

International Influences on Policymaking in China: Network Authoritarianism from Jiang Zemin to Hu Jintao

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Abstract

Previous research has credited China's top leaders, Hu Jintao and Wen Jiabao, with the social policies of their decade in power, arguing that they promoted these policies either for factional reasons or to achieve rational, problem-solving goals. But such arguments ignore the dominant "fragmented authoritarian" model of policymaking in China that centres on bargaining among bureaucratic agencies. This article asks whether top leadership factions, rational problem solving, or "fragmented authoritarianism" can explain the adoption of one of the Hu and Wen administration's flagship policies, New Rural Cooperative Medical Schemes. Based on a careful tracing of this policy's evolution, it finds little evidence for these explanations, and instead uncovers the role played by international events and organizations, and ideas they introduced or sustained within policy networks. The article highlights some of the effects that China's international engagement has had on policymaking and the need to go beyond explanations of the policy process that focus solely on domestic actors. It proposes a new model of policymaking, "network authoritarianism," that centres on policy networks spanning the domestic–international, state–non-state, and central–local divides, and which takes account of the influence of ideas circulating within these networks.

Keywords: policymaking; social policy; international; rural cooperative medical schemes

The tendency to credit Hu Jintao 胡锦涛 and Wen Jiabao 温家宝 with the social policies of their decade in power is in part a convenient shorthand. But while it is unlikely that major policies would have been adopted or implemented nationwide had China's top leaders opposed them, accounts that focus exclusively on Hu and Wen perpetuate an understanding of policymaking as straightforwardly controlled, top-down, by those at the very apex of the political system. Such accounts

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have their roots in the politics and scholarship of the pre-reform “Maoist” period,¹ when a combination of Mao Zedong’s 毛泽东 penchant for playing a direct role in policymaking, and limited access to China by foreign scholars, resulted in a concentration on his part in driving many policies. Variants of this understanding of Mao-era policymaking focussed on factional power politics among the Chinese leadership or portrayed policy as the product of leaders’ rational, problem-solving calculations.²

Challenging top leader-centred explanations are those that have focussed on bureaucratic actors. Early studies of the bureaucracy and of political organization,³ when combined with greater access to China from the late 1970s, evolved into influential work that in the late 1980s characterized policymaking as shaped by “fragmented authoritarianism.”⁴ This characterization emphasizes the decisive roles of bureaucratic actors and institutional arrangements (systems of rank, functional divisions of authority, and decentralization) and portrays intra-bureaucratic bargaining as important in shaping policy. Based on a study of economic decision making and large-scale energy policies that were important not only to some of China’s top leaders but also to certain provincial governments and ministries, the model might work less well for other policy areas.⁵ But there have been few formal or detailed attempts to test it in other policy arenas.⁶ Instead, it has remained the dominant model of policymaking,⁷ and has been modified since the early 1990s only to take account of the influence of domestic “policy entrepreneurs” – whether individual officials, journalists, editors or non-governmental organizations – who are portrayed as taking advantage of the spaces created by institutional fragmentation. In studies ranging across environmental, trade, housing and anti-poverty policies, these studies show how domestic actors have used their knowledge of bureaucratic structures and ways of working to promote their own interests or policy agendas.⁸

This article assesses the utility of “fragmented authoritarianism” and its key rivals, the leadership power and rationality models of policymaking, through a study of a major domestic social (and health⁹) policy often credited to the Hu–Wen leadership – New Rural Cooperative Medical Schemes (NRCMS; *xinxing nongcun hezuo yiliao* 新型农村合作医疗). It looks at all three models because although fragmented authoritarianism still dominates scholarship on Chinese public policy, leadership power and rational explanations are common in both

1 Influential studies include MacFarquhar 1974 and Pye 1981.

2 Barnett 1974; Harding 1981; Solinger 1984. I draw here on Lieberthal and Oksenberg’s 1988 characterization of the literature, which they discuss in detail.

3 Barnett 1967; Schurmann 1968.

4 Lampton 1987; Lieberthal and Oksenberg 1988; Lieberthal and Lampton 1992.

5 Kenneth Lieberthal himself has argued this. See Lieberthal 1992.

6 For exceptions see Lieberthal and Lampton 2002.

7 I use the term “model” loosely here and elsewhere in the article as does Lieberthal (1992), to refer to a characterization of institutions shaping policymaking rather than to a formal model.

8 Zhu 2008; Mertha 2009; Hammond 2013.

9 I take health policies to fall within the wider “social policy” category.

scholarly and media accounts of Chinese politics and policymaking – and, as we shall see, have been used to explain China’s 21st-century social policies, including NRCMS.

The article focuses on NRCMS case for several reasons. It was an early policy (trialled from 2003 and implemented nationwide from 2005) of the Hu–Wen period, and it was closely related to the major initiative to “Build a new socialist countryside” (announced in early 2006). It was important because it not only aimed to provide health insurance to all rural residents, but also rolled out for the first time in the post-Mao period a (partially) government-funded universal rural social programme. It was then followed by others, most notably means-tested income support and pensions for rural dwellers. But it was with NRCMS that the Party-state for the first time established the entitlement of this previously marginalized (though numerically significant) segment of the population to government-funded social provision.

Using NRCMS as a single case to test explanations of policymaking has both advantages and limitations. It allows this article to present more detail, but it also means that its findings need further testing in other cases. NRCMS is a “hard” case for a test of leadership power explanations due its strong association with Hu Jintao (usually portrayed as in the opposing faction to his predecessor, Jiang Zemin 江泽民) and Wen Jiabao. It is also a hard case against which to test the “rational” explanation, given that it aimed to address a particular social problem. But it is a “soft” case for testing the bureaucratic bargaining explanation, since it does not (like economic or energy policy) involve competition over significant assets or resources. The article therefore presents a potentially stronger challenge to factional and rational models, but it cannot fundamentally challenge bureaucratic bargaining models that may work well in policy arenas that (unlike NRCMS) generate greater intra-bureaucratic competition. Its own propositions about international influences and policy networks must also be tested through examination of other cases.

Methodologically, the article draws on recent attempts in political science to strengthen qualitative case study analysis by using process tracing to evaluate competing hypotheses.¹⁰ It uses previous explanations of the adoption of NRCMS to establish hypotheses,¹¹ but it identifies others from a combination of prior theoretical knowledge and detailed understanding of the case. The analysis proceeded as follows. I first traced the evolution of the policy from its beginnings in the 1980s through to the mid-2000s (when it was rolled out nationwide) using Party and government policy documents, the reports of international organizations, Chinese newspaper articles and scholarly papers. Having drawn up a policy timeline (for a greatly simplified version see the Appendix to this article),

10 Van Evera 1997; Bennett 2010; Collier 2011.

11 In the rest of this article, I refer to “explanations” rather than discussing hypotheses in formal terms. This is done to save space and to make the article more readable. My “dependent variable” is the decision (actually, a sequence of decisions, as we shall see) to adopt NRCMS and implement it nationwide.

I identified key decision points in the policy's evolution, and the actors involved around those decision points. I was also able to identify changes to the policy's content (for example the shift from township to county level administration, and from individual to combined individual-and-government funding) and to the official rationale for the policy.

Using this timeline, I evaluated prior explanations and identified new actors and influences on the policy so as to generate a new explanation of its development and a new model of policymaking. In so doing I was alert to the potential influence of factors identified in policy research elsewhere, particularly those relating to policy networks and the influence of ideas in policymaking.¹² These factors and concepts are rarely deployed analytically in Chinese policy research.¹³

The rest of the article proceeds as follows. It first gives an overview of key events in the evolution of what became NRCMS. It then elaborates the three dominant models of policymaking in China and their actual or hypothetical competing explanations of NRCMS.¹⁴ The article then assesses the evidence for these explanations, before setting out an alternative that highlights international influences – organizations operating within policy networks and their ideas, as well as international events and interpretations of them. The article concludes by discussing the changing significance of international influences over time and proposes a new model of the policy process – network authoritarianism.

New Rural Cooperative Medical Schemes: A Brief Timeline

New Rural Cooperative Medical Schemes were adopted as national policy and implemented nationwide in the first decade of the 21st century. But they can be traced back to Rural Cooperative Medical Schemes (RCMS, *nongcun hezuo yiliao* 农村合作医疗) adopted from the late 1950s and extended during the Cultural Revolution to around 80 per cent of villages.¹⁵ These schemes were, however, allowed to collapse in the early 1980s, so that by 1984 they existed in only about 5 per cent of villages.¹⁶

From 1985, the Chinese Ministry of Health, with advice and support from the World Bank and the Rand Corporation, began exploratory experiments with commercial insurance alternatives to RCMS.¹⁷ But by 1991, during a pause in pro-market reforms following the 1989 Tiananmen protests and crackdown, RCMS emerged as the preferred policy – backed by Li Peng 李鹏 and the

12 In this I was influenced by Hall 1993; Béland 2009; John 2012.

13 Though some have discussed ideas (see Li 2017), while others have identified domestic policy networks in China (see most notably Zhao 2010, Zhu 2003), they have not used them to develop a model of policymaking as I do below.

14 I refer to “explanations” here and below, rather than formally transforming explanations into hypotheses.

15 Lampton 1977.

16 Duckett 2011a, 6.

17 Sine 1994; Wang 2009.

Ministry of Health.¹⁸ In the early 1990s, Ministry of Health-led experiments with RCMS began, and in January 1997 the Party Central Committee and State Council issued an authoritative “Decision” (*juding* 决定) that announced nationwide voluntary RCMS experiments and the goal of extending schemes to all rural residents by 2000.¹⁹

With only a few exceptions, however, localities failed to implement experiments in the late 1990s because the Party-state centre simultaneously pushed forward tax-for-fee reforms aimed at reducing unpopular local government levies that were said to be creating unreasonable burdens for farmers.²⁰ The centre then issued a Notice in July 1998 that made clear that local governments should not gather fees (which included RCMS contributions).²¹ RCMS was quietly dropped until May 2001 when it once again appeared in “Guiding opinions on rural health work” drawn up by the State Council Economic System Reform Office, State Planning Commission and Ministries of Finance, Agriculture and Health.²²

In January 2002, nine months before Jiang Zemin stepped down as General Secretary of the Chinese Communist Party (CCP) and Hu Jintao took over that role, Vice-premier Li Lanqing 李岚清 ordered the formulation of rural health reform policies including rural health protection. This led to an October 2002 Party Central Committee and State Council Decision announcing rural health reforms and “new” RCMS (NRCMS) just before Hu Jintao took leadership of the CCP.²³ NRCMS differed from RCMS (in 1997) in two key ways: first, it was organized by county governments, rather than by townships; second, it involved government funding alongside voluntary farmer contributions.²⁴

The 2002 Party-state Decision, unlike its 1997 predecessor, was soon followed by “Opinions” to push the implementation of local experiments. In January 2003, two months before Wen Jiabao became premier, the State Council ordered each provincial level government to select two or three counties to pilot NRCMS,²⁵

18 Müller 2016.

19 Party Central Committee and State Council 1997. The RCMS model did not include any government funding, so that revenues were to be generated only by villager contributions.

20 The Party had been monitoring rural protests that it understood to be linked to the “farmers’ burden” caused by taxes and local government fee-charging. See Duckett and Wang 2017. The centre issued a Decision on reducing these burdens on 30 December 1996, two weeks before the January 1997 Decision on health reform. See Party Central Committee and State Council 1996.

21 Party Central Committee Office and State Council Office 1998.

22 State Council Economic System Reform Office, State Planning Commission, Ministry of Finance, Ministry of Agriculture and Ministry of Health 2001. This document refers to the 1997 Party Central Committee and State Council Decision on health reform. It encourages RCMS but stresses the need to accord with local circumstances and is vague on the government role.

23 Party Central Committee and State Council 2002.

24 Ibid. Initial local government contributions were 10 yuan per person and the Centre was to contribute 10 yuan per person in central and western parts of the country (Party Central Committee and State Council 2002).

25 The State Council circulated the “Opinions of the Ministry of Health, Ministry of Finance and the Ministry of Agriculture on Setting up the New Rural Cooperative Medical System.” These NRCMS Opinions had been prepared alongside the 2002 Decision and elaborated the policy’s key elements.

and then ordered the creation of NRCMS coordinating committees.²⁶ Experiments began that year, and were then extended. In September 2005, the Party-state centre reviewed the experiments at a National NRCMS Pilot Work Conference and announced the goal of adopting the programme nationwide by 2008, ahead of the original schedule of 2010.²⁷ By 2008 NRCMS had extended a measure of health risk protection to almost all the rural population.

Explaining the Adoption of NRCMS

Leaders and factional power explanations

Factional explanations have typically argued that a policy is adopted by one group of leaders “to rebuff a challenge from rivals,” or by a faction “for the rewards it bestows upon its network of loyalists.”²⁸ Such explanations were found in work on major policy shifts from the 1970s through into the 1980s,²⁹ but they have become much less common in policy analyses since then.³⁰ And when factions – notably the Shanghai Clique, “Youth League” faction, and “Princelings” – are mentioned, they are portrayed as more fluid than in the Mao and early post-Mao periods.³¹

Although factional power rivalries have not been used to explain the adoption of NRCMS in 2002, factions *have* been mentioned in connection with the social policies of the 2000s that include NRCMS. Shaun Breslin has argued, for example, that Hu’s social policies marked a distinct shift by the “Youth League” faction toward tackling inequality and deprivation and away from the economic growth-focussed policies of Jiang Zemin and the Shanghai clique.³² Cheng Li, meanwhile, has argued that Hu Jintao’s lack of factional support in the top echelons of the CCP motivated him to use social policies to generate popular support.³³ Neither, however, provides evidence for his claim.

In fact, factional power plays do not provide a satisfactory explanation of the adoption and extension of NRCMS in the early 2000s under Jiang Zemin and then Hu Jintao. Jiang Zemin is usually associated in factional analyses with the Shanghai Clique, and his successor as President and CCP General Secretary, Hu Jintao, with the rival Youth League faction. Yet, Jiang backed RCMS in 1996 and then revived it in 2001. He (and Premier Li Peng) attended a national health conference in December 1996 at which he spoke in support of

26 It set up an Inter-Ministry NRCMS Liaison Office, chaired by Vice-premier Wu Yi. See Wang 2009; Manuel 2015.

27 Wang 2009, 395–96.

28 Lieberthal and Oksenberg 1988, 3.

29 Ibid, 14–16.

30 Exceptions are Li 2005, and Shih 2007.

31 Miller 2015; Teiwes 2015.

32 Breslin 2008.

33 Li 2005.

RCMS.³⁴ Jiang has also been specifically linked to putting it back on the central government agenda in late 2001.³⁵ NRCMS policy was then formulated under his leadership from January 2002 and adopted in October that year, just before the 16th Party Congress in November at which Jiang stepped down and Hu took power. Measures to implement and extend the policy were sustained under Hu into 2003 and beyond.

Leaders and rational explanations

“Rational” explanations portray policies as responses to objectively existing economic, social or political problems. In some variants, the decision makers are simply “policymakers” or “the government,” and their motives are not explored. Such explanations are often implicit in studies that describe rather than analyse policies, and are common in work by scholars who focus on improving policy rather than analysing how it is made. In other variants, top leaders adopt policies “pragmatically to solve new policy problems” or in order “to keep alive [their] ideological vision.”³⁶ Work making these arguments often focuses on leaders and their values and preferences.³⁷ Others consider their background and experience. The economic growth-focussed policies of the Jiang and Zhu period are thus sometimes linked to their urban, coastal leadership experience, while Hu and Wen’s focus on rural social policy is portrayed a result of their background in poor rural areas and agricultural affairs.

Rational explanations are evident in accounts of NRCMS – particularly those that are concerned more with its outcomes than with why it was adopted.³⁸ But others interested in explaining the evolution of RCMS and eventual adoption of NRCMS have also sometimes used them. Chief among them is Wang Shaoguang, who has argued that the Ministry of Health and then central government policymakers “learned” from research and policy experimentation that RCMS was better than user-pay systems first. Top policymakers then learned from further experimentation that cooperative schemes needed government funding to make them work, and they agreed to such funding after fiscal revenues grew in the early 2000s.³⁹ Thus the government is portrayed as dealing with a social problem once it has the right policy and the finance to do so.

Wang’s study provides a fascinating account of the evolution of RCMS experiments, and it argues persuasively that the central government’s improving fiscal situation was conducive for implementing government-subsidized NRCMS. But fiscal revenues rose as a share of gross domestic product from 1997 onwards, and leaders could have chosen to spend on any number of projects and policies. Fiscal

34 Xia 2003.

35 Liu and Rao (2006, 83–85) provide a detailed account.

36 Lieberthal and Oksenberg 1988, 3.

37 Ibid., 11–13, citing Barnett 1974, Harding 1981 and Solinger 1984.

38 For example, Wagstaff et al. 2009; Babiarz et al. 2010.

39 Wang 2009.

capacity is therefore an important contextual variable, but it does not explain why a decision was taken in 2002 (rather than earlier or later) to adopt NRCMS, and why it was prioritized over other policies (such as rural pensions).⁴⁰ While Wang demonstrates the Chinese governance system's extraordinary capacity for experimentation, research and extensive discussion of some policy options, his account also tends to idealize that process – as if the adopted policy is the correct one, when as others have argued, some aspects of NRCMS were flawed: its focus on catastrophic, inpatient care, and its limited funding compared with urban programmes.⁴¹

Bureaucrats, policy entrepreneurs and fragmented authoritarian explanations

The “fragmented authoritarian” portrayal of policymaking directed attention in the late 1980s to bureaucratic actors and institutions as an important corrective to studies that had focussed on leaders.⁴² This sophisticated work revealed how policy outcomes were strongly influenced by bargaining among competing bureaucratic agencies – including central ministries and provincial governments. It showed that the system of bureaucratic rank meant that when agencies of the same rank disagreed on an issue or policy, it would be passed upward to top leaders to coordinate, mediate or adjudicate. As a result, it argued, policy processes were “diffuse,” “protracted,” “incremental” and “disjointed.”⁴³

Although fragmented authoritarianism and bureaucratic bargaining has not been explicitly invoked to explain the making of RCMS or NRCMS policy in the 1990s and 2000s, some accounts do focus on bureaucratic actors. Armin Müller, for example, characterizes the development of NRCMS as shaped by bureaucratic actors taking competing pro-government (in favour of state-funded CMS) and pro-market (in favour of commercial insurance) positions.⁴⁴ His focus is on key central government agencies that tended to favour one position or the other – the Ministry of Health in favour of CMS, for example, and the Ministries of Agriculture and Finance in favour of commercial health insurance. Müller portrays these bureaucratic positions as based on institutional perspectives – the Ministry of Agriculture wanting to reduce farmers' burdens and so against compulsory farmer contributions to CMS, the Ministry of Finance against large budgetary commitments – but also sometimes influenced by ministers' alliances with other leaders.

Bureaucratic actors certainly were important. The Ministry of Health was charged with RCMS work from the 1980s through to the late 1990s, leading

40 Wang gives no detail of events at the critical decision-making juncture of 2002, when RCMS/NRCMS came back onto the agenda.

41 Ryan Manuel (2015) also makes this point – that the problems of earlier models remain in the model that is adopted.

42 Lieberthal and Oksenberg 1988, 16–17.

43 Ibid., 24–27.

44 Müller 2016.

experimental studies and formulating RCMS policy documents. The State Council Economic System Reform Office (ESRO) and its drafting group in 2002 coordinated NRCMS policy formulation and negotiation.⁴⁵ Policy documents setting out both RCMS and NRCMS policy were often issued under the joint names of several ministries, including the Ministry of Agriculture and Ministry of Finance, indicating that they had been involved in producing them.⁴⁶

There is also some evidence of bureaucratic bargaining over the details of RCMS and NRCMS. In both programmes, farmers contributions were stipulated to be voluntary as a concession to the Ministry of Agriculture, because mandatory contributions would have undermined that Ministry's efforts to reduce local government fees and the "farmers' burden."⁴⁷ In addition, the ESRO's drafting group – consisting of representatives of the Ministries of Health, Agriculture and Finance – provided a forum for bargaining, and the 2002 Decision on Rural Health Reform reportedly went through thirty drafts over nine months.⁴⁸ Although we do not have details of the drafting group's negotiations, the Ministry of Finance will have been involved in setting the level of fiscal support for the programme. This support was obtained (on 9 October 2002 at a State Council meeting chaired by Zhu Rongji⁴⁹), but the relatively low per capita fiscal spending on the programme will have been determined in this process.⁵⁰

At the same time, however, the RCMS and NRCMS case shows the limits of bureaucratic bargaining explanations. First, the Ministry of Health developed RCMS (involving villager contributions) at the same time as the Ministry of Agriculture developed its rural tax-for-fee reform policies that sought to eliminate non-tax "fees" (that would include RCMS contributions) on rural dwellers.⁵¹ As mentioned above, a Decision to tackle fees was approved at the very top of the Party-state in December 1996,⁵² and the RCMS Decision followed in January 1997. Here we see evidence of fragmentation – with different ministries pursuing conflicting policies separately. But instead of disagreements between ministries being pushed upward for mediation and resolution during policy formulation as predicted in the fragmented authoritarian model, initially at least, the Party Central Committee and State Council adopted both policies. It was only later

45 The ESRO had been given responsibility for rural health work in November 2001 according to Liu and Rao (2006), though it had also led production of the "Guiding Opinions on Rural Health Reform and Development," promulgated on 24 May 2001 (Ministry of Health 2003, 3).

46 For example State Council Economic System Reform Office et al. 2001.

47 Müller (2016) details the Ministry of Agriculture's position on the farmers' burden and argues that the Ministry of Finance and Planning Commission in 1993 withdrew financial support for CMS – at a time when the fiscal system was seen to be in crisis – and so inter-governmental transfers to support CMS were taken off the table.

48 Ministry of Health 2003, 3–4.

49 Ibid.

50 The initial central government funding commitment was ten yuan per rural dweller (per year) participating in the programme in western provinces.

51 See also Wang in this special section.

52 Party Central Committee and State Council 1996. This document specifically said that cooperative medical schemes must be voluntary.

that the Party-state centre issued a decision prioritizing the reduction of farmers' burdens and forbidding governments to charge (non-tax) fees in the name of the collective, thus undermining RCMS.⁵³

Second, the making and adoption of RCMS – and ultimately NRCMS – policy was not noticeably diffuse (in the sense that a particularly large number of bureaucratic actors was involved), though it *was* protracted, incremental and disjointed. Following a decision to pursue RCMS in 1991, it evolved slowly and incrementally over the next 17 years: the Ministry led experiments from 1993–95, reviewed them in 1996 and the Party Central Committee and State Council issued a decision in 1997 that set a target date of 2000 for nationwide implementation.⁵⁴ RCMS then dropped off the policy agenda until 2001. (The 1998–2001 hiatus could be seen as a “disjointed” period.) It (now NRCMS) was then pursued again at an accelerated pace, with further experiments and ever-wider implementation until it had been adopted nationwide by 2008.⁵⁵

International Influences

As we can see from the account above, a critical juncture in the making of NRCMS policy occurred in 2001–02, when the Party-state decided again to adopt rural cooperative medical schemes. This shift was surprising given the neglect of RCMS since 1997, and even more so since the “new” version for the first time included governmental funding alongside voluntary villager contributions, with central government funding poor areas, and wealthier local governments funding their own.

What caused (N)RCMS to rise up the agenda in 2001 and be adopted as policy in 2002? As we have seen, neither leadership factional politics, rational policy-making nor bureaucratic bargaining have been able explain the policy shift at this time. There was no leadership change in 2001 or early 2002. Leaders had known about rural impoverishment due to ill health and high medical expenses since the mid-1990s, and the central government's fiscal situation had been improving for several years. A key point of intra-bureaucratic contention between the Ministry of Health and the Ministry of Agriculture over contributions and the farmers' burden remained.⁵⁶ Nor were bureaucratic actors influenced primarily by domestic policy entrepreneurs – the officials, the media or domestic NGOs identified in other policy arenas.

I argue below that to explain the 2002 decision to adopt NRCMS, we need to recognize the important part played by international influences. This includes international organizations, which brought resources and ideas to policy

53 Party Central Committee Office and State Council Office 1998. This document did not refer to RCMS. But according to Müller (2016), the Ministry of Agriculture had in 1997 drafted a list of illegal rural fees that included CMS premium contributions.

54 Wang 2009; Manuel 2015.

55 Since then it has been subject to modification and is likely to evolve in the future.

56 See Wang in this special section. Fees were abolished in 2003.

networks they shared with domestic bureaucratic actors and researchers. It also includes international events, which were interpreted in ways that led domestic policy actors to adjust their overall development strategy and the place of RCMS within it. Individual top leaders, accepting these ideas, played a role in pushing or supporting the policy at key moments, in turn because it fitted (or was presented to them as fitting) their overarching, evolving political and economic strategy.

International organizations and policy networks in China

China signed a memorandum of understanding with the World Health Organization in 1978 and joined the World Bank in 1980. From that time, the Ministry of Health engaged extensively with these two international multilateral institutions as well as having bilateral cooperation in the health arena with both governmental agencies and international non-governmental organizations. Wide-ranging activities – including research projects, training courses, lectures and seminars – brought many international health experts to China, and foreign study trips took Chinese officials abroad.⁵⁷

In relation specifically to rural health risk protection, the Ministry of Health partnered with a number of international organizations who funded experiments with rural insurance in the 1980s and then RCMS in the 1990s. From 1985 through to 1993 the Ministry worked together with the Rand Corporation in two counties in Sichuan province to explore rural health insurance options.⁵⁸ This followed a World Bank mission in January 1985 aimed at planning a health loan to China, and at a time when the collapse of Mao-era RCMS was becoming apparent.⁵⁹ The Rand project was included in a World Bank loan in 1986 to experiment with different rural health insurance plans between 1989 and 1990.⁶⁰

In the 1990s, after receiving a top-level steer toward CMS rather than commercial insurance under Li Peng,⁶¹ the Ministry of Health further explored RCMS policy options in tandem with the World Health Organization (WHO), the World Bank, the United Kingdom government's Department for International Development (DfID), the Rockefeller Foundation, the United Nations International Children's Emergency Fund (UNICEF), United Nations Development Programme and the Asian Development Bank (ADB).⁶² From 1993, for example, a seven-year UNICEF project examined options for financing health care for the rural poor, while the World Bank's 1998–2007 Health VIII project included rural health financing.⁶³ In 2001, a reportedly influential ADB

57 Huang 2015.

58 Sine 1994; Cai 2009.

59 Cretin, Williams and Sine 2006, 2.

60 Ibid.

61 I have not been able to find details of this important decision in 1991 and so cannot evaluate the importance of Li Peng's role relative to those of other actors.

62 Liu and Rao 2006; Wang 2009, Table 2.

63 The Health VIII project began in 1998 and ended in 2007. Wagstaff and Yu 2007.

project for the State Development and Planning Commission (SDPC) drew on the UNICEF project findings.⁶⁴ Some of these projects contributed to the regulatory framework of NRCMS as adopted from 2002.⁶⁵ It is important to note, however, that alongside these foreign-funded projects were other local experiments that appear to have had no direct international involvement.⁶⁶

This is not to say that international organizations drove policy change. It is difficult to discern whether they encouraged projects on rural health protection or whether the Ministry of Health took the initiative to solicit funding and technical support. Indeed, documented accounts of research projects often indicate that the Ministry of Health and other central government agencies invited support for projects to explore RCMS, insurance or other schemes. Those involved in the World Bank rural health projects in the 1980s for example noted that Ministry officials had “expressed an interest in developing a viable health insurance system.”⁶⁷ And in 1993, the State Council Research Office conducted a study of RCMS that concluded the government should support its revitalization to help solve the problems of access to primary health care and financial risk protection.⁶⁸ In January 2001, the SDPC commissioned the Asian Development Bank to provide technical assistance on possible social security reforms, including rural health insurance, for possible inclusion in the 10th Five Year Plan.

Although they may sometimes have supported different models of rural health financing and service delivery,⁶⁹ international organizations’ willingness to consistently fund projects helped keep rural health protection generally, and often RCMS specifically, on the Ministry of Health and wider central government agenda. The projects that they funded (often via the Ministry’s Foreign Loan Office), and to which they contributed technical support, repeatedly helped make the case first that that user-pay rural health care could not provide equitably and there was a need for either RCMS or health insurance. They then argued that RCMS was more viable than commercial insurance, would help reduce ill-health-induced poverty, and that government investment was necessary if RCMS was to provide widespread coverage.⁷⁰ Their reports and the papers that international researchers published often praised Mao-era RCMS and encouraged attempts to reinvigorate or improve on it.⁷¹

64 Liu, Rao and Hu 2002.

65 Müller argues that a “Best Practices Task Force” (which involved WHO, UNDP and Ministry of Health) and the ADB project influenced the final regulatory framework of NRCMS in the early 2000s.

66 As mentioned, for example, by Wang (2009, 385), though the projects listed in his Table 2 all involve international partners.

67 Cretin, Williams and Sine 2006, 2.

68 Liu, Rao and Hu 2002.

69 Different international organizations sometimes promoted different models, including, for example, commercial insurance. Müller (2016) argues that the Ministry of Health in 1990 specifically rejected the insurance models that had been explored in the Rand project and opted instead for state-backed CMS.

70 Wang 2009, 391–2.

71 World Bank reports in 1984, 1992 and 1997 all supported CMS and tax funding for it.

At the same time, these organizations became embedded in Chinese health policy networks and via them into elite personal networks. Their offices in Beijing employed both international and local staff and researchers, and through protracted interactions (including fieldwork, seminars and conferences), their staff and consultants joined a network of actors in the rural health policy arena alongside the Ministry of Health and domestic health researchers. This enabled them to advance and discuss options for delivering health risk protection to rural dwellers and develop arguments about rural impoverishment due to ill health. As an example, the late 1990s UNICEF and 2001 ADB projects involved Ministry of Health researchers and the Harvard School of Public Health, and the ADB report (commissioned by the SDPC and drawing on the UNICEF findings) was sent to the minister of health, Zhang Wenkang 张文康. This minister, who had worked in the past with Jiang Zemin, communicated the report's findings to him personally, with the result that the CCP Central Committee pursued its findings. Liu and Rao link this directly to RCMS moving up the policy agenda in 2001.⁷²

China's membership of the WHO and World Trade Organization

International organizations influenced NRCMS policy not only through funding and the ideas they brought to the health policy networks in which they were involved. Here the examples of the WHO and the World Trade Organization (WTO) are instructive. In relation to the WHO, there is evidence that at two points, it (or China's membership of it) encouraged the government to pursue RCMS. First, in 1985 China pledged at the WHO's World Health Assembly to "afford everyone entitlement to basic health care by 2000," something that would necessitate a move away from the user-pay medical system prevalent at that time and so encouraged the Chinese government to develop rural health risk protection.⁷³ In other words, commitments made in this international forum indicate the Chinese government accepting international ideas, benchmarks and targets that may have helped keep RCMS or an alternative on the policy agenda. Second, and more directly, the World Health Organization's *World Health Report* in 2000 evaluated and ranked health care systems around the world on several different indicators. In terms of "fairness in financial contribution," China's health care system ranked very low indeed – 188th out of 191 nations – and primarily because of poor health risk protection (insurance-type provisions) in the countryside. Several accounts of RCMS development have indicated that this shocked China's top leaders (not least because RCMS had been praised in the past for its achievements) and catalysed a renewed focus on rural health protection that contributed to the adoption of NRCMS in 2002.⁷⁴

⁷² Liu and Rao 2006.

⁷³ Wang 2009, 386.

⁷⁴ Zhang et al. 2014; Müller 2016.

China's membership of another multilateral institution also played a role in the adoption of NRCMS. China joined the WTO in December 2001 after 15 years of negotiations, and its accession was portrayed as a major achievement for Jiang Zemin, who had personally backed it. But the Chinese leadership was aware that WTO entry was likely to hit agriculture (and so farmers) harder than some other sectors of the economy. In August and September 2001, a National People's Congress investigation recommended strengthening rural social security to prepare for WTO accession.⁷⁵ A Party rural work conference held in early January 2002 discussed the likely negative impact of WTO entry on agriculture and the need to mitigate the effects of WTO entry through a series of rural policies, including RCMS.⁷⁶ Immediately after a rural health work conference in late January, Vice-premier Li Lanqing tasked the State Council Office with formulating policy documents (Ministry of Health 2003). Following this, through the rest of 2002, Li pushed forward rural health work in general, and NRCMS in particular.

International events: the Asian Financial Crisis of 1997 and its interpretation

RCMS policy was also influenced by China's regional and international economic integration and particularly by the Asian Financial Crisis of 1997. The Crisis did not directly and immediately affect China's economy, but by 1998 its effects were being felt through harder-hit trading partners in the region. Justin Yifu Lin 林毅夫, a prominent Chinese economist (who had studied in the United States), began to argue that China should seek to grow domestic demand, especially in rural areas, so as to reduce reliance on international markets.⁷⁷ This interpretation then converged with longstanding concerns about low rural incomes and the adverse impact of impending WTO entry. The January 2002 rural work conference neatly drew all these issues together before concluding on the importance of rural work, including rural health work, and the need to implement RCMS:

At present, the most prominent problem in agriculture and rural economic development is still the difficulty of raising rural incomes.... This year is the first year of our country's entry to the World Trade Organization, and agriculture may receive a quite large shock, [so] increasing rural incomes will be even more difficult. Increasing rural incomes not only relates to rural economic development, improving rural livelihoods and rural social stability, but also relates to implementing the line of expanding domestic demand and to the full picture of economic and social development. The whole Party must take this problem very seriously, make increasing rural incomes the most important task in agriculture and rural work, and put in a prominent position in all economic work.⁷⁸

75 Müller 2016.

76 Zhu 2002.

77 Lin 1999. Lin was Chief Economist at the World Bank from 2008–2012.

78 Zhu 2002. Note the reference to "social stability" in this quotation. There is not the space in this article to discuss at length the extent to which concern with rural instability might have played a role in pushing NRCMS up the policy agenda. It was a long-term concern underpinning the Party's focus on rural

In the 1990s, arguments for CMS had focussed on how it could help tackle rural poverty and well as contribute to rural development and social stability,⁷⁹ but it was not until rural health and poverty were interpreted as holding back wider national economic development that they became a priority. The 19 October 2002 document “Concerning Strengthening Rural Health Work” that announced plans for NRCMS, similarly argued that rural health work “relates to protecting rural production capacity, enlivening the rural economy and protecting social development and stability.”⁸⁰ At the rural health conference held in October 2002 further promoting these rural health policies, including NRCMS, Li Lanqing quoted Jiang Zemin to link rural health work again to the wider goal of economic development:

Comrade Jiang Zemin has pointed out: “Rural health work directly relates to rural development, thriving agriculture and rural health, [and] it relates to the achievement of our country’s economic and social development targets.”⁸¹

Conclusion

Pinning down the factors shaping policies in China is notoriously difficult,⁸² and there is much about the making of NRCMS policy that remains hidden. Despite this, the analysis above has shown that it is not simply the case that Hu Jintao and Wen Jiabao embarked on a new rural social policy agenda after they came to power. NRCMS, widely seen as their first flagship rural policy, was in fact adopted toward the end of the Jiang–Zhu administration in October 2002, while Jiang had supported an earlier variant in 1996. In addition, the commitment to funding it and coordinating its implementation was taken by January 2003, before the SARS epidemic hit the headlines and before Wen Jiabao became premier. This article thus reveals policy continuities across administrations where others have emphasized discontinuities and seen factional differences.⁸³

Top leaders have nevertheless evidently played an important role in the adoption and then implementation of NRCMS. Li Peng supported it in 1990–91, and together with Jiang Zemin, backed it in 1996. Vice-premier Li Lanqing pushed it forward in early 2002, perhaps at the behest of Jiang, who is reported to have come out in support again from 2001.⁸⁴ Hu Jintao and Wen Jiabao then

footnote continued

incomes as well as tax and fee reform, but does not explain the timing or content of NRCMS. For more discussion see Duckett and Wang 2017.

79 E.g. Party Central Committee & State Council 1997; State Council 1997.

80 CPPCC & SC 2002.

81 Li 2002.

82 Teiwes 2015.

83 Another continuity is seen in Wen Jiabao’s role as vice-premier under Jiang Zemin, though the evidence above indicates that it was first Vice-premier Li Lanqing and not Wen, who played a key role in NRCMS in 2001–02.

84 Note, however, that as first vice-premier, Li’s role was to assist Premier Zhu Rongji with State Council work, which indicates cooperation and coordination at the top.

supported its implementation after they came to power. But at the same time, the NRCMS case shows that it is not always sufficient for a top leader – even the Party General Secretary – to back a policy. Although Jiang Zemin supported RCMS in 1996, and the CCP Central Committee and State Council Decision in 1997 adopted it, the Party centre then apparently retreated, and prioritized rural tax-for-fee reform instead.

But NRCMS was not simply a rational leadership response to the discovery of a social problem. The problem of lack of RCMS coverage had been recognized by the Ministry of Health in 1985 and by the Party centre and State Council by 1991, but it took until 2002 for NRCMS to become sufficiently prioritized to be adopted and government funded, and until 2008 for it to be implemented nationwide. As we have seen through this study, the top leadership's agenda was in flux as policy ideas mixed and some rose to become prominent issues. NRCMS was adopted and implemented when it appeared to contribute to solving several prominent social, political *and* economic problems – with problem-definition partly shaped by international events and ideas.⁸⁵

Institutional arrangements encouraged and supported ministries to produce and experiment with policies, but bureaucratic bargaining over resources was not central to NRCMS development. Fragmented authoritarian explanations tend to focus on bargaining, but we see that only in the final months before the adoption of NRCMS. In the 1990s, rather than bargaining, we saw the simultaneous adoption of competing policies by the highest levels of the Party-state and then within a year the Party stepping in to clarify which policy had priority. The result was a failure to implement NRCMS. We do not know exactly what happened behind the scenes at that time, but it appears that the Party centre prioritized tax-for-fee reforms because it was concerned with rural unrest and because as the Asian Financial Crisis hit China it pushed financial probity and fiscal prudence up the agenda, perhaps particularly for Zhu Rongji.⁸⁶ Thus central Party-state priorities apparently changed not only due to learning within policy spheres, but also under the influence of international events and an evolving development paradigm.

This article also shows the important role that international organizations have played in supporting and encouraging NRCMS. They funded research and policy experiments from the mid-1980s through the 21st century that helped establish not only the impact of poor health protection on rural poverty but also RCMS's need for government funding. Nevertheless, learning, research and

85 I do not speculate on the personal motivations of individual leaders or on how their experiences might have influenced their decisions. In China's political system, there is little (reliable) information on top leaders' personal opinions and ideas. Particularly under Hu Jintao and Wen Jiabao, official sources did not reveal leaders' personal policy preferences and instead preferred to maintain a show of collective leadership. When I interviewed individual researchers closely involved in NRCMS circles about top leaders' motives, they claimed to have no information.

86 Zhu had led fiscal reforms in 1994 and there is documentary evidence that he was behind moves to clean up rural insurance schemes in the late 1990s. See Duckett and Wang 2017.

experimentation was insufficient: there was a huge amount of this from the late 1980s in relation to RCMS right through into the 21st century and yet NRCMS was not adopted until 2002. The ADB/UNICEF research finding about the scale of impoverishment due to ill health may have catalyzed Jiang to push the policy again from 2001. But it also followed the adoption of a view that overall economic development needed stronger domestic demand, the WHO's critical 2000 report and the problems that WTO entry was likely to create for farmers. This combination of factors brought together health and rural economic considerations. The 2003 SARS epidemic then most likely consolidated commitment to implementing the scheme.⁸⁷

International influences on China's social policies were not exercised, as in many developing countries, through "conditionality" – loans tied to certain conditions. Instead, they were the result of a more subtle process involving ideational influence that was mediated by Chinese Party-state agencies and the officials within them.⁸⁸ This goes beyond the impact of socializing influences of multilateral institutions on China's foreign policy decisions and its adoption of international policies and practices.⁸⁹ It indicates that China's post-Mao international integration and participation in international organizations have profoundly influenced domestic policy.⁹⁰ Influential actors within the Chinese Party-state have not only absorbed pro-market economic ideas from outside,⁹¹ and bought into the GDP growth, consumption-led, globalization model,⁹² they have also accepted social policy ideas, including concepts of social development and health-related equity.

International factors have not yet been incorporated into models of policymaking in China, no doubt due to the difficulties pinning down the influence of ideas as well as the justifiable tendency in analyses of authoritarian political systems to focus on state actors and their power plays. But – even for all their recurring concern about bourgeois liberalization and the potentially negative impacts of "Western" thinking – Chinese Party-state agencies have been keen to search abroad for policy ideas. An examination of these ideas in Chinese policymaking – including how international ideas are introduced and evolve and shape within policy networks in China – is therefore long overdue. At the

87 Note that NRCMS was not simply a response to the external shock of SARS, as argued by Heilmann (2008), because the Decision to adopt it (October 2002) preceded the outbreak (early 2003).

88 I thank one of the external reviewers for this point. For a discussion see Huang 2015.

89 Pearson 1999; Kent 1999, 2013; Johnston 2008; Huang 2015. This work has been more interested in China's compliance with global governance norms than policy influences.

90 Huang (2015) has shown the influence of the WHO, World Bank and Global Fund to Fight AIDS, Tuberculosis and Malaria on public health policies in China, arguing that these organizations are very strongly influential where for China the "negative externalities" are "significant." He notes that otherwise – as this article shows – domestic politics may play a major role, but does not elaborate on those politics.

91 Harold Jacobsen and Michel Oksenberg (1990, 143–44, cited by Huang 2015), for example, have argued that China's participation in international economic institutions helped disseminate Ricardian economic concepts.

92 Duckett 2011b.

same time, more research is needed on the mutual influence of ideas introduced by international actors and those of Chinese domestic actors in policy networks – this is after all surely a two-way process. And more research is needed on when and why international ideas are sometimes rejected or taken as negative examples.⁹³

Having shown the limitations of existing models of policymaking in China, this article proposes a new one – “Network Authoritarianism.” Rather than limiting itself to leaders or bureaucratic agencies as the key actors in policy change, this model makes space for many different actors, and sees them as interacting in policy (and personal *guanxi* 关系) networks that allow ideas to be introduced, exchanged and developed. These networks span the state–non-state (civil society) boundary as well as the central–local and national–international divides, and they may overlap.⁹⁴ While state actors still play an important role in formulating policy documents, and in making decisions (the “authoritarian” element of the model), they can nevertheless be subtly, but often fundamentally, influenced by the ideas of other network participants with whom they interact.

As with previous work on policymaking, Network Authoritarianism identifies novel features of a picture containing many actors and their complex interactions.⁹⁵ It seeks not only to highlight new actors but also to characterize better than previous models their interactions. Network Authoritarianism differs from Fragmented Authoritarianism because it emphasizes not the institutions that divide and segment bureaucratic actors (though of course these exist), but the informal as well as formal networks that form bonds between them. It differs from “FA 2.0” because it sees actors (international as well as domestic) outside the state bureaucracy not as simply finding spaces in the interstices of a fragmented polity, but as sometimes influential constituents of policy networks.⁹⁶ It also differs from “Consultative Authoritarianism,” with its focus on the Party-state’s domination of the policy process and its creation of channels to solicit policy feedback, because it sees Party-state actors as subject to influence – sometimes over the definition and identification of problems as well as over policy solutions.⁹⁷

The Network Authoritarian model of policymaking in China has been developed from research on only one social policy. The extent of international (as well as domestic civil society) participation and influence in policy networks will vary between policies and policy areas, but is unlikely to be confined to this policy

93 See for example Teets 2013.

94 While this article has not discussed the central–local relationships involved in experimentation with (N) RCMS policy, it is clear from other work on policy experimentation that policy and personal networks can play a role in facilitating experimentation (see Heilmann 2008).

95 See also Harding 1981; Lieberthal and Oksenberg 1988, 10–11.

96 Of course, not all actors in a policy network have equal power – with the balance of influence likely to vary from one policy network to another and over time.

97 He Baogang and Stig Thøgersen (2010) have used the term to describe the state’s creation of policy consultation channels, but not to characterize policymaking or explain policies. Jessica Teets (2013) uses the term for a model of the state and civil society relationship, rather than as a model of policymaking.

alone. Whether – or to what extent – the interaction with international actors in social policy extends to other domestic policies, awaits further study. But clearly many of the international actors referred to in this article – the World Bank and UNICEF, for example – have been active in China not only in this policy arena, but also in many others.

Finally, we need also to pay attention to changes in Chinese policymaking over time. Fragmented Authoritarianism refocused attention on bureaucratic actors at a time – the early post-Mao era – when individual leaders' power was a little less evident, the state bureaucracy had been rebuilt after the Cultural Revolution, and China's international engagement beyond the Communist block had only just begun. This article examines most closely the period just after that, from the 1990s through to 2002. It is possible therefore that it does not uncover factors neglected by earlier work but instead reveals changes to policymaking that took place in the 1990s. The turn of the 21st century, when China joined the WTO, was a key moment in China's deepening involvement in the international economy and world order. Jiang Zemin had made it a personal goal to secure China's entry as a defining achievement of his administration and so its influence was likely to be particularly strong at that point. China's economic integration has deepened significantly since the early 2000s and so international influence is likely to have continued to shape policymaking. But Xi Jinping has become more personally powerful in a range of policy areas, and there has been since 2015 push-back against the influence of "Western" ideas in some spheres. We thus need to ask whether (and how) international influences on policymaking in China will grow or decline in the coming decades.

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摘要: 以往研究认为, 是胡锦涛和温家宝, 作为中国前任高层领导人, 主导实施了他们十年任期里的一系列社会政策。这些研究认为, 高层领导要么出于派系原因, 要么出于理性决策的目的, 才推动了这些政策的实施。而这种观点忽视了那种以官僚机构间讨价还价为主要特征的中国政策制定的主流模式: “碎片化权威主义”。本文分别以高层政治派系、理性决策、以及“碎片化权威主义”三种政策制定模式来检验和解释胡温任期内所实施的

最重要的政策之一：新型农村合作医疗制度。基于对该制度发展演化的细致梳理，本文发现支持这三种模式及其解释的证据并不充分。相反，本文发现国际事件、国际组织，以及由国际组织引入中国并在中国的政策网络中持续产生影响的价值理念对政策制定具有重要影响。本文凸显了中国参与国际活动对政策制定所产生的某些影响，并认为解释中国的政策过程不能仅关注国内的行动者。本文进一步提出了“网络权威主义”这样一个新的政策制定模式。网络权威主义模式强调政策网络的重要性：政策网络不仅涵盖了国内-国际，政府-非政府，以及中央-地方的区分，同时，传播于政策网络中的价值理念所产生的影响力也得到了充分重视。

关键词：决策；国际影响；社会政策；农村合作医疗

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Appendix: Timeline of (N)RCMS Policy Decisions

- 1985 Health protection for all (WHO), and experiments in rural health insurance with Rand and World Bank.
- 1997 Party-state Decision on RCMS (not implemented).
- 2002 Decision on 'new' RCMS.
- 2005 Decision to implement NRCMS nationwide.