China and Global Health Governance

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Abstract

This paper examines the impact of China’s participation in global health governance (GHG) by addressing two interrelated questions. First, how has China’s involvement had an impact on GHG? Second, to what extent has China’s GHG involvement resulted in changes in its domestic health governance? It finds that in the areas of health-related development assistance, global disease prevention and control, and global health rule making, China is making a difference in global health governance processes and outcomes. Meanwhile, despite the opaque and exclusive authoritarian structure in China, global health players, norms, and processes have a significant role to play in the country’s domestic health governance, including health agenda setting, health policy formulation and implementation. The magnitude and significance of China’s participation cannot simply be accommodated by the existing analytical framework. To be sure, China’s engagement in GHG thus far is still narrow and limited, and not always constructive. But these constraints and limits are not static as the domestic and international context for China’s engagement is changing. As China becomes more sensitive to international norms, pressures, and influences, it is anticipated to play a much bigger role in global health governance.

About the Author

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Introduction

The past two decades have seen profound changes in the biological and political worlds, which fundamentally changed the landscape of global health governance (GHG), defined by David Fidler as “the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and nonstate actors to deal with challenges to health that require cross-border collective action to address effectively” (Fidler 2010).\(^1\) With the rising number and variety of global health problems (HIV, pandemic flu, and non-communicable diseases) and the expansion of the global health processes (e.g., multilateralism, transnational disease surveillance network) is the increase in quantity and diversity of global health players. Changes in the international systems saw not only the rise of powerful non-state actors calling the shot in Geneva (e.g., Gates Foundation), but also the growing participation of emerging powers (e.g., BRICS). While these countries are traditionally players in global health governance, the power shift has bestowed them with new opportunities to more directly and deeply engage in global health governance than ever before.

Among the emerging powers, China has been a player in health-related development assistance since the 1950s (State Council Information Office 2011). Also, due to the sheer size of its population, it has long been a major factor to reckon with in global health. In the 1970s, the Maoist health model, with its emphasis on equality, primary health care, community participation, and devolved decision making, not only improved the health status of 22.5 percent of the world’s population, but also had a strong bearing on the World Health Organization’s global agenda. Encouraged by China’s success, for example, the WHO declared in 1978 that “Health for All” by the year 2000 (HFA-2000) was achievable through primary health care. Despite so, conscious and direct engagement in GHG is a relatively recent development for China. In the 1950s and 1960s, since it regarded the international system as alien and illegitimate, the issue of China being a responsible stakeholder in global governance was not part of its foreign policy agenda (Huang 2010). It was not until the late 1970s did China pay membership dues to the WHO. In addition to its participation in WHO, China also began to contribute to other UN agencies such as United Nations Children’s Fund (UNICEF) and started bilateral cooperation with Western countries. The threat of HIV/AIDS epidemic and the 2002-03

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\(^1\) A similar definition was provided by Pang et al. (2010: 1181): “the formal and informal institutions, norms and processes that govern or directly influence health policy and outcomes worldwide.”
SARS crisis provide further impetus to engage in global health. Over the past years, with the growing economic prowess of China, international pressures for China to shoulder more global health responsibilities also grow (see Chow 2010).

As China becomes increasingly engaged in global health, we would expect China to play a bigger contributing role to global health governance initiatives, institutions and processes. Due to the population size and the geoeconomic importance, not only will China’s shifting health policy priorities and health system capacity building have global repercussions, but the form and substance of its health diplomacy may provide alternative approaches to GHG, even affect the willingness and capacity of other countries in coping with global health challenges. In the meantime, the dynamics of global health governance, as reflected in the proliferation of various influential actors, growing normative pressures and discourses, and availability of additional external resources and information channels, would affect China’s domestic governance and health policies.

This paper examines the impact of China’s GHG participation by addressing two interrelated questions. First, how has China’s involvement had an impact on GHG? Second, to what extent has China’s GHG involvement resulted in changes in its domestic health governance? A comprehensive and in-depth understanding of the impact of China’s involvement in GHG is needed for understanding the effectiveness and dynamics of GHG, not only because China plays a critical role in the complex dynamics among health, development, and security but also because the rising China has raised tremendous expectations on its engagement in GHG. The improved knowledge about the dynamics of the behavior of China as a GHG participant helps increase China’s capability to be a constructive participant in GHG and thus create a stronger foundation for international cooperation to address pressing global health challenges.

In examining the impact on global health governance, this study looks at China’s effectiveness in promoting health-related development cooperation, its contribution to global disease prevention and control, as well as its role in global health rule making. An examination of the impact on domestic health governance will be conducted by exploring the role of global health governance in domestic health agenda setting, policy formulation, and policy implementation.
Impact on Global Health Governance

China as an aid donor

Beginning in the 1960s, driven by the need to export revolution and expand China’s political influence in the Third World, China increased its foreign aid. The level of foreign aid reached an all-time high in the 1970s (Yang and Chen 2010: 49-50). Specifically, during 1963-1982, 6,500 Chinese health workers joined the medical teams and served a total of seventy million people in 42 countries, including 32 in Africa (Huang 2010: 108-109). Until 1978, Chinese medical teams provided services and some material supplies completely free of charge (Zhu 1984: 39). The content of Chinese health aid practice bore the firm imprint of the Maoist health system, which focused on equality and universalism. Most medical teams operated in outlying areas where local people had difficult to access health care. In doing so, they focused on primary health care. Following the Maoist approach of putting the emphasis of health care to the countryside, the medical teams also introduced mobile medical care to the recipient countries (Wang Ningjun 2009). This occurred at a time when it was increasingly evident that the western-based medical model (which emphasizes hospital-based treatment of patients, curative care, and high-technology interventions) was becoming increasingly unaffordable to meet the basic needs of populations in poor countries. In this sense, the export of the Chinese primary health care model to the Third World not only improved people’s health status of the recipient countries, but also presented an alternative approach to health care provision in limited resource settings (Lee 2009: 73). Indeed, a report of the Joint Economic Committee of the U.S. Congress concluded that “[m]edical services have proven one of China’s most effective economic aid programs in the Third World” (Fogarty 1978: 856).

Since the 1980s, there have been changes in the form and substance of China’s health aid program. With the resumption of its UN seats, China began to explore international development cooperation that combined aid money with funding from UN and other multilateral agencies (Brautigam 2009: 65). Rather than focus on the dispatch of medical teams, China diversified forms of providing health aid by cooperating with African countries in running hospitals/clinics and delivering medical services. The market-oriented economic reform and integration into the world economy had a bearing on the China’s health aid policy. Instead of treating foreign aid purely as a “political task” or providing only “one-way” free aid, China since
the mid-1990s emphasized the economic aspect of foreign aid and used it to promote mutual benefits, trade, and market expansion. In order to expand its political influence and boost pharmaceutical exports in Africa, the government launched a broader charm offensive to construct health care facilities and donate medicine to Africa. At the Sino-African Summit in November 2006, President Hu pledged to provide $37.5 million in grants to supply artemisinin and build 30 anti-malaria centers in Africa. By the end of 2009, China has completed more than 100 hospitals and health care centers and donated tremens amount of medical equipment and drug products (State Council Information Office 2011).

The contribution of China’s health-related development assistance on GHG should not be exaggerated. As the world’s 2nd largest economy, with the largest foreign exchange reserve, China is still not considered an active donor to global health – indeed, it did not officially join the donor club until December 2011 at the High Level Forum (HLF) on Aid effectiveness in Busan, Korea. Until very recently, it makes only a nominal contribution to the Global Fund for AIDS, Tuberculosis, and Malaria. But in the meantime, it has been aggressively seeking Global Fund grants. By raking in nearly $1 billion from a fund ostensibly dedicated to helping the world’s poorest countries, critics argue that China threatens to undermine the entire premise behind the Global Fund (Chow 2010). Perhaps more importantly, since global health governance is narrowly defined in terms of engaging critical stakeholders while bringing coherence to the global health initiatives and projects (WHO 2011), it is necessary to examine the degree to which China’s health aid aligns with international practice. Unlike most OECD countries, China in offering health aid does not attach political strings (except for the issue of Taiwan). Thus China’s aid programs run in direct competition to programs that emphasize governance, accountability, and human rights. Second, Chinese programs are not fully aligned on the needs of the recipient countries. In addressing the threat of infectious diseases, for example, less interest was given to tackling major health threats such as HIV/AIDS and TB. Even the commitment to fighting malaria was undermined by the fraudulent Chinese-made medicines flooded in African markets (Garrett and Huang 2011). Third, despite the interest in multilateralism, China still prefers bilateral aid. The lack of transparency in its bilateral aid programs makes it next to impossible to gauge the full extent and nature of its health aid program. There is also issue of efficiency. As noted by Amanda Glassman, through pooled funding multilateral aid is more efficient than bilateral aid because the latter raises administrative costs,
and greatly increases burden on recipients, on the one hand, and caused problems of coordination and harmonization, on the other (Glassman 2012). Fourth, while the U.S. and other OECD countries have moved away from tied aid, China’s health aid was repackaged to promote the exports of its pharmaceuticals (Brautigam 2009). In Tanzania, for example, the Chinese government bought the antimalaria drug artemisinin from the Chongqing-based Holley Pharmaceuticals to make donations to local hospitals and clinics. Finally, the lack of participation of Chinese CSOs in health aid further narrows the space of cooperation between China and other donors. Successful implementing of foreign aid projects often hinges upon the support of civil society entities. The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), for instance, channels resources to nongovernmental organizations (NGOs) that propose and implement programs abroad (Ng and Ruger 2011). Chinese citizens and NGOs began to participate in global health-related humanitarian aid in the mid-1980s, but so far they have played only a very limited role in global health aid. All this raised concerns about coherence issues of health-related development assistance in regions such as Africa. The coherence and coordination issue is exacerbated by the dominance of decentralized and fragmented foreign aid institutions in China. Unlike the United States, China does not have foreign aid laws, so its existing foreign aid policies are based on ad hoc central ministerial documents and regulations, which are not subject to approval by the legislative branch (Huang 2011b). China also does not have a specialized foreign aid agency like the US Agency for International Development (USAID) to coordinate foreign aid. Instead, four central institutions are considered crucial for health aid: the Ministry of Finance (MOF), Ministry of Commerce (MOFCOM), Ministry of Foreign Affairs (MFA), and Ministry of Health.

*Contribution to global disease control*

China’s emergence as a health donor improved access to health services and medicine in Africa. But its contribution to global health governance goes beyond the continent. China is now a leading supplier of drugs and drug ingredients in the world. According to a 2007 GAO report, China is the largest number of registered drug manufacturers exporting drugs to the US; in 2008, China also manufactured 14 percent of the $31 billion dollar market for active drug ingredients. Most suppliers of shikimic acid, the base ingredient in Tamiflu – which is considered the most effective antiviral drug against H5N1 and H1N1, are in China (Garrett and
Recent developments also raised hope that China’s vaccine makers could become major players in the field. In March 2011, the WHO announced that SFDA met the international standards for vaccine regulation, which opened the doors for Chinese vaccines to be submitted for WHO approval so that they could be purchased by UN Agencies and GAVI Alliance (which buys vaccines for 50 million children worldwide annually) (AP 11/29/2011). China’s push for exports is anticipated to lower costs of some life saving drugs and vaccines for the world’s poor and provide major new competition for the big Western pharmaceutical companies. As noted by a senior official at the GAVI Alliance, China’s entry into the vaccine market should be considered a potential “game changer” (AP 11/29/2011).

But if there is an event that taught China the importance of seriously engaging global health governance, it is the 2002-03 SARS crisis. SARS highlighted China as a “weak link” in global health governance (Patrick 2011). It generated momentum for China to strengthen its disease surveillance and surge response capacities (see below). It also created strong incentives for China to establish mechanisms to effectively communicate with the international society on the country’s public health problems. Beginning in 2004, China has worked with UNAIDS to issue joint reports on China’s AIDS spread and control. In compliance with the IHR (2005), the Chinese government has made good progress in cooperating with WHO and international scientific community in sharing data and information about disease outbreaks. China’s willingness to share the H5N1 virus samples was in sharp contrast to Indonesia, which used the idea of “viral sovereignty” to justify its failure to cooperate with WHO in avian influenza sample sharing and disease reporting (see Holbrooke and Garrett 2008). During the 2008 hand, foot, and mouth disease (HFMD) outbreak, China’s Ministry of Health disseminated six information newsletters to health departments in Hong Kong, Macau, and Taiwan while working closely with WHO on the prevention and control of the disease (Caijing 5/6/2008). Efforts to narrow the internal health governance gap and growing transparency contributed to WHO’s Global Outbreak Alert and Response Network (GOARN) and strengthened its early warning and surveillance activities.

Since then, China has demonstrated its ability to orchestrate multilateral cooperation over international health at global, regional, even sub-regional levels. At the global level, China has shown strong interest in working closely with major international organizations in disease prevention and control. In January 2006, China hosted an International Pledging Conference on
Avian and Human Influenza. During this event, the international community pledged $1.9 billion dollars in financial support, including $10 million dollars from China (Huang 2010). In June 2009, during the global fight against H1N1 pandemic, China took the initiative of hosting the International Scientific Symposium on Influenza A (H1N1) Pandemic Response and Preparedness. Two years later, China organized the first meeting of health ministers from the BRICS countries, who pledged in the Beijing Declaration to explore the transfer of technologies to enable poor nations to produce cheap and effective lifesaving medicines for diseases such as HIV/AIDS, tuberculosis, and hepatitis. China has also been active in participating in health forums in regional platforms, including the ASEAN+3 Summit, the East Asia Summit, and the Asia Europe Meeting (ASEM). Through these venues, China proposed a series of important initiatives on the control of avian flu and the management of public health emergencies. In addition, China sponsored the Greater Mekong Six-Nation Ministerial Meeting on Disease Surveillance Cooperation Project and also hosted the second GMS Public Health Forum in 2009.

The new health diplomacy has its own constraints. In responding to international public health emergencies such as the 2005 H5N1 outbreak or the 2009 H1N1 pandemic, China’s contribution is still marred by the problems of cover-up and lack of transparency (see Huang’s forthcoming book). In the 2009 H1N1 pandemic, China probably violated the IHR by instituting trade and travel-restrictive measures not based on WHO recommendations or legitimate public health justification (Huang 2010). The discrimination against Mexican citizens² and the ban on pork products from North American countries also sent a signal to other countries that those complying with IHR and honestly reporting diseases in their territories will not be rewarded but punished by other countries. The overreaction and the pursuit of short-term domestic political goals thus undercut trust and goodwill among states, potentially exacerbating the “stag hunt” dilemma in international disease prevention and control (see Tang 2009).

Despite the increasing interest in multilateralism, Beijing’s traditional resistance to shared sovereignty and the constrained policy autonomy that accompanies collective decision making lead China to pursue a multilateral approach in global health governance on a selective and strategic basis. Beijing pursues multilateral cooperation most enthusiastically either with global multilateral settings where the dominance of US or its allies is weak (e.g., WHO, UN, and

² According to the Mexican Ministry of Foreign Affairs, China was the only country where Mexicans had been confined against their will (Financial Times 5/4/2009).
UNESCO) or regional settings where it is the most powerful participant (e.g., ASEAN+3, SCO, East Asia Summit). In WHO, China’s participation in a group with 193 members offers a more attractive alternative because its agenda is less likely to be dominated by the U.S. and any single powerful state.

There are also concerns of China’s misuse of its influence in global health governance, especially the WHO. In recognition of the unprecedented authority and power of the WHO demonstrated during the SARS crisis, China has been more interested than other BRICS countries (e.g., India) of using the WHO as a central venue to engage in global health governance. In 2006, China mobilized its entire diplomatic apparatus to lobby hard to the election of Margaret Chan as the WHO Director-General. Since then, Chan has made great efforts to regain the WHO’s leadership role in global health governance. But during the H1N1 outbreak the government referenced several times the support of Chan and WHO in justifying its aggressive response toward the outbreak, while Chan herself refused to criticize China for its travel and trade restrictions that clearly clash with her agency’s advice (Huang 2010: 127). It threw its support to Chan again when she was seeking the reelection. In January 2012, Chan was nominated by the WHO executive board to be the next WHO DG. For the first time in WHO history, there was only one candidate for that position. Some speculated that fear of fighting an unwinnable war with China was the primary reason of the absence of more candidates for the job.3

China’s role in shaping global health rules

China has also shown willingness to work cooperatively with other players to set rules and norms of global health governance. Even with the largest state-owned tobacco monopoly in the world, China surprised many in negotiating the Framework Convention on Tobacco Control (FCTC) by supporting some important provisions, including the one that would have given public health precedence over trade and the one that allows countries to sue tobacco companies in accordance with their domestic laws. It was considered the “least vigorous” opponent among the “big four” (i.e., China, Japan, Germany and the U.S.) (Mamudu and Glantz 2009). Equally important, China has been directly involved in the revising of the IHR, one of the most radical changes to govern international cooperation over public health emergences since the mid-19th

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3 Author’s interview with a senior WHO officials, February 20, 2012.
century (Fidler 2005). Few would deny China’s determination to defend the validity of sovereignty as an inviolable principle in governing international affairs. Keenly aware that introduction of the universality principle might be used by Taiwan to see formal WHO membership, thereby threatening China’s sovereignty and territorial integrity, China’s chief negotiator made it clear that “health is a very important issue, but sovereignty and territorial integrity are more important to a sovereign state. China will firmly defend its sovereignty and territorial integrity at all cost.” Playing China’s sheer population size as a trump card, he further warned that “the future IHR has no universality without China’s participation.” 4 But in the meantime, it has shown great flexibility in revising the IHR. It dropped its opposition to include the universal application when the chair of the draft committee substituted “all people” to “all countries” so that the new text reads: “The implementation of these Regulations shall be guided by the goal of their universal application for the protection of all people of the world from the international spread of disease” (Article 3.3). Similarly, China, a country which attaches utmost importance of social-political stability, showed flexibility in allowing the WHO to take into account rumors, or sources of information provided by non-State actors in making decisions. Its negotiators indicated that it preferred WHO to deal with these rumors and found it acceptable when the wording was changed to “sources other than notifications or consultations.” 5

During the negotiations, it also allowed the WHO DG to send a special envoy to consult Beijing and Taipei to find an agreement, which paved the way for Beijing to sign a Memorandum of Understanding (MOU) with WHO in which it agreed that Taiwanese medical experts could enjoy “meaningful participation” in WHO-related activities. China further changed its tough stand on Taiwan’s participation when the newly elected Taiwanese president Ma Ying-jeou satisfied China’s nominal sovereignty concern by acknowledging the “One China Principle. In May 2009, Taiwan became an observer at the World Health Assembly.

More recently, China sought to affect the GHG agenda setting and rule making by participating in the WHO reform process. At a meeting on global health governance called for by the WHO DG in March 2011, the Chinese representative was said to propose that “In the

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5 Interview with a senior Swiss health official, Feb. 20, 2012.
future, make the rule that countries can introduce a resolution only if they can commit money to implement the resolution.”

Despite so, China approach toward shaping global health governance rules and norms remains narrow and limited. Unlike Brazil, which has shown leadership on the global health rule making over a wide range of issues, China was not an active participant in the negotiation of the Framework Convention on Tobacco Control (FCTC), the universal access to HIV/AIDS medications, or pharmaceutical intellectual property rights. China’s participant in GHG is not always positive. During the negotiations of FCTC, China along with Japan, Germany and the US were the leading opponents of key provisions to minimize the treaty’s effectiveness. With members of tobacco industry included as members of its delegation to the negotiation, China called for deletion of pictorial warning labels on tobacco packages from the proposed text and joined the US against NGO access to the informal sessions (Mamudu and Glantz 2009). In addition, while allowing WHO to interact with Taiwan, the implementation of the 2005 MOU set out clear restrictive procedures on such contact. Among others, the invitation of Taiwanese health experts or dispatch of WHO experts to Taiwan should be justified from “both a technical and policy point of view” and must obtain the approval of the Chinese Ministry of Health (WHO 2005).

Impact on Domestic Health Governance

Public policy refers to what governments do as they transact with civil society, the economy, and states within a global state system (Katznelson 2001: 11541). Sensitive on the issue of state sovereignty, China was widely believed to be resistant to international intervention in what it defines as internal affairs. Yet as Lieberthal and Oksenberg’s (1988) study of China’s energy sector and Economy’s (2004) research on China’s environmental protection efforts have suggested, outside forces can still intrude the seemingly opaque and exclusive Chinese body politic to exert influence in its public policy process.

Like other sectors, the impact of foreign influence in the health sector is not new. The scope, significance and nature of that influence however varied across different periods of time in the sector. Initially, the US-led blockade and isolation forced China to “lean toward one side”

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6 Author’s interview with a participant of the meeting, New Delhi, February 2, 2012.
and prioritize health-related international cooperation with socialist countries. The bias toward heavy industry (as enshrined in the Soviet development model) explains why workers in that sector were the first and only labor group entitled to comprehensive health coverage. In the late 1950s, China decided to abandon the Soviet development model in pursuit of an approach that emphasized mass mobilization and decentralization. With direct international exchange minimized, more indigenous policy experiments such as Cooperative Medical Services (CMS) were popularized in the countryside. China’s lack of significant interaction with the outside world in the 1960s (thanks to the deteriorating Sino-Soviet relations and sustaining Sino-American confrontation) not only allowed a clear demarcation between domestic and international health, but it also reduced the need to respond to international demands and pressures over domestic health governance issues.

The frequency of health policy intersecting with the outside world increased in the 1970s, when China resumed its membership at the U.N. and the WHO. In September 1972, China signed the Basic Agreement with the UNDP, allowing the latter to fund projects covering areas of health-manpower development, traditional medicine, pharmaceutical standards, and primary health care. In December 1978, it signed a historic Memorandum of Understanding with WHO, paving the way for WHO to designate forty-one research institutes in China as WHO Cooperation Centers. In addition to its participation in WHO, China also began to contribute to the United Nations Children’s Fund (UNICEF) and use loans from the World Bank to improve medical education and rural health care. Meanwhile, China and the United States began to cooperate under the auspices of a Health Protocol signed in 1979. While much of its international health cooperation was carried out on a bilateral basis, the space of China’s health governance has expanded tremendously. If in the Mao era China paid little heed to international influence in internal health policy making, now it found itself a calculating actor vis-à-vis three sets of new policy actors: Western states and international governmental organizations (IGOs), an increasingly assertive international civil society, and multinational companies, including pharmaceutical firms. WHO’s 1978 initiative for Health for All by the Year 2000 (HFA/2000), for example, prompted the Chinese government leaders to make an external commitment in fulfilling the WHO objectives, and provided a raison d'être to sustain the state’s engagement in the health sector.
Today, international governmental agencies (e.g., UN, UNICEF, World Bank, WHO, UNAIDS), Public-Private Partnership (e.g., Global Fund, GAVI Alliance), non-state actors (e.g., Gates Foundation, Oxfam), major pharmaceutical companies (e.g., Merck) and foreign government agencies (e.g., HHS, CDC, FDA) have offices, programs, and/or businesses in China. Those that do not have country offices have their official communication channels with China. Global Fund, for example, works with China through the Funding Portfolio Manager for China and its Partnership Cluster. Engaging these global health actors led to China’s exposure to transnational networks, new information channels and governance mechanisms which potentially have a bearing on China’s domestic health governance structure and process.

This section focuses on the impact of China’s GHG participation on its domestic health governance. In particular, it examines on how the actors, processes, and institutions of global health shape the health policy agenda setting, policy formulation, and implementation in China.

**Global health governance and health agenda setting**

Agenda setting is a process in which issues or problems start in the public (non-governmental “systemic” agenda) and move to government (“governmental agenda” and “decision agenda”). A given condition gets defined as a problem awaiting government action through means by which government officials learn about conditions (e.g., indicators, focusing events, formal and informal feedback about the operation of existing programs) and ways in which conditions become defined as problems (when conditions violate important values or comparison with other countries led to unacceptable results; or a condition is reclassified into a “problem” category) (see Kingdon 1995).

By investing in China’s surveillance and laboratory capacity building and by providing formal and informal policy feedback, global health actors facilitated policy learning in China’s health governance, which in turn helps transform a systemic agenda into a government agenda. Moreover, global health processes, through bilateral and multilateral exchanges, workshops and conferences, international media coverage, and policy reports released by reputable international agencies, can be instrumental in reclassifying public health conditions in China into the “problem” category, while at the same time bringing to the fore a new discourse on health-related issues. This is especially the case when a public health threat is reframed as a

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development or security challenge. As a result, the Chinese government increasingly subjects its agenda-setting regime to the organizational goals of global health actors. China’s HIV/AIDS agenda setting is a case in point. Until the mid-1990s, there was no serious attention to the rising HIV/AIDS problem at the national level (Huang 2004). Contradicting to the government’s Pollyanna attitude, United Nations officials then warned that unless effective measures were taken, China could have over 10 million HIV cases by 2010 (“China could face…” 1998). Their warnings against the backdrop of the rapid spread of HIV/AIDS in China alarmed the Ministry of Health officials. In early May 1998, the Health Minister presented an update on the HIV/AIDS situation to the State Council executive meeting in an effort to increase government awareness of HIV/AIDS (Xinhua 5/6/1998). From then on, HIV/AIDS began to draw attention from national leaders. In this process, UNAIDS and other international health actors became the best ally of the MOH in pushing for agenda shift. On May 6, 1998, in a move that was believed to be first of its kind, Vice-Premier Li Lanqing met in Beijing with Peter Piot, Executive Director of UNAIDS. Despite the cover-up at the sub-national level, since 1999 scientists, health workers, and international society have joined the Ministry of Health to identify the problems and push for the inclusion of HIV/AIDS in the decision agenda. In a rare move, a UN report entitled “HIV/AIDS: China’s Titanic Peril” was released in June 2002, which criticized Chinese government on the insufficient political commitment (UN Theme Group on HIV/AIDS in China 2002: 7). While Chinese officials rejected the report, it became clear by the end of 2002 that HIV/AIDS is not just a public health problem, but also one that has significant social, economic, political, and security implications, and therefore demands the highest level of attention. In a speech at China’s Zhejiang University in October, UN General Secretary Kofi Annan defined AIDS as a problem relating to development and security and called for “leadership at every level” to deal with the epidemic (Xinhua 10/15/2002). The same month, China announced plans to provide “comprehensive care and treatment” for HIV/AIDS victims in 100 counties hit particularly hard by the disease (Zhang Feng 2002).

Not all international engagements are promoting positive change in health agenda setting. Driven by their own interests or organizational objectives, international actors sometimes send wrong messages that are then used by the Chinese government to justify the sustaining of “bad” policies. Again, take China’s HIV/AIDS control. Until the release of the 2002 UN report on China’s HIV/AIDS, international pressure on China to effectively address HIV/AIDS remained
low. Indeed, the lack of understanding of the true HIV/AIDS situation in China led foreign health watchers to endorse existing government measures. In 1991, a WHO official was reported to express confidence in China’s ability to curb the spread of HIV/AIDS on grounds that China had an excellent county-town-village epidemic prevention system in the countryside (Xinhua 7/22/1991). Another WHO expert went as far as to call China “the first country to have policies and plans in place before an epidemic” (AP 11/5/1995). Such statements did not do any help but sending wrong signals to the Chinese leadership and justifying inattention and inaction.

China’s emergence as a global power has further complicated the picture. If in 2003 Beijing received opprobrium from the WHO for its initially secretive and lackadaisical approach toward the SARS outbreak, during the 2009 H1N1 outbreak the same organization refrained from criticizing China’s travel and trade restrictions, even though they clearly clashed with the WHO’s recommendations. The WHO acquiescence was then used by the government to justify its aggressive and often unnecessary domestic health governance regime (China Daily 6/4/2009; Renmin ribao 8/22/2009). The danger is that as China’s voice in GHG reaches a crescendo, international agencies and foreign governments muffle their criticism of China. In 2010, the executive director of Global Fund in his visit to China thanked the Chinese government for its efforts on AIDS prevention, treatment and care, but said nothing publicly about the rights of HIV infected people and the plight of activists working in this area (Los Angeles Times 7/11/2010).

Global health governance and China’s health policy formulation

Policy formulation is the development of effective and acceptable courses of action for addressing what has been placed on the policy agenda. It involves the process of specifying alternatives that narrows the set of conceivable alternatives to the set that is seriously considered for governmental action. Specialists usually play an active role in the analytical phase of policy formulation.

Compared to the Mao era, when the anti-intellectualism often led to marginalization of expert opinion in the policy process, the post-Mao state rebuilding has increased the importance of the consultative process in policy making. The emphasis on expert opinion led to the establishment of various new policy research organs at different levels, and the use of national survey and case work for more “scientific” decision making. The international exchanges
between government officials/ researchers and international agencies (foreign governments, IGOs, and think tanks) facilitate information flows within the government, enhancing the ability of leaders in policy formulation. International actors in exerting influence can try out proposals in a variety of ways: through official visits, conversations with government leaders, circulation of policy papers, and international conferences. China’s growing interactions with US HHS, CDC, and FDA contribute to the establishment of similar agencies (Chinese CDC and SFDA) in China. China’s participation in global health governance and exposure to dominant international health norms and institutions also provide the opportunity for China to familiarize the most appropriate or legitimate means to pursue domestic health governance. The learning experience for example was evidenced in China’s negotiations of IHR: Margaret Chan was seen on several occasions to pull the Chinese negotiator aside and tell him “you can’t do that”. International pressures also played an important role in persuading China to tackle HIV/AIDS prevention and treatment in a pragmatic and transparent way. For a long time, the government prevention and control efforts deemphasized more pragmatic measures such as condom use and access to anti-retroviral drugs (ARVs). Indeed, most health experts then agreed that “it was impossible to try to control AIDS with special medicines and condoms” (Xinhua 11/9/1990). In March 1994, Michael Merson, Executive Director of the World Health Organization’s (WHO) Global AIDS Program, publicly called for China to implement a nationwide sex education program and to encourage the use of condoms (United Press International 3/9/1994). This was followed by the release of a State Council-approved policy report in September 1995, that formally incorporated the idea of behavioral intervention for HIV infected people and high-risk groups (Xinjingbao 3/20/2004). Transparency and timely information sharing is another important international norm China learned from its engagement in global health governance. After the country’s first application to the Global Fund to Fight AIDS, Tuberculosis & Malaria was rejected (in part because of the government’s closed attitudes about the problem), health officials decided to talk more candidly about disease. In September 2002, China raised its estimate of the number of Chinese infected with the AIDS virus, in an attempt to show some good faith efforts on AIDS to help its application. Beginning in 2004, China has worked with UNAIDS to issue joint reports on China’s AIDS spread and control.

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8 Interview with a senior Swiss health official, February 20, 2012.
After systemic agenda is transformed into governmental agenda, international health actors and regimes not only affect the choice set available for decision makers, but can also play a critical role in affecting the timing of government action. To some extent, China’s crisis-driven policy process highlights the importance of such actors. Starting February 11, 2003, the Western news media began to aggressively report on SARS in China and the government’s cover-up of the outbreak. On March 15, the WHO issued its first global warning about SARS. While China’s government-controlled media was prohibited from reporting on the warning, the news circulated via mobile phones, email, and the Internet. On March 25, three days after the arrival of a team of WHO experts, the government for the first time acknowledged the spread of SARS outside of Guangdong. The State Council held its first meeting to discuss the SARS problem, two days after the Wall Street Journal published an editorial calling for other countries to suspend all travel links with China until it implemented a transparent public health campaign. The same day, the WHO issued the first travel advisory in its 55-year history advising people not to visit Hong Kong and Guangdong, prompting Beijing to hold a news conference in which the Minister of Health promised that China was safe and SARS was under control. Enraged by the Minister’s false account, a retired surgeon at a military hospital sent an e-mail to two TV stations, accusing the Minister of lying. While neither station followed up on the e-mail, Time magazine picked up the story and posted it on its web site on April 9, which triggered a political earthquake that led to the sack of Beijing major and the Minister of Health. As Tan (2009) nicely summarized, “The Chinese government’s change in position in April 2003 to admit the full extent of the SARS outbreak and to declare the situation a national emergency, would not have occurred without the actions, countervailing authority and pressure from the global scientific community and in particular the WHO.”

Compared with its reactive response to international pressures during SARS, Beijing since 2003 has actively sought international input in health policy formulation. In the new round of healthcare reform, Chinese policy makers reportedly collected and studied health care systems of a number of countries. The government in the reform policy formulation invited nine policy organizations to submit proposals, including WHO, World Bank, and international consulting firm McKinsey. Based on the input and feedback from both national and international experts, China formally released the new health care reform plan in April 2009.
Despite the growing participation of international actors, their role in policy formulation is confined to the analytical phase, or “the process of specifying alternatives that narrows the set of conceivable alternatives to the set that is seriously considered for governmental action” (Kingdon 1995: 4). International actors have a say in this process as long as their policy ideas are technically/budgetary feasible, and/or congruent with the values of policy community. But the policy idea must be authorized through a political process before being enacted. It is in the political phase that decision makers, not specialists, have their way. The danger is that when a health issue is placed in the realm of realpolitik, it runs the risk of being “dependent on the logic of such politics—which is not based on science and not subject to public deliberation and peer review, but on the Machiavellian instincts of those in power” (Obemann 2007: 1688). The discrepancy between the government openness and receptivity in alternative specification, on the one hand, and the autonomy of decision makers in policy enactment, on the other, may explain why “good” international influence in one case may have “bad” impact on the other. As we have discussed, concern about international image was a major factor in China’s policy shift toward the 2002-03 SARS outbreak. The lessons the government leaders drew from SARS had a powerful impact on their response toward the 2009 H1N1 outbreak (Huang 2010). The political leaders were more interested in presenting an image that the government was acting differently in combating H1N1, that it indeed placed top priority on people’s health and well-being. In their eyes, the failure to differentiate between SARS and H1N1 is secondary as compared to having a visible approach the top leaders want to demonstrate to the Chinese people and the international society. As a result, China turned out the most aggressive among nations in responding to H1N1, only to find that most of the draconian measures were not necessary, even counterproductive (Huang 2010b).

Global health governance and China’s health policy implementation

Policy implementation is the process by which policies enacted by government are put into effect by the relevant agencies. While various factors can affect policy implementation, state capacity constitutes a key variable in connecting the wheel to the rudder. But building state capacity also means building effective partnerships and institutions internationally. Given that a country’s public health problems reduce state capacity when ever-increasing capacity is needed to tackle the challenges, purely endogenous solutions to build capacity are unlikely to be
successful, and capacity will have to be imported from exogenous sources such as massive foreign aid (Price-Smith 2002: 127). In this respect, the role of global health governance actors and processes is two-fold. First, they increase the government’s financial capacity in the health sector by opening an alternative source of financing. In the early 1980s, for example, UNICEF provided equipment worth US$20 million to build the cold chain in child immunization, which was matched by funding from the Chinese government. After the funding problems were solved, the cold chain covered more than 90 percent of the regions, providing more than six immunization services annually (Jiankang bao 1/15/1999). Second, international aid can strengthen the bureaucratic capacity through technical assistance, policy counseling, and personnel training. In 1990, the Ministry submitted an application to the World Bank requesting funding for the project on epidemic and endemic disease control. Starting from 1992, 42 percent of the funding was spent on providing free diagnosis and treatment services for potential TB patients in 12 provinces. By September 1996, the project had covered 1,148 counties in 12 provincial units (ZGWSNJ 1997: 100). Providing free diagnosis and treatment gave incentives for people to seek care, especially in poor provinces. As a result, China was able to provide free diagnosis for 2.56 million potential TB carriers, from which more than half million patients were identified for treatment. In six counties of Hunan Province, within two months in 1992 1,874 TB cases were identified as positive, compared with only 907 cases identified in the past year (Jiankang bao, 8/2/1992). Once the full extent of the problem became known, China became serious about providing subsidies for treatment and appropriate incentives for providers of care. Through a WHO-recommended method Directly Observed Therapy Short Course, or DOTS, the cure rate increased from less than 50 percent to 91.3 percent, although the TB registration rate had increased from 8.63/100,000 to 18.43/100,000 (Jiankang bao 9/29/1996; ZGWSNJ 1997: 99).

More recently, China has collaborated with World Bank in avian/human flu prevention and control. Implemented in 10 counties, this three-year project aimed to strengthening local state capacity in planning and responding to outbreaks of avian flu. With the Bank donation of US$2.65 million, the project strengthened the ability of agricultural and health departments in
identifying, diagnosing, reporting and systematically addressing HPAV infections. The success led to an additional $3.5 million funding to launch the second-phase project.

The engagement of the global health actors was probably the most intensive in the area of HIV/AIDS prevention and control. In this area, organizations such as UNAIDS and the WHO play a major leadership and coordination role. And with the blessing of government authorities at the national level, numerous governmental and non-governmental international initiatives also operate major programs in China (see Gill and Thompson 2006). They either provide funding directly to the government or forge partnerships with local government actors in health policy implementation. Initiated by the United Kingdom’s Department for International Development, for example, the China-UK HIV/AIDS Prevention and Care Program (“China-UK”) was primarily reliant upon the centers for disease control at various levels to provide treatment and care in the target provinces (Yunnan and Sichuan). Similarly, the US government, through the USAID’s HIV/AIDS programs, concentrates on HIV-prevention initiatives targeting at-risk persons in the Mekong provinces of Yunnan and Guangxi, while the Australian government, through its Agency for International Development (AusAID), sought to help build capacity for health authorities in minority-dominated regions such as Xinjiang and Tibet. Other governments such as Germany, Sweden, and the European Union also have bilateral HIV/AIDS programs with Chinese partners.

While foreign governments work with Chinese partners at the national or provincial level, numerous international charities, foundations, nonprofits, and companies have programs and projects that focus on making a difference at the community level by “providing technical advice, education, and awareness programs; harm reduction interventions; health care worker training; media training; and peer group counseling programs; and by providing funds directly to local implementing agencies” (Gill and Thompson 2006: 21). They include Clinton Foundation, which deviated from its standard practice of facilitating negotiations between drug suppliers and governments and focused instead on providing technical and in-kind assistance in China; Merck & Co., which launched a five-year, $30-million partnership to comprehensively combat HIV/AIDS in the Liangshan prefecture in Sichuan province; Project HOPE, whose projects involved training health care providers in local areas; Gates Foundation, which funded various

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10 Ibid.
reproductive and rural health projects in China that have HIV-related components; and Bayer China, which forged a partnership with Tsinghua University, aiming to strengthen news media and information dissemination on HIV/AIDS (Hubbard and Itoh 2010).

Among those international partners, Global Fund has been in a very unique position to influence China’s anti-HIV policy. In addition to be an importance funding source, Global Fund, through the country coordinating mechanism (CCM), has played a crucial role in strengthening China’s health governance. As demonstrated in China CARES program, its funding has led to more government commitment to HIV/AIDS prevention and control. Its funding and its requirement of involving communities affected by HIV/AIDS in CCM also led to the proliferation of health-related NGOs and CBOs (community-based organizations) in China. Its push for CCM reform not only led to an open, transparent, and thoroughly documented election of CCM NGO representative in April 2006, but also – through its independent review group -- legitimized election results as well as the rising civil society. Perhaps more, through the election processes awareness of the necessity and merits of public participation was greatly strengthened among civil society groups. For most of the NGOs that participated, the elections marked their first experience with self-organization (Jia Ping 2009).

The active engagement of global health actors by no means guarantees the successful implementation of their initiatives or programs. Effectiveness in policy implementation depends on variables including policy/program design, institutional structures in which the program is implemented (including state capacity), and the wider sociopolitical context in which these structures and processes operate. Interference from entrenched domestic special interests has prevented China from honoring its international obligations by distorting the domestic policy/program design. In 2003, China signed the WHO’s Framework Convention on Tobacco Control and pledged to ban smoking in workplaces and indoor public spaces by January 9, 2011. But due to the powerful influence of tobacco industry in drafting and enforcement of tobacco-related polices, the deadline passed without any major change. Although the Ministry of Health banned smoking in indoor public places in March 2011, the ban has largely been disregarded. Indeed, over the past five years, China’s cigarette production actually rose by 17 percent, making China’s anti-tobacco policies are among the least effective in the world (Huang 2011).
GHG players also found it difficult to influence policy implementation because of the perverse central-local relationship. As Gill and others have observed: “Even when funds are made available in poorer areas to combat HIV/AIDS, such as a major World Bank loan or a grant from the central government, there is no assurance that the resources will be spent efficiently by local government officials, and there is always the possibility that funds for one project will be diverted to fund a different program that lacks resources and is determined to be a higher priority” (Gill and Thompson 2006: 8).

The frustration of international donor and NGOs reflects the collision between the traditional state-centric approach and a new governance approach that incorporates new actors and accepts them as legitimate partners. In engaging international players to implement domestic health projects and initiatives, the government seems to be consistent not to let their ideas dominate the entire process. As Yukon Huang, former head of the World Bank’s country director for China observed:

Chinese government was very strong in deciding what do and deciding how to do. The Bank’s view was prevailing in many recipient countries, but not in China, because Chinese government had a clear idea of what it should do…Through cooperation with the Bank Chinese government can achieve higher efficiency with higher speed. But it would not follow the Bank’s ideas or do what the Bank told it to do. (Zhongguo qiyejia 8/14/2004).

The state-centric approach also accounts for the lack of effective civil society engagements in implementing international health projects in China. While increasing level of international engagement provides important sources of information and resources for disease prevention and control, it also threatens Chinese state’s historical monopoly regarding the control of public health information. As a result, governments at various levels often are distrustful of these health-promoting civil society organizations, viewing them as organizations with political agendas that potentially threaten the survival of the communist state. This in turn leads to sustained suppression of genuine health-promoting NGOs and activists in China. NGO leaders are often harassed by police and security officials, with lucky ones (Gao Yaojie, Wan Yanhai) leaving the country and unlucky ones (Hu Jia) ending up in jail. The Arab Spring only confirmed Beijing’s fear that CSOs supported by international actors may serve as a Fifth Column in making a Jasmine Revolution in China. In May 2011, news came out that the Global Fund had frozen payments of grants to China worth hundreds of millions of dollars. The Fund’s
decision was “rooted in a collision between the fund’s conviction that grass-roots organizations must be intrinsically involved in the fight to control diseases like AIDS, and the Chinese government’s growing suspicion of any civil-society groups that are not directly under its control” (New York Times 5/21/2011). Government bias against CSOs led to the inclusion of many government organized NGOs (GONGOs) in CCM, which receive the bulk of the Global Fund funding and resources. This not only results in inefficiency in fund use, but also hinders the rise of an independent and autonomous civil society. It is no surprise that even today China’s NGOs still lack the skills and experience to engage the Global Fund as effectively as more seasoned NGOs in other countries. Moreover, because of the continuous lack of government financial support of the civil society organizations (CSOs), Global Fund money contributed to vicious competition among various NGOs which, in conjunction with government divide and rule strategy, results in infighting and distrust among those groups. Those NGOs with more funding but poor accountability end up gaining disproportionately more power than others, and used that power in an irresponsible manner that jeopardizes the growth of Chinese civil society. The problem is that in absence of effective participation of CSOs, China not only will find it difficult to comply with global health rules, but it will face implementation problems in coping with major health challenges. Its shift from reactive response to overreaction in fighting H1N1 influenza is good example.

**Discussions and Conclusions**

In examining China’s engagement in global health governance, Tan (2009) argued that China’s fundamentally state-centered, reactive and material interest-driven approach not only leads to a fairly narrow and limited engagement in global health governance, but may also be unsustainable in the long run because it is increasingly out of synch with the standards for responsible behavior globally. That pessimism was shared by David Fidler, a leading global health scholar, who indicates that China’s ability to influence global health governance might be limited by the tensions between the emerging multi-polarity (which calls for bold collective

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11 Civil society movements are “central to securing and ensuring adherence to a global health agreement” (Gostin et al. 2011).
action for effective global governance) and the “Asian style” of consensus and consultation (Fidler 2010b).

A close examination of China’s participation in global health governance suggests two parallel and interrelated processes that seem to defy the pessimistic logic. On the one hand, China’s participation is making a difference in global health governance processes and outcomes. Through its health-related foreign aid it contributes to the health system capacity building in the developing world, especially Africa. Its rise as an exporter of pharmaceutical products also promises to be a game changer in the access to medicine and vaccines. Equally important, as its engagement becomes more substantial, it has shown strong interest and flexibility in global health agenda setting and rule making. On the other hand, despite the opaque and exclusive authoritarian structure in China, global health players, norms, and processes still have a significant role to play in the country’s domestic health governance. In terms of agenda setting, they are often critical in moving “latent” public health issues to governmental agenda. In terms of policy formulation, they can affect not only the timing of government action, but also the content of policy design. International actors can also affect policy implementation by influencing the financial and bureaucratic capacities in China. The magnitude and significance of China’s participation cannot be simply accommodated by the state-centered Westphalian approach (as argued by Tan) or a structural-normative model (as indicated by Fidler). It seems more appropriate to characterize China’s approach as a pragmatic one that combines the utilitarian logic of reaping material benefit, the realist objective of expanding its global power and influence, the neoliberalist interest in pursuing absolute gains from international cooperation, and the constructivist attempt to become a responsible stakeholder in the system.

To be sure, China’s engagement in GHG thus far is still narrow and limited, and not always constructive. As evidenced in its handling of the H1N1 outbreak in 2009, while China recognizes the importance of international cooperation in coping with global health challenges, realpolitik continues to drive its foreign policy behavior in international health cooperation. Approaching GHG in an individualistic and state-centric manner thus threatens to lead to further fragmentation of the global health regimes. But the discrepancy between the neoliberal penchants of international cooperation and the realist-driven actual state response is not unique
Similarly, the influence of GHG players, processes and institutions on domestic health governance is limited and is not always positive. They may send wrong and inconsistent signals to the government, which may be used by the latter to justify the maintenance of ineffective policies. Their influence in policy formulation is mainly confined to the analytical stage. When the discussions and pressures move from the scientific to the political, decision makers have more incentives to disregard international pressures or rules. They may have little influence in determining the outcomes of policy implementation at the local level. The constraints and limits of GHG on domestic health governance may be attributed to the state-centered governance mentality, but they also reflect the perverse state-society relations and the influence of entrenched domestic special interests.

Perhaps equally important, these constraints and limits are not static as the domestic and international context for China’s engagement is changing. In view of the growing international pressure for shouldering more global responsibilities, nationalist intellectuals and officials may still view the demands and pressures as part of an international conspiracy to thwart China’s development. But more pragmatic officials do feel strongly the need to expand China’s participation in GHG. The Ministry of Health, for example, is following the Swiss example and drafting its own global health strategy, which is expected to be released this coming summer. The new strategy may lead to the establishment of a specialized development assistance agency. For 2012-13, China’s share in the WHO assessed funding increased to 3.18 percent, which makes China the largest contributor among all the developing countries (WHO 2010). On the domestic front, there are signs suggesting the state is willing to give more space for civil society groups in the health policy process. In July 2010, the Chinese government and civil society joined hands for the first time in responding to HIV/AIDS by launching China Red Ribbon Beijing to share information and pool resources in fighting the disease (China Daily, 7/6/2010). More recently, the government pledged greater support for civil society organizations involved in the fight against HIV/AIDS (China Daily, 3/2/2012). As China becomes more receptive to international norms, pressures, and influences, it is anticipated to play a much bigger role in global health governance.

12 In October 2009, the HHS secretary suggested that the U.S. would not donate the vaccine to poor countries until 150 million at-risk Americans had been inoculated against the H1N1 virus.
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