The policy process and context of the Rural New Cooperative Medical Scheme and Medical Financial Assistance in China

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Abstract

A vast amount of research has been carried out on the rural New Cooperative Medical Scheme and Medical Financial Assistance Scheme in China over the past years, but there still exists a gap in the literature, in terms of research of the rural health policy process. This paper tries to answer two questions: what is the rural health policy process like; what are the main dynamics behind this policy process and how did they influence the process?

This paper first reviews the development of the policy process of NCMS and MFA discussing how public concerns emerged and were translated into political issues and how later on in the process, policy alternatives were chosen and legitimated. Implementation and evaluation of policies are also included in this review to give the reader the whole picture of the policy process.

The second part analyzes the dynamics of the rural health policy process, including the impact of economic transition, social structure transition, a change in decision-making model and policy paradigms, health sector reform at macro level, and influences of different stakeholders at micro level.

Conclusions are: rural health policies should take the economic, social and political context into account; non-governmental forces should be developed and united to represent the public interest; a favorable climate for all stakeholders to 'voice' their interests has been fostered but there is still a long way to go in developing sustainable formal mechanisms.

Introduction

China has experienced rapid economic development during the past twenty-five years, associated with its transition to a market economy. Changes to the rural health system have lagged behind the economic reforms. This paper traces the growing concern among policy-makers about problems in the rural health system and explores the factors that led up to the announcement in 2002 of two major medical security schemes for rural residents, the rural New Cooperative Medical Scheme (NCMS) and Medical Financial Assistance Scheme (MFA).

A considerable amount of research has been carried out on the design, implementation and outcomes of NCMS and MFA (see in this issue also Xu *et al.*). Before the NCMS and MFA schemes were established some researchers argued that reimbursement for major illness and multiple channels for funding should be the basic principles in the design of new schemes. And besides the NCMS scheme, multiple tiers needed to be established in the health care system to meet different needs of rural residents (Hao 1996 and 1999; Zhang 2003). As for the policy implementation, a lot of researchers analyzed the reasons for the failure of the old CMS, and identified the challenges the new scheme faces, such as insufficient funds, adverse selection under the voluntary participation guidelines and the lack of competent health human resources at the township and village levels (Wang 2001; Mao 2005; Wang 2004). Besides, some researchers provided further evidence that there is a significant inequity in net benefit within the NCMS because the settings of its financing and benefit rules include low premiums but high co-payments (Wang *et al.* 2005). With respect to the outcomes of NCMS, some researchers measured the effect of the NCMS on relieving "poverty caused by disease" and they found that the "Poverty Gap Index" has decreased after the reimbursement by NCMS in Hubei province (Chen *et al.* 2005).

Relatively few papers have been published on MFA so far: some senior researchers who have analyzed the challenges confronted by MFA have given some recommendations, and also proposed the necessity of linkages between NCMS and MFA. Some valuable ideas were provided on the linkage of the two schemes at the management level and services level (Liu 2005; Zhang 2006).

Much less attention has been paid to the process and context in which policy agendas were set, political alternatives were chosen, and stakeholders influenced the development of policy. Walt and Gilson have argued that much health policy wrongly focuses mainly on the content of reform, and tends to neglect the actors involved in policy reform, the processes contingent on developing and implementing change and the context within which policy is developed (Walt and Gilson 1994). This paper aims to bridge this knowledge gap. Not too much emphasis is laid here on the content and technical issues of rural health policies. Instead focal points are the development of policy processes and their context, as well as a stakeholder analysis of the NCMS and MFA in rural China. More in particular the paper zooms in on the setting of the policy agenda and formulation of detailed policies. In this way it tries to shed more light on what happened in the policy process of rural health and on the reflections of relevant stakeholders, like policy makers, scholars, on some critical issues. The review of the policy process and the analysis of the policy context and the interaction among different stakeholders might increase our understanding of the development of rural health policies in China.

After a brief section on the methodology used in this paper, we will review in a third section of the paper the development of the policy process of NCMS and MFA; more specifically we outline how public concerns emerged and then were translated into political issues, and how policy alternatives were chosen and legitimated. Implementation and evaluation of policies are also included to give readers the whole picture. In the fourth section we analyze the dynamics in the rural health policy process, including influences of economic transition, social structure transition, a change in decision-making model and policy paradigms, health sector reform at macro level, and influences of different stakeholders at micro level. Conclusions based on the analysis will be drawn in the last part of the paper.

Methodologies

As the policy making process is a sensitive and complex political issue and most of it is not open to the public, the methodology of this research involves a combined strategy of literature review, in-depth interviews and observations in policy seminars and workshops.

Domestic and international research papers, reports and newspaper

articles on public policies and rural health policy in China have been collected and studied. Much attention has been paid to the documents issued by the Communist Party of China, the State Council, and Ministries of the central government. They show the pathway of health policies development in rural China.

In-depth interviews were conducted with key informants, such as senior officers from the Ministry of Health, Ministry of Civil Affairs, Ministry of Finance, and with local officers from Health and Civil Affairs Bureaus, as well as with rural residents in the counties of Zhongxiang and Shimen (Hunan province, Central China), Shangyu (Zhejiang province, Eastern China), and Yuzhong (Chongqing Municipality, Western China). Some senior scholars were also interviewed. This was a key method to get insight into the story behind the rural policy process from the dominant actors and other participants in this process.

Observation of policy seminars and workshops on national health policies focusing on NCMS and MFA was also an important method to derive useful information and clues from the way different stakeholders spoke or from what they said and did not say. This technique could disclose some further information that was either missed or concealed in the literature review and interviews.

The development of policies on NCMS and MFA

The policy process is often cyclic: starting with the recognition of a problem or an issue, moving to agenda setting and formulation of policy to address the issue, then to implementation of the policy and finally its evaluation or assessment. The outcome of this assessment gives feedback for the next policy cycle (Sabatier and Jenkins-Smith 1993). Although many have pointed out that the stages do not necessarily follow a linear pattern, it still provides us with a useful perspective to analyze the establishment and development of these two new health policies in rural China.

SETTING THE POLICY AGENDA

The emergence of public concerns on rural health

In the late 1970s, the market economy reform started in rural China, and the rural collective economy gradually imploded. In most localities this led to the collapse of CMS and households had to bear the full financial risk of

major illness from then on.

Gradually public interest in the problems of the rural health services increased and the vicious circle of illness and poverty became more known as stories appeared in newspapers, television programmes and websites. Over the past 20 years, the mass media have brought the following issues to public attention: disparity in the allocation of health resources, rapid increase in the cost of health care, tensions between doctors and patients, and problems with the quality and safety of medical care.

Although exaggeration and errors are inevitable in news reports, and public opinion might consequently have been misinformed, the media have played important roles in raising public awareness of rural health problems and in transforming the problem into a public issue.

THE TRANSLATION OF PUBLIC CONCERNS INTO POLITICAL ISSUES

Not all public concerns are translated into political issues. Resources and political attention are limited and the government makes choices according to its political priorities and considers whether there is any policy solution available and a supportive political environment. If the policy makers become convinced that a problem is urgent, a window is opened for policy makers to reach into the policy stream for alternatives that can reasonably be seen as a solution (Kingdon 1995).

The government was relatively slow to respond to the problem despite the rural health system crisis being well-reported by think-tanks, and by national and international scholars for more than 15 years. During this period two influential focus events led to a 'window of opportunity' for the case of rural health care. These focus events influenced governmental officials and their advisors to see the public concern as "big" and "crucial" which helped to translate the public concern into a policy issue. While the emergence of these focus events had its contingency and uncertainty, they generated an inevitability rooted in the economic and socio-cultural context, which will be discussed later in the section on the analysis of dynamics. The first focus event was the Report to the Premier by Mr. Li Changping. Li Changping, a Party Secretary in a town in Hubei province, wrote to former Prime Minister Zhu Rongji about the precarious health situation of farmers

in 2000[1]. His letter drew the attention of policymakers and the mass media to the health problems in the rural areas and opened a political window. The second focus event took place in late 2001 when the former Vice-Director of the System Reform Office of the State Council, Mr. Li Jiange, called for serious attention by policy-makers to the big problems with rural health services and stated that the government had to shoulder its responsibility for providing rural residents with essential health care (Li 2001). This alerted senior political leaders and placed the issue firmly on the policy agenda.

Since then think-tanks and the political elites acted to bring the issue onto the policy agenda. According to the statistics of the Chinese Journals Full-text Database, the most authoritative database of academic journals in China, the total number of papers embodied into the database from 1911 to 1979 which contain "rural health" or "rural cooperative medical scheme" in their titles is about 221, but this number rose up to 3,121 from the year 1980 to 2002. This attests to the extensive academic attention given to this issue by researchers in the past two decades. Accompanying this trend, political proposals submitted by the delegates of the National People's Congress (NPC) and members of the Chinese People's Political Consultative Conference (CPPCC) have also drawn attention to rural health. The Vice Chairman of the National Committee of the CPPCC, Zhou Tienong, undertook a four-year investigation of rural health, starting from 2002, concluding that there was a need to establish a formal rural medical security system and offering a number of policy suggestions.

Meanwhile a favorable policy environment was developed with a change of policy paradigm and an increase in financial capability, which will be discussed later. In this context these focus events and public actions accelerated the rise of rural health on the policy agenda and provided some policy alternatives.

[1] In Li Changping's letter, he has not only put forward the problem of rural health, but also stressed the seriousness and urgency of the situation in the Chinese countryside. He summarized the entire situation with the following three phrases: the life of rural residents is so hard; the countryside is so poor; agriculture is so risky. As rural health is part and parcel of the current countryside predicament, it also attracted the attention of policy makers. Later in Jan. 2002, his book entitled "I tell the truth to the Premier" was published and immediately caught the attention of the media.

CHOICE OF POLICY ALTERNATIVES

Agenda-setting determines what public concerns will be put on the policy agenda, but a number of factors determine whether it leads to a new policy. A policy alternative must be financially and politically viable. The choice between policy alternatives reflects a complex tradeoff between different interests and the result is always the "better" alternative, not necessarily the "best" option.

Take the example of NCMS. Before the NCMS became a nation-wide policy, the Chinese government had already collaborated closely with institutions from the international community, such as the World Bank, World Health Organization, the Department for International Development of the UK, Rand Corporation of the United States, and also with domestic research institutes to conduct pilot experiments[2] in a number of counties. The aim was to explore ways to provide rural residents with reliable healthcare after the old cooperative medical scheme had collapsed. These ideas derived from these pilot projects boosted policy makers' confidence that the rural health care system could be rebuilt. At that stage though, explicit policy alternatives were not yet well developed. Nevertheless, the general direction and the policy framework gradually crystallized.

In the year 2002, a more detailed policy design became necessary when the central government finally planned to establish a new type of rural Cooperative Medical Scheme. This generated intense discussion on various policy alternatives, for example on the funding issue. Although the central government agreed to provide more funding, there were diverging views and

[2] These projects have involved many international organizations and domestic institutes: between 1985 and 1993, the World Bank, Rand Corporation (USA) and the Ministry of Health (China) conducted a series of research activities on rural health insurance in Sichuan province (western China) in the Health Project; Anhui Medical University, the Ministry of Health (China) and the Research Office of the State Council (China) have conducted research on the rural Cooperative Medical Scheme and health care system in the late 1980s and in 1993. Thereafter the Ministry of Health (China) collaborated with the World Health Organization by setting up pilot experiments in 14 counties of 7 provinces from 1994 to 1998; the World Bank, the Department for International Development (UK), and the Ministry of Health (China) collaborated in the Health VIII Project to conduct pilot experiments in 10 provinces in the middle and western China between 1999 and 2007. These experiments aimed to improve the capacity of health services provision and utilization in poor areas, and provided many policy concepts for the subsequent development of the Medical Financial Assistance Scheme.

occasional disputes between government departments and between central and local governments. The Ministry of Health proposed a total contribution of 50 yuan per capita, half of the estimated per capita funding required for delivering appropriate rural health care. But the Ministry of Finance insisted on the principle of "what I can do is up to what I have", because health is not the only concern when government budgets are agreed. Economic development always comes first (Wang 2002; Wang 2007). Meanwhile, the central government expected local governments to play a leading role in financing NCMS, whereas local governments counted on the central government to provide fiscal transfers for this purpose. After a period of negotiation the final result was an agreement that the local government and rural residents should each contribute 10 yuan and in addition, in the western parts of the country the central government would provide a further 10 yuan per capita. The question as to which levels of local government should contribute most was resolved with the provincial governments becoming the main source of funding with the governments at city, county, and township levels contributing lesser proportions. However, in the eastern part of the country, the reality has been that government at county level has contributed most of the financing (Evaluation team of NCMS 2006).

Apart from the funding issue, the question whether the NCMS should be voluntary or compulsory was also highly controversial. The government and some scholars (Shen 2003; Dong *et al.* 2007) preferred the voluntary participation principle for rural residents, because from the year 2000, the central government started the "Fee to Tax" Reform to alleviate the financial burden of rural residents. Consequently, the government was very reluctant to compulsorily collect fees from rural residents for NCMS as it would be interpreted as violating the tenet of alleviating rural residents' financial burden. Additionally, the voluntary participation principle was posited as showing respect for rural residents' freedom to choose. Other scholars and international organizations (Liu *et al.* 2002; Bloom and Tang 2003; Long and Luo 2005; Li and Wang 2008) advocated compulsory participation to avoid the "adverse selection" issue. They urged the government to regard the NCMS as a government dominated health insurance scheme and to provide more and steady financial support. In the end, after carefully considering all these different opinions the central government opted for voluntary participation. The official rationale behind the decision as mentioned in the interviews with officials from the Ministry of Health was that this would

make the new scheme more acceptable for rural residents.

LEGALIZING THE NEW RURAL HEALTH POLICY

After choosing the preferred option among several policy alternatives, policymakers and legal subjects have to enact this policy through issuing formal documents. Legitimacy and authority is granted to the new policy by both political and legal authorities, after policymakers reach a consensus on the way to move forward (Dye 1988; Zhang 1996).

In order to give legal status to the new policy on rural health, the central government had to promulgate certain documents. The NCMS and MFA were established by the 'Decision on Strengthen Rural Health Care' issued by the CCPCC and State Council in 2002, with the aim of complementing each other in relieving the economic burden of major illness on rural residents and improving access to essential health care (CCPCC and State Council 2002). It was the first time in Chinese history that the government (from central to local level) had taken a leading role in providing health security for rural residents (in terms of fiscal, management and supervision responsibility).

Following the Decision, the Ministries of Health and Civil Affairs issued a joint 'Opinion on Establishing the New Cooperative Medical Scheme' and the 'Opinion on Implementing the Rural Medical Assistance Scheme' with the Ministries of Finance and Agriculture respectively in 2003. These became the guideline documents in the development of NCMS and MFA

The outbreak of SARS in 2003 exposed the vulnerability of the public health and health provision system in rural areas, making the public and policy makers recognize the urgency of developing systematic rural health systems, including accelerating the set-up of the NCMS and MFA schemes. Henceforth the Ministries of Health and Civil Affairs issued several documents to regulate funds management and monitoring the NCMS and MFA

In 2006 the Ministry of Health and other related Ministries promulgated the 'Notice on Accelerating Pilot Work of the New Cooperative Medical Scheme', including the schedule for NCMS development, guidelines on raising fiscal subsidies for each participant and further development of NCMS. The government subsidy was also raised from 20 to 40 yuan.

The development of the NCMS was accelerated when in 2007

President Hu Jintao in his report to the 17th National Congress of the Communist Party of China proposed the acceleration of the establishment of a social security system and essential health care system for rural residents. With top political commitment, a further increase in the financial subsidies for NCMS was made in 2008, which will be mentioned in the policy adjustment.

Implementation of Rural Health Policy

The central government has only stated general principles, leaving local governments with a lot of flexibility and leeway in policy implementation. On the whole, local governments have taken positive measures to develop rural health care schemes under the guidelines proposed by the central government. This is evidenced by the rapid roll-out and scaling-up of the NCMS over the past few years. Table 1 illustrates the overall impact of this roll-out.

Table 1. Roll-out of the Rural New Cooperative Medical Scheme in China (2004-2007)

		2004	2005	2006	2007*
Coverage	N°of pilot counties	333	678	1,451	2,448
	N°of participants (billion)	0.08	0.18	0.41	0.73
	Enrollment rate (%)	75.20	75.66	80.66	85.96
Fund	Total funds (billion yuan)	40.13	92.83	213.59	353.26
	Total expenditure (billion yuan)	25.09	61.75	155.81	220.31
Benefit	N°of beneficiaries (million)	7.60	12.24	27.22	26.33
	Average fees for hospitalization (yuan)	2,818.56	3,343.88	2,774.54	-
	Actual reimburse-ment rate per inpatient (%)	24.67	23.41	27.80	-

Note: * Full year data for 2004, 2005 and 2006; 9 month data for 2007.
Source: Center for the China Cooperative Medical Scheme, Ministry of Health (MOH, China): http://www.ccms.org.cn

By the end of the third quarter of 2007, 2,448 counties nationwide had implemented the NCMS, and 730 million farmers were enrolled in the NCMS, putting the enrollment rate at 85.96%. This shows the development of NCMS has been boosted ahead of the schedule proposed by the central government. The total NCMS fund collected and expended by the third quarter of 2007 was nearly 9 times of that in the whole of 2004, but the increase of the beneficiaries has not reached this speed and the number of beneficiaries only accounts for less than 10 percent of the total amount of participants. This suggests a problem of accessibility in NCMS reimbursement. In addition, the exclusion of coverage of many diseases, examinations and drugs has led to the actual reimbursement rate of NCMS for the inpatient beneficiary reaching only 27.8% of their total health expenditure in 2006.

Although substantial progress has been booked in the reform of the rural health care system over the past few years, there is always a gap between the anticipated policy implementation and how it turns out in reality. The lack of institutional linkage between the NCMS and MFA schemes is an illustration of this. As explained in other chapters in this book (Xu *et al.*, Zhang *et al.*), the MFA is intended to supplement NCMS by helping the rural poor participate in and benefit from NCMS. The schemes have been managed by the Ministry of Health (for NCMS) and the Ministry of Civil Affairs (for MFA) respectively and the organizations affiliated to them. In many situations there was little linkage between them, leading to inequities and inefficiency. For example, the NCMS defined a deductible in its reimbursement rules but the MFA did not help its beneficiaries pay the NCMS deductible. Meanwhile, another deductible had to be applied when the rural poor applied for MFA. This has resulted in confusion and the persistence of financial barriers that prevented poor people from benefiting from both NCMS and MFA.

Many problems popped up during implementation, and at times policy intentions were violated. There has been a discrepancy between the high cost of NCMS for families and the rather limited benefits. The Ministry of Health has disclosed some rule-breaking behaviors in the policy implementation: health facilities and patients conspired sometimes to cheat the NCMS funds by excessive examination, unnecessary prescriptions or other over-servicing activities. Some local governments were reported as taking unlawful measures to achieve a high coverage rate in the early stage of

launching the NCMS[3]. Most of these issues resulted from a lack of effective supervision and accountability mechanisms, and to some extent from perverse political incentives for local governments.

Evaluation and Adjustment of Rural Health Policy

Over the past three years, the performance and effects of the NCMS and MFA have drawn a lot of attention from home and abroad. The World Health Organization (WHO 2004), United Nations Development Programme (UNDP 2005), World Bank (WB 2006), the National Center for Health Statistics, China (NCHS, China 2007) and the NCMS evaluation team composed of experts from Peking University and some other institutes (Evaluation team of NCMS 2006) have carried out evaluations of the rural health security system.

The conclusions of these evaluations suggest that rural residents have benefited from the NCMS and MFA schemes, their utilization of health services has increased and the economic burden of disease has been alleviated to some extent. Nevertheless these evaluations also identified a number of problems and issues associated with the low levels of financing and reimbursement for both schemes, the equity issues faced by the rural poor to getting essential health services and reimbursement, the types of household to be covered by MFA, inadequate management and monitoring mechanisms for both schemes.

The government has taken these criticisms into account and acted to adjust its policies. In late 2006 some researchers advocated policy adjustments of the MFA and the NCMS including the ending of the MFA co-payment for the rural poor, and assisting the rural poor to pay the NCMS co-payment. These policy recommendations have been followed by most

[3]Evidence is found in the press briefing on NCMS and some news reported in the newspaper and on the website. The spokesman for the Ministry of Health has disclosed in 2007 that the health facilities in Xichuan County of Henan province and in Yang county of Shanxi province have cheated the NCMS fund by false reporting of the population receiving physical examination. The fraudulently received money was returned and the related officers and doctors were punished. The Medicine Economic News of China and the Journal of Weekly Outlook have also reported some rule-breaking behaviors, such as the local government's fraudulent claim on the central governmental transfer payment for NCMS (in Hunan province), and conspiring by the health providers and the patients to receive unwarranted NCMS funds in Jiangsu province. The reports also contained details of countermeasures taken by the local government.

counties. In 2008, the central government and local government declared their intention to increase the financing for the NCMS at a National Health Conference. The total funding from the central and local government was raised from 40 yuan per capita to 80 yuan per capita. Although this increase does not fully meet the huge actual needs of the NCMS funds to ensure adequate reimbursement for rural residents, the action demonstrates the positive response of the government to the demands of Chinese society and international institutions.

Analysis of the Dynamics in Rural Health Policy Process

This section explores the macro and micro factors that have influenced the policy process. Macro-level factors refer to the impact of economic and social structure transitions, changes of policy paradigms and decision-making modes, as well as Chinese health reform of rural health policies. They explain why some rural health issues entered the policy agenda at this particular time, and cover the societal and political background and the trends that influenced this policy process. Micro-level factors refer to the conflicts of interests and compromises between stakeholders in the development of rural health policy, and their influence on the choice made and the implementation of policies.

MACRO-LEVEL FACTORS

Impact of economic transition on rural health policy process

The evolution of China's rural health policy is closely related to the nation's economic transition. From the 1970s, the Chinese economic system has passed through two phases. The first phase (1978-1984) focused on rural reform and development. Through implementation of the Household Contract Responsibility System, rural residents were encouraged to develop various kinds of business and industries and associated production to promote the development of rural commercial circulation. This led to the rural collective economy, on which the old Cooperative Medical Scheme relied, breaking down and the collapse of the CMS. As a result, health security was one of a number of risks that rural residents faced during the economic transition.

In the second phase (after the 3rd Plenary Session of the 12th National Congress of the Communist Party of China (CPC) Central

Committee 1984), the economic focus shifted to urban development, and overall development of a socialist market economy became the goal. During this period, emphasis was given to the readjustment of social and economic interests. Although agriculture and rural areas provided a lot of resources to help sustain industrialization and urbanization, resources constantly flowed to urban areas and the gap between rural and urban areas widened. The urban-rural dualistic structure in the health sector was obvious: urban residents had access to social medical insurance financed by the national budget and their employers, while rural residents had no protection for essential healthcare.

After over 20 years of development and a short blip due to the Asian economic crisis (and its subsequent recovery) at the end of the 1990s, the Chinese economy was merged into the global setting by entering the WTO. This gave a further boost to the economy. The government finally had sufficient revenues to finance basic health protection for the rural population. At the same time, the government became increasingly aware of the need to ensure that rural residents secured adequate benefits from the nation's economic development to maintain their support for reforms and to ensure stable and sound economic development.

In short, economic transition enlarged the disparity between the urban and the rural areas, which became a serious social, political and economic problem and imposed the urgency of providing the farmers with security. Meanwhile economic growth and the associated rise in government revenue laid a solid foundation for the introduction of rural health protection into the policy agenda and for the issuance of the rural health protection policy in 2002.

Impact of social structure transformation on rural health policy process

The policy process of rural health also reflects the concern of the government to reduce the contradictions and conflicts generated by changing social structures.[4] The reform of the economic system from the late

[4] As for social structures changes: the "Decision on Some Major Issues Concerning Building a Socialist Harmonious Society" issued by the 16th CPC Central Committee at the 6th Plenary Session in 2006 pointed out: "China has moved to a crucial period of the reform process, in which the economic system, the social structure, the interests of different groups and people's ideas and thoughts are experiencing profound transformation and changes."

1970s increased the mobility of various resources in the society that used to be under the control of the state. There was more social mobility which fostered the rise of independent interest groups. Social relationships that used to be characterized by a "strong state, weak society" framework were significantly transformed, as the state's role decreased, enabling a transition from a previously totalitarian government to a limited state.

As a consequence, new government regulation became necessary on the identification and delineation of people's social status, ways of employment and income distribution, social insurance, welfare and other social sectors in China (Sun 2004). However, compared with the economic reforms and development, social development and transformation have relatively lagged behind in China. This resulted in a situation where the traditional role of state had reduced, yet an effective autonomously functioning social system or a sphere of civil society had not fully developed. Various social problems concerning social equity have emerged in the Chinese society. At the core behind all of them, as cited by Premier Mr. Wen Jia Bao in 2004 at the National People's Congress, has been the equitable share of the outcomes of reform among different social groups.

From thereon creating fair access to the social benefits generated by the reform has become a central platform for promoting social sector development. On the academic front, the concept of social capital in the emerging social stratification of China has come to the fore for social policy development. Social capital has been brought back to a very tangible concept of societal assets, such as respect, status, income, safety, health, ... a well known term in political sciences (see for example Lasswell 1992) and is used in policy analysis. Strong groups and factions (with substantial political, economic, cultural and intellectual power) have acquired most of these societal assets through all kinds of legal and illegal distribution mechanisms. On the other hand, rural residents, migrant workers, the unemployed, the retired and other vulnerable groups in China are loosely organized and have little means to claim social assets generated by the economic reform (Cheng, Huang and Wang 2003).

Consequently, rural residents have a lower social status in comparison with the Mao era. Without the necessary skills and power, and with little access to sound mechanisms for their participation and expression, they have had little influence over the policy process. Consequently they became more vulnerable to the suffering of poverty, unemployment and illnesses. Migrant

rural residents became even more fragile in this new social configuration.

These societal phenomena have had a profound influence on rural health policies. China has always maintained a relatively strict dualistic characteristic in its policies on urban and rural issues. However, in the reform era this separation became more problematic, as a great number of surplus rural workers migrated to the cities to join the labor force there. The massive influx of migrant workers put a lot of pressure on the capacity and resources of urban areas and presented a huge challenge to both urban and rural health security systems. The floating population found themselves somewhere stuck between their informal mobile status and the formal urban institutional arrangements available to certified urban residents. The situation in the countryside was even less promising, as rural residents had no health insurance.

By the end of the 90s the health issues of rural residents and rural-urban migrants and the pressure of health had gotten full attention of Chinese society. Health issues have ranked high in the list of social issues that people care most about since 2000. According to statistics from a national sample survey conducted by the Chinese Academy of Social Science (CASS) in 2007, inaccessibility and unaffordablility of medical care ranked No. 1 among the three most crucial social issues (CASS 2007). It seems obvious that if rural health issues are not being dealt with properly, this could spark social instability.

Impact of changes in decision-making model and policy paradigm on rural health policy process

Chinese decision-making generally follows the top-down elite model (Lu[5] 1998, Li 2004). Over the past 20 years, the decision making model in China has changed from an individual decision making model - i.e. dominance of one political leader - in the Mao era to a group decision making model towards the end of the Deng era, whereby the Party leadership takes the decisions jointly. More recently, a more democratic participatory decision making model is adopted by the third generation of the Party's leadership

[5] Lu Mai, Senior Research Fellow of Development Research Center of the State Council and the Secretary General of the China Development Research Foundation, pointed out in his paper entitled "The Decision Making Process of Rural Reform in Chin" that the saying "Deng Xiaoping is the general designer of China's Reform and Open Policy" is a vivid reflection of the top-down decision making process in China.

(Hu 2006) within the party. Policy mainly reflects preferences of the elites and their way of observing the real world, it is their interpretation of the world that matters most.

The political, economic and intellectual elites that make up the elite in China possess resources and have substantial influence over the society and social life in general. Due to the social configuration, the non-elites lack the knowledge and access to resources to influence the policy process. Wei Shuyan (Wei 2006) compared the political elites in China and Western society in terms of their structure, culture, influence and common practices. She pointed out that the political elites in China play a more prominent role and have more influence over the economic and intellectual elites than is the case in the West. Political elites are also more likely to express and represent the general interest than politicians and policymakers in western society, who tend to represent their own interest groups and voters leaving them with comparatively less influence than their Chinese counterparts.

The rural health policy process in China reflects this situation. From the previous discussion, we found that a long-term momentum was created by the political elites (the ruling party and the government) and academic elites. They made a significant effort to promote the development of the rural health policy process by conducting investigations, research and advocacy. Apart from the abovementioned two elite groups, the media and other stakeholders and interest groups also played an active though less dominant role, especially during the agenda setting and in widening the discussion of rural health policy alternatives. Detailed analysis of the influence and action strategies of these stakeholders will be discussed in the latter part of this paper. So there is a trend towards a more pluralistic elite decision-making model in China, as the leadership is aiming for more scientific and democratic decision-making. From the previous review of the rural health policy process development, it appears that the rural residents are not yet fully aware of this development and have had consequently little influence over decision-making. However, this trend bodes well for the public's active participation in the rural health policy process in the future.

The above discussion also implies that the degree to which rural health policy can reflect the interests of rural residents and conform to the principles of a balanced and harmonious development of the economy and the society depends basically on the policy paradigms embedded in the elites' minds.

According to the definition of policy paradigm by Peter Hall, policymakers usually work within a framework of ideas and standards that specifies not only the goals of policy and the kind of instruments that can be used to attain them but also the very nature of the problems they are meant to address. Such interpretative framework is called a "policy paradigm" and policy can shift in three ways depending on the changes in three central variables: the overarching goals, the policy instruments and the precise settings of these instruments (Hall 1993)[6]. Only when all three components are changed, the term 'policy paradigm shift' is appropriate; Hall coins this situation a 'third order change'.

For the 20 years after the start of the Reform and Open-door policy, the policy paradigm in China could be labeled as "policies centered on economic growth". As the overarching goal was to promote economic development, the central government proposed a "Three-Step Strategy"[7], hoping that economic development could bring at the same time overall development. Consequently many policies were issued to promote economic growth, without considering issues of the development of the social sector and other sectors. This resulted in a rather imbalanced development of the economic sector and other sectors. As lots of social problems emerged overtime as mentioned above, including rural health care issues, Chinese policy makers have adjusted the precise settings of existing policy instruments and changed some policy instruments to try to deal with these social problems. Evidence of this trial and error - Hall would call these incremental policy adjustments first and second order changes - can be

[6] The three orders of change in policy making proposed by Peter Hall are as stated below: first order change - the levels or settings of the policy instruments are changed, while the overall goals and instruments of policy remain the same; second order change - the instrument of policy as well as its settings are altered, while the overall goals of policy remain the same; third order change - all three components of policy are changed. The first two order changes are regarded as normal policy making, while the third order change is considered as a paradigm shift.

[7] Three-step strategy: China's overall economic development objectives were clearly stated in the Three-Step Development Strategy, set out in 1987: Step One ~ to double the 1980 GNP and ensure that the people have enough food and clothing ~ was attained by the end of the 1980s; Step Two ~ to quadruple the 1980 GNP by the end of the 20th century ~ was achieved in 1995 ahead of schedule; Step Three aims to increase per-capita GNP to the level of the medium-developed countries by mid-21st century. At that point, the China's people will be fairly well-off and modernization will basically be realized.

found in the policies issued to reduce the financial burden on rural residents, to implement the "fee to tax" reform, to rebuild the cooperative medical scheme in rural areas without governmental input etc. But these incremental changes in policy could not improve the predicament of rural residents substantially. Worse still, the failure of these first and second order changes challenged the locus of authority over the policy.

China has been implementing Deng's saying of "crossing the river by touching the stones"[8], and it took time before the Chinese government realized what the true goal of the reform process should be. Some members of the elite groups gradually grasped the need and opportunity for a third order change. While they continued to support economic development as the center and forefront of reform, they saw it as not the only factor to be taken into account. Without synchronous development both of the economy and society, China would not be able to achieve sustainable economic and social development. The ultimate goal was transformed to economic and social development to allow people to live a happy life and to share equally in the benefits generated by the reforms and development in China.

This change in the overarching goal is obvious from the proclaimed ambition to establish a "Xiaokang Society", as[9]recorded in the Report of the 16th National Congress of the CPC Central Committee in 2002. Later the "establishment of a harmonious socialist society" was raised in the 4th plenary session of the 16th National Congress of the CPC Central Committee in 2004 as one of the five aspects necessary to strengthen the party's capacity to govern the country and display strong leadership. "The

[8] "Crossing the river by touching the stones at the riverbed" refers to one of the core ideas of Deng Xiao Ping about the Chinese development path. This implies that there are no good answers for reference, so the Chinese people have to work out a proper development mode on their own by trial and error. This sentence was first put forward by Chen Yun (1905-1995) in 1950. He was a great proletarian revolutionary, Vice-Premier and one of the initiators and founders of the Chinese socialist economic system. In the early stages of the reform of the Chinese economy, Deng Xiao Ping agreed with Chen Yun's ideas and incorporated these into his theories of Chinese Reform and Opening-up.

[9] Xiaokang Society: The report President Jiang Zemin delivered at the 16th National Congress of the Communist Party of China (CPC) on November 8 was titled "Build a Well-off Society in an All-round Way and Create a New Situation by building Socialism with Chinese Characteristics." In the Chinese original version, the equivalent of "a well-off society" is "a xiaokang society". Scholars agree an exact English equivalent for 'xiaokang' does not exist; 'xiaokang' means less affluent than "well-off" but better off than 'freedom from want'.

Central Party's Decisiosn on Several Key Issues Concerning Constructing a Harmonious Socialist Society" issued in 2006 (Central Committee of the Communist Party of China 2006), paid more attention to people's livelihood, justice and equity. With the policy paradigm shifting from "economic development centered" to "harmonious development", improving the health status of rural residents inevitably became one of the most urgent social issues on the central government's policy agenda.

To sum up, both greater pluralism in the elite decision-making model and the changed policy paradigm played a key role in the evolution of rural health protection policy. The New Cooperative Medical Scheme and Medical Assistance Scheme were produced against this political landscape. Over time the schemes were mentioned more and more in all kinds of policy documents and public reports, and were widely discussed.

Impact of the overall health sector reform on rural health policy process

Rural health reform is just one aspect of overall health reform. Adjustments of rural health policy must be consistent with the basic principles of the sector-wide reform.

The government introduced a series of health reforms in the late 1990s to deal with issues such as an imbalanced distribution of health resources, a shortage of financial input, disruptions to drug distributions and local availability, slow development of medical insurance, and rural residents' poor access to essential health services. Health reform had originally focused on urban areas. At the National Health Working Meeting in 2002, Premier Wen Jiabao pointed out that the focus of future health work would be rural health, and thereby laid a foundation for the issuance of NCMS and MFA policies. Urban health reform continued to be a key policy issue and attracted more resources, but the priority given to reform of rural health policy definitely increased.

"The Chinese Communist Party Central Committee's Decisions on Several Key Issues Concerning Constructing a Harmonious Socialist Society" in 2006 clearly stated the need for "establishing an essential health care system covering urban and rural residents", "facilitating up-scaling of NCMS", and "developing social medical assistance", all of which focused on developing NCMS and MFA as critical parts of the essential health care system. In the "Government Working Report" at the 5th session of the 10th National Congress of the CPC Central Committee in 2007, Premier Wen

Jiabao identified four key tasks to establish a vital health care system. The first key task recommended the active promotion of NCMS. This was the highest political priority the rural health protection policy has ever gained in the policy agenda. This created a unique opportunity for the development of NCMS and MFA schemes and laid the foundation for more resources and support for the rural health policy.

MICRO-LEVEL FACTORS

Competition between various stakeholders has been an important influence at micro-level on the development of rural health policy. The following analysis of stakeholders is mainly relevant for the agenda setting and policy formulation stage. Obviously, key stakeholders need to be identified first. In the rural health policy network, relevant departments of the central and local government, think-tank institutes, delegates of the National People's Congress (NPC) and members of the Chinese People's Political Consultative Conference (CPPCC), health providers and rural residents are the key stakeholders.

In-depth interviews were conducted with these key stakeholders, and national health policy seminars were attended to observe the way different stakeholders speak or what they say. The analysis of these can be summarized in the following points. The interests, advantages and disadvantages of the key stakeholders, and their basic attitudes, influences and strategies are portrayed in Table 2. Different ministries within the government and the governments at different levels (central, provincial, county, and township level) are clearly different stakeholders. Nevertheless, compared with other independent stakeholders outside the administrative circle, the government can be considered as a united stakeholder, this for didactic purpose, in a first and rather rough analysis. In addition to this government versus external stakeholder analysis, a more detailed analysis of the stakeholders within the government at different administrative levels and departments is also incorporated in the paragraphs below.

Table 2. Stakeholder analysis of rural health policy process

Stake-holders	Interests	Advantages & disadvantages	Attitudes	Influ-ence	Strategy
The govern-ment	- Mitigate poverty caused by illness - maintain political support	*Advantages*: Absolute control of various resources; strong mobilization capacity. *Disadvantages*: Insufficient information; lack of knowledge on specific issues; suffer political risks.	Active support for the policy, but ambiguity among different ministries	Very strong	- Try to increase the support for action among the other stakeholders - make use of the assistance from think tanks - strengthen monitoring mechanisms and avoid political risks.
Think-tank institutes [10]	- Improve the health status of rural residents - increase political influence and status - increase funding resources - introduce advanced ideas and techniques to China	*Advantages*: Expertise and knowledge; close relationship with policy makers and the media; good access to the policy and information; rich international experience *Disadvantages*: Lack of economic and political mobilization power; difficult to understand the Chinese context for international organizations.	Active support	Quite strong	- Keep a close relationship with political circles - try to understand political views and aims of senior policy makers - try to maintain a close relationship (between domestic and inter-national institutes) in order to get more insight into the Chinese background (for inter-national organizations) and international experience (for domestic institutes) - act as policy "gate-keepers" - try to bridge the gap between the demands of rural residents and political attention - cooperate with the media to gain support from the public - enhance their political

[10] Think-tank institutes here refer not only to domestic research institutes but also to some international organizations that have been actively involved in Chinese health policy over the past few decades, like the World Health Organization, World Bank, Department for International Development (UK), European Union, etc.

Stake-holders	Interests	Advantages & disadvantages	Attitudes	Influ-ence	Strategy
					and academic influence
NPC and CPPC delegates/ members	- Report the needs of those at grassroots level - represent the interests of specific political or economical groups; - boost their own political careers.	*Advantages*: Extensive information; have a certain political influence. *Disadvantages*: Lack resource mobilization power.	Supportive	Quite strong	- Try to understand political views and priorities - advocating the protection of rural residents' interests through official channels and the media
Health providers	- Maximize profits - serve the public interest if possible.	*Advantages*: Control on information and techniques. *Disadvantages*: Lack of involvement in policy process.	Ambiguous	Relati-vely strong	- Make use of their information advantage, and approach political circles to maximize or protect their interests. - try to maximize profits within the framework of laws, rules and regu-lations.
Rural resi-dents	- Care for individual and actual interests - want more benefit at a low cost.	*Advantages*: Potential force in shaping public opinion in favour of or against policies. *Disadvantages*: Few economic and intellectual resources; lack of cohesion as an interest group; lack of proper channels for voicing their concerns.	Doubtful and even potentially distrustful (if outcomes do not correspond with input)	Quite weak	- Give support only after they really benefited

From the analysis in the table above we can see that the government and the think-tank institutes are the driving forces in the policy process. They try to represent the rural population, and to counterpoise the interests of other stakeholders, and they can help achieving their interests through mobilization of the resources they possess.

The relationship between the central and local governments in the policy process is very interesting. The central and local governments support promoting the rural health policy process to maintain and gain political support and advance the careers of individuals. However, the local governments, including the provincial, county and township governments have more power over the agenda setting and policy implementation than they do over policy formulation, so they are likely to make a choice based on the central government's aims and commitment, as well as on their own assessment of cost-benefit. In this sense, the local governments do not unequivocally support the policies adopted by the central government, as they lack sufficient financial resources to meet their responsibilities. Here the benefit as mentioned above refers mainly to the general public's interest. Nevertheless obviously their personal and departmental benefits, such as individuals' political prospects or potential additional resources for their departments, are also taken into account in their assessment. When benefits exceed the input, the local governments, (and especially the county government) will give real support whereas if the input is higher than the benefits, they give only superficial support, or pay lip service to the policy. Therefore, in the bargaining and interplay between the central government and local governments in the policy process there is good reason for local decision makers to be involved as much as possible. From another point of view, to increase the expected benefits from the local governments, the central government should stress the importance of launching and implementing rural health policy and show its great commitment. They should also encourage them to increase the local (financial) input and rely less on the central input. At the same time, the central government should strengthen the political monitoring of the policy implementation and reduce the risk of accountability failure that exists between different administrative levels of governments

Within central government and local government there is also constant interplay between ministries and bureaucratic departments. Rural health administration involves over ten ministries at the central level,

including the Ministry of Health, Ministry of Civil Affairs, Ministry of Finance, Ministry of Human Resources and Social Security, the State Development and Planning Commission, the Ministry of Agriculture, etc. Their interests are all reflected at each local government level by their relevant local bureaus. The interests of each ministry are distinctive and at times conflicting:

The Ministry of Health takes the leading role in the rural health policy development, and claims to alleviate poverty due to illness and to improve the health status of rural residents. In its work however, it often confronts role conflict in attempting to manage the interests of both the supply side (hospitals) and the demand side (the population). As the Ministry of Civil Affairs is in charge of the welfare of the rural poor, it is a key player. The Ministry oversees MFA, and tries to ensure that the rural poor have equal access to essential health services, that its commitment to pay NCMS premiums for the poor is efficiently managed and that the poor are able to get proper reimbursement from the NCMS. The Ministry of Finance will cautiously take into account the respective applications for more financial input in rural health care schemes and make its choice according to the priority of the overall economic and social development and other civil affairs. The Ministry of Agriculture focuses on the interests of the demand side and insists on not aggravating the financial burden on rural residents by seeking reductions in the various levies placed on rural residents. In addition to their stated public interests, all the ministries seek to expand their political clout, get more and recurrent resources, and boost their own interests. So this has resulted in constant manoeuvring, occasional bickering, and eventually in compromises between ministries and departments in particular on the policy alternatives of the NCMS and MFA as well as on the policy adjustment of the two schemes within the overall rural policy process.
Think-tank institutes act as partners for the government, providing it with policy recommendations and consultancy. In the Chinese situation, academic elites maintain close relationships with key decision-making bodies inside the government, so their influence and power in policy processes is very critical. In order to realize their own social values, they usually work as policy "gatekeepers", making use of their own strengths in terms of intellect, knowledge, techniques and information while at the same time understanding the political goals and policy intentions of policy makers (Kingdon 1995; Hu 2006; Wei 2006). They put some social issues on the

policy agenda and persuade policy makers to pay attention to policy needs at grassroots level. In this way, they push specific policy items upward on the policy agenda and assure that the policy recommendations are scientific and practical through their involvement in policy design and selection of policy recommendations.

Delegates of the National People's Congress (NPC) and members of the Chinese People's Political Consultative Conference (CPPCC) play a more complex role. Theoretically, they should represent the people's interests and care for the welfare of the masses and the development of the country, but sometimes this does not hold as some political and economic groups may act in the interest of certain social groups (Xiao 2005; Ren 2008). Their attitude and behavior are not only influenced by individual political values but also by their interest groups and the political context of China. Some members of CPPCC thought that when solving rural health problems corresponds to their political and economic groups' interest, they may advance the political prominence of the rural health issue by providing the government with relevant policy options; only then they will actively promote the development of rural health policies.

Health providers are seldom involved directly in the top-down elite decision making model that characterizes the policy formulation in China. However, they may have a potentially major influence on the policy implementation stage because of their technical monopoly and information advantage in medical matters. In order to protect or maximize their interests, they will stay close to the political circles at the top to express their concerns to them. Their interests are mainly represented by relevant departments in local health bureaus. So they might have less political power but could still possibly exert strong influence in the policy process.

As the target group of rural health policy, rural residents are critical stakeholders. Nevertheless they are the weakest group in the policy network. Although rural residents have some influence on shaping public opinion, bringing rural health issues by their own effort onto the policy agenda is out of their reach. For instance, in the policy implementation, according to the principles proposed by the central government[11], delegates of rural residents

[11] In the document issued by the State Council, 2003, Opinions on the Implementation of the New Rural Cooperative Medical Scheme, proposed to establish a management committee and a supervision committee respectively with delegates from a number of government

(who are also the NCMS participants) are supposed to be included in the management committee or the supervision committee, However, many counties have excluded the delegates of rural residents from these two committees, while in other cases, counties have relegated the roles of these committees and rural resident delegates to a token formality. The rural population's weak impact on the policy making process is partly due to their lack of knowledge, their weak economical and intellectual resources, and to the lack of an effective institutional arrangement. All these explain the failure to bundle forces and form a united front with an influential voice. As a result, they are just passive recipients of policy. Without relevant knowledge and sufficient involvement in the policy process, they can hardly make informed judgments on the benefits expected to be generated by rural health policy. Therefore, rural residents may have positive views of the policy when they themselves or their acquaintances experience or receive benefits; on the other hand they usually distrust the policy if they themselves or their acquaintance did not get expected benefits from the policy at certain costs. This implies that a shortcut for the government to gain support from the grass-roots level is to truly benefit the target groups of the policy. To ensure the sustainable development of rural health policy however, the active participation of rural residents and sound institutional arrangement are required.

Conclusions

In summary, from the analysis of the development of rural health policy process and the dynamics in this process, we can draw the following three conclusions:

Firstly, the transition in economic and social structure together with the overall health sector reform provided the context for setting policy agenda setting and policy innovation. This context led to pressure for rural health reform and set the basic rules and principles for the design of policies.

Secondly, the changes in decision making model and the shift in emphasis from economic development towards social development were

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departments including the health, finance and audit department, from the anti-corruption agency of the Communist Party and from local representative bodies and some delegates of NCMS participants.

decisive factors in the rural health policy process. The decision making model in the health policy process is now changing from the traditional top-down model, in which policy making was dominated by the political elite, to a more pluralistic but still elitist and technocratic decision-making model in China. We can infer from the above analysis an active and significant role played by political delegates (like the NPC delegates and members of CPPCC) and think-tanks, for instance some domestic research institutes affiliated to the central government and various international organizations that have cooperated closely with the Chinese government in the rural health policy process. Administrative authorities and research institutes both at home and abroad have joined forces to bridge the gap in communication among stakeholders and promote the development of rural health policies. The change towards a more scientific development philosophy and a people-oriented concept in 2005 determines what policy will become prominent and who will benefit most from the reform in the future.

Thirdly: a more open political climate has gradually been created and is encouraging stakeholders to participate in the policy process. Nevertheless, there is still a long way to go to shape formal and effective rules to ensure the active participation and positive influence of all stakeholders, in particular (input from) the rural population in the rural health policy process. Further progress was made in this regard when the 17th National Congress of the CPC Central Committee convened in October 2007 and proposed to protect people's rights of information participation, expression, and supervision. This will allow rural residents and other stakeholders to voice their interests more explicitly.

From the viewpoint of public policy, to make the rural health policy more consistent with the needs and interests of stakeholders involved and to reduce the gap between the policy intentions and actual implementation, three guidelines should be taken into account: first, rural health policies should reflect the whole background of economic and social structure transition, as well as the political and cultural context. Whether a policy will be sustainable in the long run and function properly depends to a large extent on the degree to which it is configured for and embedded in the Chinese context. Second, the non-government interest groups, who emphasize the public interest, like think tanks, people's delegates, medical associations, international organizations, villagers' autonomous organizations, etc. should be further developed. Indeed, people in China are

increasingly becoming aware of their role as citizens, their duty towards the nation, and feel more and more responsible for other Chinese people (Huang 2008). The government should capitalize on this rising citizen consciousness in the development of rural health policy. Lastly, formal mechanisms should be established to provide a forum for the expression of different interests and for the management of conflicts of interests. These mechanisms could be created in but also outside the government, like through regular cross-Ministries coordination workshops to promote the communication among Ministries, and regular symposia between policy makers and their consultation groups. Steps should be taken to ensure that the voice of rural residents and their claims could be heard and reflected in current NCMS management committees and monitoring committees at township and county level by the effective participation of rural delegates.

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