector in the Type C regions. Qian (2017) suggests that at the local level, the regional health resource plan favours public hospitals, in terms of quota and land resources. These governments weaker in governance to imitate effective reform.

For the regions which are not responding to SHBY, they mostly have manageable debt pressure and spend a relatively low portion of the government expenditure on health. These regions usually also have a high strong capacity for social control and low risk for protests. In terms of the promotion incentives, they mainly have other top tasks to deal with than health policies.

[50] State Council, 2016, People's Republic of China, priorities for economic reform in 2016, http://www.gov.cn/zhengce/content/2016-03/31/content_5060062.htm, accessed 18th July 2020 (in Chinese).

With its large population and regional variations, Chinese has developed various mechanisms to ensure the national policymaking can be adjusted to a different locality. When implementing central policy, there are spaces not to following. So, the national policies are sometimes more of permission than a requirement. Feng et al. (2013) suggest that there are informal bargaining processes between central and local governments, and there is flexibility in both the central control and the local autonomy.

For example, Hebei province locate in Northeast China and it surrounds Beijing. While it has rich natural resources including heavy metal and oil, it used to be the leading economic power for its State-Owned-Enterprises in heavy industries like iron and car manufacture at the beginning decades in PRC history. However, as the industrial focus in China shifted, the SOEs faced huge decrease in demand side, and it faces several environmental issues. Health policy is not the policy priority for the local leadership. In SHBY, there is no concrete following-up local policy still.

CEU eTD Collection

Conclusion and Discussion

In understanding *She Hui Ban Yi*, the policy of promoting privatisation in health in China, at the central government level, the Chinese government is promoting privatisation to control the health expenditure. It is mostly influenced by the central-local fiscal relations and the government continuing approach of setting economic development as the priority, since its legitimacy still largely grounds on its economic performance rather than egalitarian redistribution.

This is made also due to the heightening pressure of expanding local government debt, since it does not want to break the hard budget constraint nor the local government to have fiscal breakdowns. It is also influenced by the continuous neoliberal leaning ideology. The authoritarian system enables the trend to sustain. At the subnational level, the local governments face hard budget constraints from the central government and impose softer budget constraints to the public hospitals and other public sectors. They react to the SHBY policy in different ways.

I argue that the fiscal sustainability is the priority for the local government, that if they have high fiscal pressure, they will promote SHBY. If a region does not have high fiscal pressure, it will calculate the cost-benefit of implementing SHBY at their regions. While in some regions, the officials are incentivised by the promotion potential to show better governance, some regions do not respond to SHBY, since there are obstacles in carry on the policies. The thesis categorises three types of responses at the subnational levels.

I emphasise that firstly, for the local governments, the fiscal impact, especially the hard budget constraint from the central government and soft budget constraint to the local public sector, plays the key role in privatisation policies in health in China. Secondly, that political incentives, such as promotion within the Chinese government ranks, also influences local policy makers and their

CEU eTD Collection

decisions. However, in the sphere or health policy making, it is hard to prove, with the low attention in the overall health sector.

Health policies in China is a highly complex topic. Due to the availability of data and the length, the thesis does not take many other factors into the main analysis. For example, if the researchers can get CCP's internal policy guideline in the political performance criteria or the detailed funding resources for the public insurance pool, it would be greatly helpful in understanding health policymaking. Also, there are a relatively low but not necessarily ignorable amounts of central transferred fund to some provinces specifically for health policies, which might also influence the regional governments. Whether if, and if so, how, Covid-19 will change the relative weight of health policies in the central government is also worth examining.

Further studies can also do comparative studies between China and countries. Some cases in post-soviet countries might be comparable, with changing roles of public versus private provisions in their public health systems; comparison with countries like India or Brazil in demography, geography or fiscal federal system and the influence over health policies might provide insights too.

The turbulent changes the Chinese health system has gone through was evident that health policies are one of the most fundamental way the political system can influence each individual's life. To understand the politics of health policymaking in China from the subnational government's level different provides us with a vivid and solid image on the process.

CEU eTD Collection

References

André, C., & Hermann, C. (n.d.). *1 Privatisation of Health Care in Europe*.

Bahl, R. W., & Bahl, R. P. of E. R. W. (1999). *Fiscal Policy in China: Taxation and Intergovernmental Fiscal Relations*. 1990 Institute.

Bel, G., & Fageda, X. (2007). Why do local governments privatise public services? A survey of empirical studies. *Local Government Studies*, *33*(4), 517–534. https://doi.org/10.1080/03003930701417528

Béland, D., & Yu, K. M. (2004). A Long Financial March: Pension Reform in China. *Journal of Social Policy*, *33*(2), 267–288. https://doi.org/10.1017/S004727940300744X

Bhattasali, D., & Wong, C. P. W. (n.d.). *China - National development and sub-national finance : a review of provincial expenditures*. The World Bank. Retrieved 20 May 2020, from https://agris.fao.org/agris-search/search.do?recordID=US2012414681

BLUMENTHAL, D., & HSIAO, W. (2005). Privatization and its discontents: The evolving Chinese health care system. *Privatization and Its Discontents: The Evolving Chinese Health Care System*, *353*(11), 1165–1170.

Blumenthal, D., & Hsiao, W. (2015). Lessons from the East — China's Rapidly Evolving Health Care System. *New England Journal of Medicine*, *372*(14), 1281–1285. https://doi.org/10.1056/NEJMp1410425

Bo, Z. (1996). Economic performance and political mobility: Chinese provincial leaders. *Journal of Contemporary China*, *5*(12), 135–154. https://doi.org/10.1080/10670569608724246

Cao, Y., Qian, Y., & Weingast, B. R. (1999). From federalism, Chinese style to privatization, Chinese style. *Economics of Transition and Institutional Change*, *7*(1), 103–131. https://doi.org/10.1111/1468-0351.00006

China's Changing Welfare Mix: Local Perspectives. (n.d.). CRC Press. Retrieved 25 June 2020, from https://www.routledge.com/Chinas-Changing-Welfare-Mix-Local-Perspectives-1st-Edition/Carrillo-Duckett/p/book/9781138016910

Choi, E. K. (2012). Patronage and Performance: Factors in the Political Mobility of Provincial Leaders in Post-Deng China*. *The China Quarterly*, *212*, 965–981. https://doi.org/10.1017/S030574101200118X

Dittmer, L., & Wu, Y.-S. (1995). The Modernization of Factionalism in Chinese Politics. *World Politics*, *47*(4), 467–494. https://doi.org/10.1017/S0043887100015185

Duckett, J. (2012). China's 21st-century welfare reforms. *Local Economy: The Journal of the Local Economy Policy Unit*, *27*(5–6), 645–650. https://doi.org/10.1177/0269094212444574

Duckett, J. (2014). The logic of market reform or the politics of retrenchment? *China Information*, *28*(1), 93–94. https://doi.org/10.1177/0920203X13519381

Duckett, J. (2020). Neoliberalism, Authoritarian Politics and Social Policy in China. *Development and Change*, *51*(2), 523–539. https://doi.org/10.1111/dech.12568

CEU eTD Collection

Duckett, J., & Wang, G. (2017). Why do Authoritarian Regimes Provide Public Goods? Policy Communities, External Shocks and Ideas in China's Rural Social Policy Making. *Europe-Asia Studies*, *69*(1), 92–109. https://doi.org/10.1080/09668136.2016.1274379

Economic Logic of Political Promotion: Prefectural Mayors of China--《Public Management Research》2007年00期. (n.d.). Retrieved 20 May 2020, from http://en.cnki.com.cn/Article_en/CJFDTotal-GGGY200700004.htm

Economic performance and political mobility: Chinese provincial leaders: Journal of Contemporary China: Vol 5, No 12. (n.d.). Retrieved 20 May 2020, from https://www.tandfonline.com/doi/abs/10.1080/10670569608724246

Eggleston, K., Shen, Y.-C., Lu, M., Li, C., Wang, J., Yang, Z., & Zhang, J. (2009). Soft budget constraints in China: Evidence from the Guangdong hospital industry. *International Journal of Health Care Finance and Economics*, *9*(2), 233. https://doi.org/10.1007/s10754-009-9067-1

Erik, B. K. (2018). China's political order under Xi Jinping: Concepts and perspectives. *China: An International Journal*, *16*(3), 1-17.

Fan, Y. (2014). The Centre Decides and the Local Pays: Mandates and Politics in Local Government Financial Management in China. *Local Government Studies*, 1–18. https://doi.org/10.1080/03003930.2014.968706

Fang, G., & Cao, H. (2020). State versus private provision: How does China's market-oriented reform affect healthcare delivery? *Economics of Transition and Institutional Change*, *28*(3), 381–411. https://doi.org/10.1111/ecot.12239

Feng, X. (2014). Local Government Debt and Municipal Bonds in China: Problems and a Framework of Rules. *The Copenhagen Journal of Asian Studies*, *31*(2), 23–53. https://doi.org/10.22439/cjas.v31i2.4332

Feng, X., Ljungwall, C., Guo, S., & Wu, A. M. (2013). Fiscal Federalism: a refined theory and its application in the Chinese context. *Journal of Contemporary China*, *22*(82), 573–593. https://doi.org/10.1080/10670564.2013.766381

Forrat, N. (n.d.). *Why Do We Need the Theory of Authoritarian Social Policy in Comparative Research?* 29.

Gordon, R. H., & Li, W. (2012). Provincial and Local Governments in China: Fiscal Institutions and Government Behavior. *Capitalizing China*, 337–369.

Guan, X., Xu, B., & Xu, B. (2011, June 10). *Central–local relations in social policy and the development of urban and rural social assistance programmes: Xinping Guan and Bing Xu*. China's Changing Welfare Mix. https://doi.org/10.4324/9780203832776-11

Guo, X. (2001). Dimensions of Guanxi in Chinese Elite Politics. *The China Journal*, *46*, 69–90. https://doi.org/10.2307/3182308

Heilmann, S. (2015). From Local Experiments to National Policy: The Origins of China's Distinctive Policy Process. *The China Journal*. https://doi.org/10.1086/tcj.59.20066378

CEU eTD Collection

Herrmann-Pillath, C., & Xingyuan, F. (2004). Competitive Governments, Fiscal Arrangements, and the Provision of Local Public Infrastructure in China: A Theory-driven Study of Gujiao Municipality. *China Information*, *18*(3), 373–428. https://doi.org/10.1177/0920203X04047622

Hillman, B. (2010). FACTIONS AND SPOILS: EXAMINING POLITICAL BEHAVIOR WITHIN THE LOCAL STATE IN CHINA. *The China Journal*, *64*, 1–18. https://doi.org/10.1086/tcj.64.20749244

Holliday, I. (n.d.). *Productivist Welfare Capitalism: Social Policy in East Asia*. 18.

Hsiao, W. C. (2007). The political economy of Chinese health reform. *Health Economics, Policy and Law*, *2*(3), 241–249. https://doi.org/10.1017/S1744133107004197

Huang, X. (2014). *Social Protection under Authoritarianism: Politics and Policy of Social Health Insurance in China* [Columbia University]. https://doi.org/10.7916/D8MC8XN4

Jin, H., Qian, Y., & Weingast, B. R. (2005). Regional decentralization and fiscal incentives: Federalism, Chinese style. *Journal of Public Economics*, *89*(9–10), 1719–1742. https://doi.org/10.1016/j.jpubeco.2004.11.008

Jin, J., & Zou, H. (2005). Fiscal decentralization, revenue and expenditure assignments, and growth in China. *Journal of Asian Economics*, *16*(6), 1047–1064. https://doi.org/10.1016/j.asieco.2005.10.006

Jones, C. (2002). *New Perspectives on the Welfare State in Europe*. Routledge.

Keller, F. B. (2016). MOVING BEYOND FACTIONS: USING SOCIAL NETWORK ANALYSIS TO UNCOVER PATRONAGE NETWORKS AMONG CHINESE ELITES. *Journal of East Asian Studies*, *16*(1), 17–41. https://doi.org/10.1017/jea.2015.3

Kornai, J. (1986). The Soft Budget Constraint. *Kyklos*, *39*(1), 3–30. https://doi.org/10.1111/j.1467-6435.1986.tb01252.x

Lessons from the East — China's Rapidly Evolving Health Care System | NEJM. (n.d.). Retrieved 20 May 2020, from https://www.nejm.org/doi/full/10.1056/nejmp1410425

Li, H., & Zhou, L.-A. (2005). Political turnover and economic performance: the incentive role of personnel control in China. *Journal of Public Economics*, *89*(9), 1743–1762. https://doi.org/10.1016/j.jpubeco.2004.06.009

Li, L. C. (2010). Central-local relations in the people's Republic of China: Trends, processes and impacts for policy implementation. *Public Administration and Development*, *30*(3), 177–190. https://doi.org/10.1002/pad.573

Libman, A., & Rochlitz, M. (2019). *Federalism in China and Russia*. Edward Elgar Publishing. https://doi.org/10.4337/9781788972192

Maarse, H. (2006). The Privatization of Health Care in Europe: An Eight-Country Analysis. *Journal of Health Politics, Policy and Law*, *31*(5), 981–1014. https://doi.org/10.1215/03616878-2006-014

Martinez-Vazquez, J., Lago-Peñas, S., & Sacchi, A. (2017). The Impact of Fiscal Decentralization: A Survey. *Journal of Economic Surveys*, *31*(4), 1095–1129. https://doi.org/10.1111/joes.12182

CEU eTD Collection

Mok, K. H., & Qian, J. (2019). A new welfare regime in the making? Paternalistic welfare pragmatism in China. *Journal of European Social Policy*, *29*(1), 100–114. https://doi.org/10.1177/0958928718767603

Mok, K. H., & Wu, X. F. (2013). Dual decentralization in China's transitional economy: Welfare regionalism and policy implications for central–local relationship. *Policy and Society*, *32*(1), 61–75. https://doi.org/10.1016/j.polsoc.2013.02.002

Oates, W. E. (2005). Toward A Second-Generation Theory of Fiscal Federalism. *International Tax and Public Finance*, *12*(4), 349–373. https://doi.org/10.1007/s10797-005-1619-9

Park, A., Rozelle, S., Wong, C., & Ren, C. (2017a). *Distributional Consequences of Reforming Local Public Finance in China*. Brill. https://doi.org/10.1163/9789004304987_050

Park, A., Rozelle, S., Wong, C., & Ren, C. (2017b). *Distributional Consequences of Reforming Local Public Finance in China*. Brill. https://doi.org/10.1163/9789004304987_050

Peng, I., & Wong, J. (2010). *East Asia*. Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199579396.003.0045

Qian, J. (2015). The Emerging Private Sector in the Chinese Health System. *East Asian Policy*, *07*(03), 61–72. https://doi.org/10.1142/S1793930515000288

Qian, J. (2017). Increasing Government Social Expenditure and Intergovernmental Fiscal Relations in China. *East Asian Policy*, *09*(04), 101–111. https://doi.org/10.1142/S1793930517000393

Qian, Y., & Weingast, B. R. (1996). China's transition to markets: market-preserving federalism, chinese style. *The Journal of Policy Reform*, *1*(2), 149–185. https://doi.org/10.1080/13841289608523361

Qiao, B., Martinez-Vazquez, J., & Xu, Y. (2008). The tradeoff between growth and equity in decentralization policy: China's experience. *Journal of Development Economics*, *86*(1), 112–128. https://doi.org/10.1016/j.jdeveco.2007.05.002

Rahman, R. (2019). The privatisation of healthcare system in Bangladesh. *International Journal of Health Care Quality Assurance*, *32*(1), 97–107. https://doi.org/10.1108/IJHCQA-11-2017-0217

Ratigan, K. (2012). Bringing the (Subnational) State Back In: Provincial Variation in Welfare Regimes in China. In *APSA 2012 Annual Meeting Paper*.

Ratigan, K. (2014). Bringing the subnational state back in: Provincial welfare regimes in China. In *International Political Science Association World Congress, Montreal*.

Ratigan, K. (2017). Disaggregating the Developing Welfare State: Provincial Social Policy Regimes in China. *World Development*, *98*, 467–484. https://doi.org/10.1016/j.worlddev.2017.05.010

Rithmire, M. E. (2014). China's "New Regionalism": Subnational Analysis in Chinese Political Economy. *World Politics*, *66*(1), 165–194. https://doi.org/10.1017/S004388711300035X

Rochlitz, M., Kulpina, V., Remington, T., & Yakovlev, A. (2015). Performance incentives and economic growth: regional officials in Russia and China. *Eurasian Geography and Economics*, *56*(4), 421–445. https://doi.org/10.1080/15387216.2015.1089411

CEU eTD Collection

Rodden, J., & Eskeland, G. (2003). *Fiscal Decentralization and the Challenge of Hard Budget Constraints*.

Rodden, P. J. A., Rodden, J., Eskeland, G. S., & Litvack, J. I. (2003). *Fiscal Decentralization and the Challenge of Hard Budget Constraints*. MIT Press.

Social Security in South Korea and Singapore: Explaining the Differences - Ramesh - 1995 - Social Policy & Administration - Wiley Online Library. (n.d.). Retrieved 20 May 2020, from https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1467-9515.1995.tb00466.x

Svolik, M. W. (2012). *The Politics of Authoritarian Rule*. Cambridge University Press.

Tam, W. (2010). Privatising Health Care in China: Problems and Reforms. *Journal of Contemporary Asia*, *40*(1), 63–81. https://doi.org/10.1080/00472330903270700

Tan, X. (2017). Explaining provincial government health expenditures in China: evidence from panel data 2007–2013. *China Finance and Economic Review*, *5*(1), 9. https://doi.org/10.1186/s40589-017-0054-2

Wallack, J. S., & Srinivasan, T. N. (2005). *Federalism and Economic Reform: International Perspectives*. 528.

Wang, Y. (2017). Why Tax Policy Is Not Politics in China: Public Finance and China's Changing State-Society Relations: WHY TAX POLICY IS NOT POLITICS IN CHINA. *Politics & Policy*, *45*(2), 194–223. https://doi.org/10.1111/polp.12200

Wildasin, D. E. (2004). The Institutions of Federalism: Toward an Analytical Framework. *National Tax Journal*, *57*(2), 247–272. JSTOR.

Wong, J. (n.d.). *Growing Out of the Developmental State:* 26.

Wu, A. M. (2019). The logic of basic education provision and public goods preferences in Chinese fiscal federalism. *PLOS ONE*, *14*(12), e0225299. https://doi.org/10.1371/journal.pone.0225299

Yip, W., & Hsiao, W. (2014). Harnessing the privatisation of China's fragmented health-care delivery. *The Lancet*, *384*(9945), 805–818. https://doi.org/10.1016/S0140-6736(14)61120-X

Zhu, X. (2016). Dynamics of central–local relations in China's social welfare system. *Journal of Chinese Governance*, *1*(2), 251–268. https://doi.org/10.1080/23812346.2016.1166903

Zhuravskaya, E. V. (2000). Incentives to provide local public goods: fiscal federalism, Russian style. *Journal of Public Economics*, 32.

Jin JJ, Dong LJ, Qian WJ. Development of China's private health providers under the governments' encouragement and guiding policies. Chin J *Health Policy*. 2017;10(9):68–74. (in Chinese)

Appendix: Provincial Data

Data sources: China Health Yearbook 2019 and China statistical yearbook 2019.

Provinces	GDP per capita (cny)	GHE per capita (cny)	GHE as % of Health Cost	Health Sector as % GDP	GHE as % of Total Government Expenditure	Debt in % of GDP
Anhui	47712	991.46	33.36%	6.71%	9.54%	21%
Beijing	140211	2274.84	23.13%	7.83%	6.56%	14%
Chongqing	65933	1199.23	31.05%	6.05%	8.19%	21%
Fujian	91197	1119.01	30.27%	4.36%	9.13%	15%
Gansu	31336	1186.95	35.91%	10.59%	8.40%	27%
Guangdong	86412	1240.08	28.61%	5.15%	8.95%	10%
Guangxi	41489	1108.40	37.27%	6.83%	10.28%	24%
Guizhou	41244	1336.11	42.22%	7.71%	9.56%	64%
Hainan	51955	1541.76	35.03%	8.28%	8.52%	39%
Hebei	47772	914.51	28.02%	6.11%	8.94%	17%
Heilongjiang	43274	797.77	22.67%	8.29%	6.44%	21%
Henan	50152	966.16	30.75%	6.11%	10.07%	12%
Hubei	66616	971.78	28.70%	6.15%	7.92%	16%
Hunan	52949	908.83	27.68%	6.21%	8.38%	22%
Inner Mongolia	68302	1243.09	32.97%	6.27%	6.52%	39%
Jiangsu	115168	1049.56	21.91%	4.30%	7.25%	14%
Jiangxi	47434	1258.61	39.63%	6.03%	10.32%	21%
Jilin	55611	1039.20	28.24%	6.59%	7.42%	21%
Liaoning	58008	802.94	21.41%	6.86%	6.56%	27%
Ningxia	54094	1526.16	33.52%	8.65%	7.40%	36%
Qinghai	47689	2338.31	47.51%	10.29%	8.56%	57%
Shaanxi	63477	1177.54	27.61%	7.02%	8.58%	25%
Shandong	76267	880.86	23.59%	4.92%	8.76%	13%
Shanghai	134982	1938.94	21.54%	6.81%	5.63%	16%
Shanxi	45328	962.88	29.99%	7.01%	8.36%	17%
Sichuan	48883	1055.03	27.55%	8.26%	9.07%	23%
Tianjin	120711	1230.77	23.26%	4.66%	6.19%	18%
Tibet	43398	3081.40	68.55%	10.63%	5.38%	
Xinjiang	49475	1149.98	29.19%	10.01%	5.71%	31%
Yunnan	37136	1190.48	36.63%	9.15%	9.47%	41%
Zhejiang	98643	1091.16	21.18%	5.46%	7.25%	15%

CEU eTD Collection