## Appendix B: Policy Recommendations

| Content | Comments | Revisions | Media |
|---|---|---|---|
| Strengthen Work in Health Prevention | 23 | 1 | 2 |
| Increase Investment in Public Health | 6 | 1 | 3 |
| Make Public Health Free | 2 | 0 | 0 |
| Make Checkups Mandatory | 1 | 0 | 0 |
| Subsidize Checkups | 2 | 0 | 0 |
| Make Checkups Free | 2 | 0 | 0 |
| Subsidize Vaccinations | 5 | 0 | 0 |
| Make Vaccinations Free | 2 | 0 | 0 |
| Increase Investment in Infectious Disease Prevention Capacity | 2 | 0 | 0 |
| Increase Health Knowledge Education | 13 | 1 | 0 |
| Government Should Primarily Invest in Public Insurance Funding | 2 | 0 | 1 |
| Encourage Entry of Diverse Types of Social Forces into Hospitals | 12 | 1 | 3 |
| Encourage Hospitals' Reliance on Themselves to Generate Revenues | 2 | 0 | 0 |

| | | | |
|---|---|---|---|
| Government Should Primarily Invest in Providers | 22 | 0 | 0 |
| Make Provinces Responsible for Investment in Providers | 2 | 0 | 0 |
| Do Not Make Private Providers Eligible for Insurance Compensation | 0 | 0 | 1 |
| Do Not Allow the Entry of Social Forces into Hospitals | 1 | 0 | 0 |
| Do Not Separate Hospitals from Pharmaceuticals | 5 | 0 | 3 |
| Government Should Directly Manage Public Hospitals | 10 | 0 | 2 |
| Uphold the Public Interest | 23 | 1 | 3 |
| Do Not Privatize Public Hospitals | 1 | 0 | 1 |
| Do Not Marketize Providers | 6 | 0 | 1 |
| Do Not Incorporate Public Hospitals | 1 | 0 | 0 |
| Do Not Maintain Public Hospitals as Core | 1 | 0 | 0 |
| Abolish Division of For- and Non-profit Hospitals | 1 | 0 | 0 |
| Maintain Only Non-profit Hospitals | 1 | 0 | 0 |
| Do Not Adopt Two Distinct Avenues of Fee Collection | 2 | 0 | 1 |
| Government Should Not Directly Manage Public Hospitals | 2 | 0 | 0 |
| Separate Management and Regulation Authorities | 4 | 1 | 7 |
| Privatize Public Hospitals | 1 | 0 | 0 |
| Establish Private Hospitals | 6 | 0 | 3 |
| Marketize Public Hospitals | 8 | 0 | 6 |
| Incorporate Public Hospitals | 8 | 1 | 6 |
| Break the Monopoly of Public Hospitals | 3 | 0 | 0 |
| Improve Quality of Management | 5 | 0 | 0 |
| Improve Financial Management | 4 | 0 | 0 |
| Alter Appointment Procedure of Hospital Directors | 4 | 0 | 0 |

| | | | |
|---|---|---|---|
| Appoint Professional Directors with Management Background | 5 | 0 | 0 |
| Set Up Rules and Regulations to Increase Oversight | 12 | 0 | 0 |
| Improve Transparency Mechanism in Public Hospitals | 8 | 0 | 2 |
| Punish the Corrupt/Create Deterrence Mechanism | 19 | 0 | 5 |
| Control Waste of Resources | 7 | 0 | 1 |
| Control Excessive Medicine | 10 | 0 | 1 |
| Make Information Publicly Available | 2 | 0 | 0 |
| Improve Complaint Mechanism | 5 | 0 | 0 |
| Set Limits on Construction and Expansion | 1 | 0 | 0 |
| Abolish Commissions/Kickbacks | 8 | 1 | 0 |
| Control Excessive Treatment through Insurance Regulation | 2 | 0 | 2 |
| Set Up Laws and Regulations to Define Responsibility | 3 | 0 | 0 |
| Improve Vertical Coordination Between Big Urban Hospitals and County Hospitals | 14 | 1 | 0 |
| Improve Coordination Between Rural County Hospitals and Township/Village Units | 12 | 1 | 1 |
| Government Needs to Distribute Resources in a Fair Manner | 1 | 0 | 1 |
| Government Needs to Equalize Rural and Urban Health | 3 | 0 | 2 |
| Government to Equalize among Developed and Poor, Remote, Ethnic Minority Areas | 1 | 0 | 0 |
| Government Needs to Address Regional Differences | 1 | 0 | 2 |
| Construct Hospitals/Clinics in Rural Areas | 2 | 1 | 1 |
| Construct Hospitals and Clinics in Poor, Remote, and Ethnic Minority Areas | 1 | 1 | 1 |

| | | | |
|---|---|---|---|
| Invest in Equipment and Buildings in Rural Areas | 7 | 1 | 0 |
| Increase Ratio of Personnel Per Patient | 2 | 1 | 0 |
| Increase Number of Personnel | 3 | 1 | 1 |
| Increase Government Support and Investment in Chinese Medicine | 6 | 0 | 1 |
| Provide Salary Security | 27 | 1 | 2 |
| Provide Access to Old Age Insurance | 9 | 0 | 0 |
| Provide Housing Benefits | 1 | 0 | 0 |
| Provide Paid Vacations | 4 | 0 | 0 |
| Pay for Overtime Work | 2 | 0 | 0 |
| Policy Recommendation: Improve the Morale of Medical Staff | 18 | 1 | 1 |
| Policy Recommendation: Improve the Social Prestige of Medical Doctors | 5 | 0 | 0 |
| Curb the Authority of Hospital Directors | 9 | 0 | 0 |
| Create Mechanisms to Improve Doctor–Patient Frictions | 4 | 1 | 0 |
| Improve Doctor–Patient Relations | 16 | 1 | 7 |
| Strengthen Standardize Occupational/Medical Accident Insurance | 8 | 1 | 0 |
| Protect Doctors | 5 | 1 | 0 |
| Improve Implementation of Training Programs/Qualifications Procedures | 8 | 0 | 0 |
| Government Should Adequately Compensate for Training Programs/Qualifications | 4 | 0 | 0 |
| Expand Coverage: Catastrophic Health | 13 | 1 | 3 |
| Expand Coverage: Chronic Disease | 9 | 0 | 1 |
| Expand Coverage: Inpatient | 4 | 1 | 2 |
| Expand Coverage: Outpatient | 10 | 1 | 1 |
| Expand Coverage: for Pharmaceuticals | 5 | 0 | 0 |

| | | | |
|---|---|---|---|
| Expand Coverage: to Include Handicap | 4 | 1 | 1 |
| Expand Coverage: for Poor | 4 | 1 | 2 |
| Increase Level of Government Subsidies for Premiums | 6 | 1 | 0 |
| Make Insurance Enrollment Mandatory | 1 | 0 | 1 |
| Improve or Rectify Management of Individual Accounts | 2 | 0 | 0 |
| Set Limits on Individual Account Expenses | 1 | 0 | 0 |
| Rectify Abuse or Mismanagement of Insurance Funds | 3 | 0 | 0 |
| Increase Level of Government Investment | 4 | 0 | 3 |
| Facilitate Processing of Insurance Claims | 1 | 0 | 0 |
| Merge Insurance Programs | 13 | 1 | 6 |
| Facilitate Compensation Outside of huji (Retired Migrants) | 8 | 1 | 2 |
| Enroll in Local Insurance: Migrant Workers | 5 | 0 | 0 |
| Enroll in Local Insurance: Retired Migrants | 1 | 0 | 0 |
| Equalize Levels of Compensation or Coverage across Different Insurance Programs | 3 | 0 | 1 |
| Equalize Levels of Compensation or Coverage across Rural and Urban Insurance Programs | 2 | 0 | 0 |
| Promote Private Insurance | 4 | 1 | 1 |
| Do Not Promote Private Insurance | 2 | 0 | 1 |
| Allow Insured to Select Hospitals | 5 | 0 | 1 |
| Emphasize Quality Rather than Price in Regulation of Price | 1 | 0 | 1 |
| Abolish Discrimination of Local Industry in Government Regulation of Price | 1 | 0 | 1 |
| Abolish System of Basic Medicines | 1 | 0 | 1 |
| Abolish Pre-Selected Manufacturers/Centralized Procurement of Basic Medicines | 1 | 1 | 3 |

| | | | |
|---|---|---|---|
| Abolish Government Procurement of Drugs | 3 | 0 | 0 |
| Increase Oversight of Drug Procurement | 3 | 1 | 0 |
| Set Up an Environment to Support R & D | 2 | 1 | 0 |
| Do Not Maintain the Existing Multi-layered Structure of Pharmaceutical Industry | 13 | 1 | 0 |
| Protect Patents | 1 | 0 | 0 |
| Enable Universal and Free Access to Health | 3 | 0 | 1 |
| Enable Universal Access to Health Insurance | 3 | 0 | 3 |
| Enable Universal Access to Basic Health Services | 10 | 1 | 1 |
| Address Inequalities in Access to Health | 1 | 0 | 1 |
| Reform Needs to Have Concrete Items/Direct Vision | 20 | 1 | 15 |
| Reform Should Be Written in a Clear Language | 5 | 1 | 6 |
| Reform Should Take into Account Perspective of Medical Staff | 4 | 1 | 0 |
| Reform Should Take into Account Perspective of Medical and Pharmaceutical Sector | 3 | 0 | 0 |
| Reform Take into Account Perspective of Grassroots Medical Staff | 2 | 0 | 0 |
| Reform Take into Account Perspective of Rural Medical Staff | 4 | 0 | 0 |
| Reform Should Be Faster | 3 | 1 | 0 |
| Increase Government Support in Medical and Pharmaceutical Research | 7 | 1 | 0 |
| Abolish Inappropriate Fees for Rural Clinics | 1 | 0 | 0 |
| Increase Oversight and Transparency Over Drug Prices | 17 | 1 | 1 |
| Create Punishment for Offenders (Commercial Bribes) | 2 | 0 | 0 |
| Create Punishment for Offenders (Pharmaceuticals Industry) | 1 | 0 | 0 |

| | | | |
|---|---|---|---|
| Create Punishment for Offenders (Delivery of Pharmaceuticals) | 1 | 0 | 0 |
| Create Punishment for Offenders (Prices) | 3 | 0 | 0 |
| Create Punishment (Drug Manfecturing) | 1 | 0 | 0 |
| Create an Information-sharing Network for Oversight of Pharmaceuticals | 3 | 1 | 1 |
| Reduce Medical Fees | 33 | 1 | 6 |
| Reduce Pharmaceutical Prices | 22 | 1 | 3 |
| Make Insurance Enrollment Voluntary | 0 | 1 | 1 |
| Reform Should Be Slow/Gradual | 0 | 0 | 4 |
| Focus on Chronic Disease (for Insurance Coverage) | 3 | 1 | 2 |
| Government Should Guarantee Salaries of Pharmaceutical Manufacturing Workers | 1 | 0 | 0 |
| Provide Subsidies to Pharmaceutical Industry | 1 | 0 | 1 |
| Health Reform Needs to Be Carried Out Resolutely | 0 | 1 | 0 |
| Health Reform Should Be Carried Out According to Country Characteristics (guoqing) | 0 | 1 | 0 |
| Unify All Aspects of the Urban and Rural Medical Systems | 0 | 1 | 0 |
| Focus on Migrants in Public Health | 0 | 1 | 0 |
| Have County Hospital in Charge of Training Personnel at Township Hospitals (Public Health) | 0 | 1 | 0 |
| Have County Hospitals Focus Only on Basic Health (Instead of Inpatient and Basic Health) | 0 | 1 | 0 |
| Increase Oversight of Private Insurance | 0 | 1 | 0 |
| Province Should Be in Charge of Setting Up a Unified Price for Pharmaceuticals | 0 | 1 | 0 |
| Increase Investment in ‘Occupational Disease Hospitals’ | 0 | 1 | 0 |
| Take Out Price Published on Drug Package | 0 | 1 | 0 |

| | | | |
|---|---|---|---|
| Increase Oversight of Medical Waste | 0 | 1 | 0 |
| Increase Oversight of Medical Research | 0 | 1 | 0 |
| Increase Oversight of Rural Medicines | 0 | 1 | 0 |
| Increase Social Participation in Oversight | 0 | 1 | 0 |
| Construct a System for Training Resident Doctors | 0 | 1 | 0 |
| Emphasize Continuing Health Education | 19 | 1 | 2 |
| Have an Information-sharing Network for Basic Medicines | 0 | 1 | 0 |
| Grassroots Medical Facilities Should All Use Basic Medicines | 0 | 1 | 0 |
| Other Medical Facilities Should, in Accordance with Regulations, Also Use Basic Medicines | 0 | 1 | 0 |
| All Retail Pharmacies Should Sell Basic Medicines | 0 | 1 | 0 |
| Stimulate Internal Consumption | 0 | 1 | 0 |
| Improve Assessment and Oversight of Public Health Services | 0 | 1 | 0 |
| Facilitate Enrollment in Health Insurance Outside of Place of Residence | 11 | 1 | 6 |
| Every Province, Prefecture, and Municipality Will Be Responsible for the Pilot Projects (Instead of 'Local Government' in the Pre-consultation Draft) | 0 | 1 | 0 |
| Increase Level of Public Trust | 0 | 1 | 0 |
| Implement Mutual Recognition of Medical Checks among Hospitals of the Same Rank | 0 | 1 | 0 |
| Increase Public Hospitals' Oversight | 59 | 1 | 5 |
| Increase Salary of Medical Personnel | 49 | 1 | 0 |
| Total | 878 | 74 | 165 |

## Appendix C: Coding Scheme and Procedures

I develop an intricate, hierarchical coding scheme that captures both general themes and granularity in the contents of comments. I first divide the data into six key topics—Healthcare Providers and Services, Medical Staff, Insurance, Pharmaceuticals, Affordability and Healthcare Blueprint—and under each topic I generate subtopics representing broad categories. For example, for the topic 'Medical Staff', I created the following subtopics: 'Work Treatment', 'Medical Accidents' Insurance', 'Professional Qualifications', 'Morale', 'Relations with Patients', 'Relations with Hospitals Directors', 'Social Prestige' and 'Employment Flexibility'. Relying on these comprehensive categories, I am able to identify dominant trends in relation to problems that commentators are most concerned about. Under these subtopics, I also develop codes that correspond to particular policy items. For example, under 'Work Treatment' (*gongzuo daiyu*), I create particular codes for medical staff's opinions and complaints: 'Low Salary', 'No Income Security', 'No Access to Pensions', 'No Paid Vacations'. Taking note of grievances, I separately code recommendations for the implementation of concrete policy items, such as 'Increase Salary', 'Guarantee Income Security', 'Provide Access to Old Age Insurance'，'Provide Paid Vacations'.

Similarly, in coding for netizens' recommendations in favor of increasing the level of insurance compensation, I generate a coding scheme to capture the particular attributes of insurance compensation (catastrophic health, outpatient services, inpatient services for chronic disease, etc.).

In my coding scheme, I derive the conceptual separation between 'suggestions' and 'opinions' from official documents. In State Council Legislative Affairs Office document on online consultation, it is stipulated that policymakers should conduct an analysis of both

'opinions' (*yijian*) and 'suggestions' (*jianyi*) (LAO, 2010a). According to Chinese sources, 'opinions' refer to subjective views on issues, whereas 'suggestions' denote more concrete course of action that should be taken (LAO, 2010a). While coding both 'opinions' and 'suggestions', in the dataset, I include only the former. This is because 'suggestions' contain clear guidelines regarding what the government needs to do, therefore, serving as a more valid indicator of potential correlations between public input and policy revisions.

In coding netizens' recommendations, I do not simply use a keyword to make coding decisions. Instead, I code the actual policy suggestion put forward by commenters. For example, I have two distinct codes for recommendations in favor and against the privatization of public hospitals. Moreover, in some cases, commenters opposing either privatization of public hospitals or the privatization of pharmacies might use safety concerns to support their arguments. I code their safety concerns under the category of 'Hospitals' Oversight'. Meanwhile, in the dataset, I include the actual policy suggestions—'Do Not Privatize Public Hospitals', and 'Do Not Separate Hospitals' from Pharmaceuticals'. This because my key interest is in the policy implications of netizens' comments.

## Appendix D: Difficult Comments

The combination of manual coding and high level of familiarity with the details of the proposed healthcare reform blueprint permitted me to construct a coding scheme that captures nuance differences in content across comments. The attention to fine-grained details is essential for identification of the fit in meaning between citizen input and policy revisions. I provide below four example of how, using this coding scheme and procedure, I was able to distinguish and code these difficult comments.

*Marketization of Health Services:* The sample contained comments that were both in favor or against the marketization of health services. Below, I provide examples of comments representing each of these contrasting policy orientations.

**Table 5. Comments on Marketization of Health Services**

| **Policy Recommendation** | **Comment** |
|---|---|

| | |
|---|---|
| **Marketize** Health Services | The problem of 'Seeing a Doctor Is Difficult ' (*kan bing nan*) is mainly because the people go to tertiary hospitals in big cities for medical treatment. Sometimes, it is impossible to register for a medical check *(guahao*) even within a single day, not to mention to see a doctor. What is the reason for this? It is because health resource distribution is tilted towards urban centers. Why are high-quality medical resources distributed to large cities? Because 'non-profit' public hospitals hold a monopoly over medical services. Moreover, public hospitals were established during the Planned Economy Era. After so many years of development, there has not been a large increase in the number of hospitals, and private hospitals have not been allowed to enter the health market. Even if they did enter, they were classified as 'For-Profit', and it was difficult for them to survive. In the 30 years of reform and opening up, China's economy and society have been greatly developed. However, since competition has not been introduced into the medical market, there has not been any major development in the health sector, and this has caused the problem of 'Seeing a Doctor Is Difficult and Expensive.' The shortcomings of the current public medical services institutions are obvious. Efficiency is low, quality of service is not high, internal competition mechanism is absent, and the phenomenon of denying people medical treatment due to poverty is ubiquitous.<br>It can be seen that the medical market must adhere to the principle of fair competition. Only by introducing competition can we improve efficiency, and distribute resources according to market demand. Pharmaceutical prices should also be determined according to market mechanisms. These measures will solve the problem of 'Seeing a Doctor Is Difficult and expensive.' (Section 3, #863) |

| | |
|---|---|
| **Do Not Marketize** Health Services | Medical personnel should be remunerated according to their skill; they should not be blindly pursuing profit. Their salary should reflect their adherence to the public interest (*gongyi xin*) and their level of medical skill. Medical staff are not business people. They should concentrate on learning. The market economy cannot be brought into hospitals. Instead, the state should invest in hospitals and medical training in order to improve the quality of medical services. If medical personnel depend on the market to make money, the national medical sector will not develop. (Section 4, #1239) |

*Separation between Hospitals and Pharmaceuticals:* One of the key controversies surrounding the healthcare reform was the question of separation between public hospitals and pharmaceuticals. Some argue that the separation would lead to reduction in the prices of medical services. Others insist that the privatization of pharmacies would compromise patients' safety. I code the comment below as a recommendation against the separation of pharmacies from hospitals. While the commenter raises safety as a concern, my interest is in *policy implication* rather than in the way the argument is constructed.

**Table 6. Comment on Separation Between Hospitals and Pharmaceuticals**

| **Policy Recommendation** | **Comment** |
|---|---|

| | |
|---|---|
| Do Not Separate Pharmaceuticals from Hospitals | Pharmacies can't be separated from hospitals. This is because both hospitals and pharmaceuticals are related to health, doctors need to have oversight over pharmacies. The separation of hospitals and pharmaceuticals will eventually lead to the pursuit of self-interest among drug manufacturers at the expense of people's health. This is also the reason why a large number of drug incidents have occurred in recent years. (Section 7,#2364 |

*Migrants:* The sample of comments includes two types of migrants: 1) **migrant workers**, who are normally young and from rural areas, and, 2) **retired migrants**, who are not necessarily rural dwellers. Often, retired individuals move with their children to urban centers where the latter found employment. In this manner, they could take care of the grandchildren, while their children financially support and take care of the aging parents. Because of China's Household Registration System (*hukou*) both migrant workers and retired migrants faced administrative hurdles in receiving insurance reimbursement in their new place of residence. Therefore, in the comments, members of both groups plead with the government to facilitate the administrative procedures that would allow access to insurance coverage for medical treatment outside of one's original place of Household Registration (*huji*).

Even though the content of the demands articulated by both groups was identical, the demographic distinction is key for causal identification. This is because the pre-consultation blueprint endorsed the facilitation of reimbursement procedure for migrant workers, whereas the post-consultation blueprint also stipulated the enactment of a similar policy vis-a-vis retired

migrants. The differentiation between the two social groups allows us to accurately measure policy change.

**Table 7. Comments on Migrant Workers and Retired Migrants**

| **Policy Recommendation** | **Comment** |
|---|---|
| Facilitate Obtainment of Insurance Compensation for **Retired Migrants** | We live in the area of Shengli College, University of Petroleum (Dongying City, Shandong). We are old and very sick. However, our children are not working in Dongying. If you are in a child's place of residence, you are not able to see a doctor. You have to return to your city's health insurance bureau every year in order to get reimbursement. You can only access medical care (at the child's place of residence) in cases of emergency. What can we do if we are still unable to move there? (In Dongying) There are no family members to take care of us, and there is no community support for the elderly. It is difficult! I hope that this reform can solve the problem of elderly people seeking medical care outside their place of household registration (*huji*). |
| Facilitate Obtainment of Insurance Compensation for **Migrant Workers** | We are migrant workers whose medical insurance is practically equal to having no insurance. Because we do not have a local household registration, we cannot get reimbursed for medical service, and, thus, cannot afford to seek medical treatment. Think about how many migrant workers in China! I hope you can solve this issue. |

*Chronic Disease:* The revised blueprint of the healthcare reform emphasized that public health policies should focus on the monitoring and prevention of chronic disease. The sample contained

comments on chronic disease. Yet, they were coded differently depending on their contents. Some comments referred to chronic disease in the context of *public health and disease prevention policies*. Others recommended coverage of chronic disease treatment by health *insurance*. In the coding scheme, I differentiated these two types of comments.

**Table 8. Comments on Chronic Disease**

| **Policy Recommendation** | **Comment** |
|---|---|
| **1) Focus on Chronic Disease Prevention**<br>**2) Increase the Salary of Medical Personnel** | Illness is divided into two situations, one is inevitable or unforeseeable; the other is just the opposite, controllable and predictable, as long as there is scientific health education, public's promotion of reasonable eating habits and health lifestyles, the introduction of pragmatic and effective methods of strengthening the body, and the standardized treatment and prevention of some common diseases and chronic diseases will definitely reduce the national mortality rate. But all this requires the true work of medical staff, especially for health workers in the grassroots community. Take a community health service center as an example. If the total number of medical staff in the urban community health center is fixed and the community population served is also a relatively stable number, and the level of government of funding is stable, then the number of illnesses will drop significantly. Do you think that community health workers who contribute to this should receive an income? (Section 7, #712) |

| | |
|---|---|
| **Expand Insurance Coverage to Include Chronic Disease Treatment** | Medical reform policies must prioritize long-term patients suffering from chronic disease and disability. The most important thing in a socialist medical reform is to prevent patients from either becoming poor or returning to poverty due to illness. Therefore, it is recommended that the government and commercial insurance cooperate, share the account information of insured patients, and use financial subsidies to help patients participate in the medical insurance for catastrophic illnesses. (Section 1, #782) |

*Insurance Coverage: Outpatient versus Inpatient Services:* Recommendations to increase insurance coverage included two types of reimbursements: outpatient and inpatient services. The table below illustrates the two distinct types of comments.

**Table 9. Comments on Outpatient and Inpatient Services**

| **Policy Recommendation** | **Comment** |
|---|---|
| Expand Insurance Coverage for **Outpatient Services** | The state has implemented the New Rural Cooperative Medical Scheme and Urban Resident Medical Insurance, partially reducing the cost of medical treatment. However, because of the high cost of drugs, outpatient drug charges are not reimbursed, and the ordinary people are still unable to obtain medical treatment. It is recommended that the government further increase the proportion of reimbursement, and outpatient expenses must also be reimbursed on a pro-rate basis, since ordinary people use outpatient service more frequently than inpatient ones. (Section 7, #656) |

| | |
|---|---|
| Expand Insurance Coverage for **Inpatient Services** | Improve the rate of medical insurance reimbursement. For any disease that can be prevented, the state should fund prevention free of charge. If the disease is the person's fault since the person did not prevent it, then the proportion of reimbursement should be greatly reduced. The proportion of reimbursement for inpatient services for unpreventable diseases and post-operation treatment can greatly reduce the phenomenon of becoming poor due to illness. (Section 7, #269) |

## Appendix E: Coding Scheme Development & Reliability

The procedures for writing the coding scheme and ensuring inter-coder reliability were iterative, comprising of consecutive stages of reading, discussion, refinement and revisions. In collaboration with a research assistant, we first read 50 randomly selected texts to generate an initial coding scheme consisting of both broad themes and specific policy recommendations. We then met in order to discuss and share our separate coding schemes. Having merged both schemes, I drafted an initial manual for the coding scheme. The manual was then further refined through a stage where the research assistant and I individually coded an additional set of 50 random comments. While coding, we exchanged via email difficult comments and suggested new codes. Afterwards, we met again to revise the coding scheme. Following the revision, each of us proceeded to code a separate random sample of 50 comments, and afterwards, we further updated the coding manual. Throughout the process of revising coding scheme, I ensured that the research assistant was updated of the proposed changes by sending her memos once revision was completed.

Having finalized the coding scheme, both the RA and I separately coded an identical set of 50 randomly selected comments. After comparing our coding, I went over the coding with the RA and pointed area were mistakes were made. Later, my research assistant coded 240 comments and I coded 318 comments. During the coding process, I discussed difficult comments with the research assistant, while adjusting the coding scheme as problems arose.

To assess reliability, I conducted my own blind-coding of a set of 240 of the comments coded by the RA. I ran the reliability test for the six comprehensive topics in the coding scheme: 'Healthcare Providers and Services', 'Medical Staff', 'Insurance', 'Pharmaceuticals', 'Affordability' and 'Healthcare Blueprint'. The average percentage agreement for coding the six topics was 93.3%, while the Kappa value was 0.8.

There are two reasons for focusing on a limited number of topics. First, it is difficult to compute reliability for a large number of categories—162 in this sample. Second, as the majority of coding categories in the dataset are infrequent, the standard index of reliability, Cohen's kappa, is likely to yield very low k values (Di Eugenio & Glass, 2004), even if the degree of observed agreement is high (Syed & Moin, 2015). Because kappa can misrepresent reliability when there is a high number of non-prevalent categories, I only ran the test for the comprehensive categories.

**Table 10. Reliability Scores**

| | Percent Agreement | Cohen's Kappa | N Agreements | N Disagreements |
|---|---|---|---|---|
| **Health Providers** | 89.2 | 0.77 | 214 | 26 |
| **Medical Staff** | 93.75 | 0.87 | 225 | 15 |
| **Insurance** | 94.2 | 0.83 | 226 | 14 |
| **Pharmaceutical** | 92.9 | 0.76 | 223 | 17 |
| **Affordability** | 94.2 | 0.74 | 226 | 14 |
| **Health Blueprint** | 95.8 | 0.81 | 230 | 10 |

## Appendix F: Key Policy Revisions & Corresponding Comments

*Nature of Revisions*: Although major policy documents in China tend to be abstract and thin in content, the paucity of concrete details in central government documents does not necessarily entail that responsiveness is merely symbolic. Rhetorical changes within official documents do have an impact on implementation on the ground. Because the language of official documents is parsimonious, the meaning of every word is significant. If revisions to the document occur, local officials and bureaucrats are likely to take cues from these words to interpret the intentions and shifting priorities of the central government and Party leaders. Underlings who act in a contrarian manner to the language of official documents could be held accountable for violations of central directives.

*Key Policy Revisions:* I provide below ten key revisions as well as comments that match in content policy revisions.

**Table 11. Key Policy Revisions**

| | |
|---|---|
| 1) Increase Public Hospital Oversight | In today's commodity economy, the directors and employees of township hospitals are only interested in the wallets of the masses. They never want to improve the level of medical technology, reduce the people's medical spend expanses, and enable patients to receive good medical treatment. At present, the status quo of township hospitals is the following: 1) 'family hospitals' are everywhere. Just take a township hospital, out of every ten employees, six have relatives working in the same hospital. 2) The hospital director treats the hospital as her own. Expenditures and employment policies are carried out at her discretion, without being subject to any laws and regulations. Illegal expenditures are ubiquitous, and there are commissions for drug purchases, for which the ratio is quite high. 3) At present, in township hospitals, small diseases are treated as catastrophic diseases, short-term illnesses are treated as long-term ones, and patients requiring outpatient services are assigned to inpatient services. This is a serious violation of the state's regulations on the New Rural Cooperative Medical Scheme, and a large amount of state funds are funneled to hospitals. The hospital and the director make the masses suffer. No wonder the masses do not support the national health reform! Therefore, the more funds the state invests in township hospitals, the greater the losses for the state. If you do not strengthen the management and oversight of township hospitals, reform will not succeed! The above three facts we witnessed are the biggest types of corruption in hospital management! However, there are no departments and units such as |

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| | discipline inspection, supervision, anti-corruption, auditing, and price to investigate and deal with them. Occasional hospital inspections conducted by the New Rural Cooperative Medical Bureaus are meaningless! To this end, we suggest that oversight of township hospitals should be rapidly strengthened. (Section 4, #1095) |

| | |
|---|---|
| 2) Equalize the Salary of Grassroots Medical Doctors to that of Public Service Units (*shiye danwei*) Employees.[1] | I am a grassroots medical worker. I am very excited to see the full text of the 'Opinions on Deepening the Reform of the Medical and Health System'. I know that this is a prelude to the medical reform program, which will soon enter a substantive phase. For a long time, we, the grassroots medical workers, have been anticipating the medical reform. Let's talk about our treatment (*daiyu*). I work in the county. My pay is less than 800 yuan per month. The current prices are so high. My salary can only cover food and clothing for me and my children. Although we have a low income, we still need to take exams that charge high fees. Sometimes I really can't stand it, but I still can't help it. How can we work for the people with peace of mind in such circumstances? Even though our hospital is a public service unit, ~~but~~ there is very little government investment in the hospital. The hospital has to be self-sufficient. The doctors have to prescribe medications in order to make a living. Otherwise, there will be no wages. If the doctor cannot make ends meet, how can the doctor's family survive? The doctor also wants to eat! The suggestion I want to make is: abolish the practice of living off prescribing drugs and, increase the doctor's salary so that doctors can better serve the people. (Section 7, 6720) |

[1] By equalizing the salary of medical personnel to that of employees in other public service units, the state is increasing the salary of medical personnel. This is because prior to the healthcare

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|---|---|
| 3) More Concrete Policy Items and Specificity (e.g., timeline for implementation: 2009 to 2011, specific amount of government subsidy per person for insurance, 120 RMB; public health subsidy per person 15 RMB; a concrete number of medical facilities to be constructed, 29,000 township hospitals, 2400 urban community service centers in poor areas) | The medical reform plan submitted for pubic consultation should be clearly outlined, since it is too long and difficult to understand. It seems to be all-inclusive. In fact, it feels empty and not specific. For example: How many community or township health centers have been established so far? How much is the standard and level of investment? How many facilities will be built after the medical reform? What would be the standard and level of investment? How much will the state invest to solve the specific problems of the people? Because the country's current medical services that can be guaranteed for the whole people are low-level, what would be the lowest standard for medical services and how much money would be provided. The medical reform blueprint is still unclear about the usage of national funds. If it is opaque, it will be easy to operate in a black-box. If citizens are unable to supervise, it will not change the existing situation, which in medical institutions and pharmaceutical production enterprises lobby the government. As the medical reform is about the Ministry of health and medical system, the reform will not be successful. (Section 7, 8714) |

reform the salaries of those employed in grassroots medical facilities were lower than their counterparts in other public service units (Fang F., 2010; MOH, 2009; Zhou & Fan, 2009).

| | |
|---|---|
| **4) Improve the Morale of Medical Staff** (through an Improvement in the Overall Working Conditions and Environment of Medical Personnel). | Recent healthcare reforms have gradually reduced the income of village-level clinics. There is no state funding. It is impossible to rely on income from the sale of pharmaceuticals to support medical facilities. As a result, the morale of personnel in village-level clinics has been severely hit. Many people want to change their careers. This is not conducive to the purpose of the proposed healthcare reform. I hope that the state will consider the morale of personnel at village-level clinics, so as to retain qualified staff. (Section 3, #3001). |
| 5) Improve Doctor-Patient Relations | Vigorously improve the public opinion environment for doctors and patients, creating a harmonious doctor-patient atmosphere, and appropriately improving the treatment of medical personnel. The government needs to correctly lead the direction of public opinion, with the understanding that public hospitals are representatives of the government, and that, therefore, the government must be vigilant at resolving conflicts. The current situation cannot go on. Otherwise contradictions between medical personnel and patients will be deepened, causing people to feel distrustful of the government. （Section 5, #429）. |

| | |
|---|---|
| 6) Protect the Legal Rights (*hefa quanyi*) of Medical Personnel | Some people in the current society, when they find out that someone in the village died at the hospital, instead of sympathizing with the deceased, take the opportunity to incite the family of the deceased against the hospital, and provoke chaos. It is recommended that the government formulate regulations, on the bases of the current laws, to combat 'medical trouble' (*yinao*), ensuring the normal operation of hospitals protecting the personal safety of medical personnel. (Section 2, #771) |
| 7) Facilitate Obtainment of Insurance Compensation for Retired Migrants | We live in the area of Shengli College, University of Petroleum (Dongying City, Shandong). We are old and very sick. However, our children are not working in Dongying. If you are in a child's place of residence, you are not able to see a doctor. You have to return to your city's health insurance bureau every year in order to get reimbursement. You can only access medical care (at the child's place of residence) in cases of emergency. What can we do if we are still unable to move there? (In Dongying) There are no family members to take care of us, and there is no community support for the elderly. It is difficult! I hope that this reform can solve the problem of elderly people seeking medical care outside their place of household registration (*huji*). |

| | |
|---|---|
| 8) Expand Insurance Coverage for Outpatient Services | The state has implemented the New Rural Cooperative Medical Scheme and Urban Resident Medical Insurance, partially reducing the cost of medical treatment. However, because of the high cost of drugs, outpatient drug charges are not reimbursed, and the ordinary people are still unable to obtain medical treatment. It is recommended that the government further increase the proportion of reimbursement, and outpatient expenses must also be reimbursed on a pro-rate basis, since ordinary people use outpatient service more frequently than inpatient ones. (Section 7, #656) |
| 9) Expand Insurance Coverage for Catastrophic Illnesses | With regard to catastrophic illnesses, the greater the need for medical care, the higher the proportion of insurance reimbursement. Reimbursement rate for catastrophic illnesses should be increased. (Section 7, #234) |

| | |
|---|---|
| 10) Standardize and Strengthen Occupational Insurance for Medical Doctors | With the improvement in the quality (*suzhi*) of the people, understanding of the legal system has been continuously enhanced, and medical disputes have increased significantly. Some patients believe that their legal rights have been violated. Other patients exploit the government's tendency to seek stability and avoid trouble, maliciously petitioning the authorities. Few patients behave calmly and act according to procedures. In addition, the dual identity of the Ministry of Health as both the 'trainer' (*jiaolian yuan*) of the medical system and the arbitrar makes it difficult for patients to accept their investigation results and decisions. 'Medical trouble' (*yinao*) has now become a malignant tumor that seriously interferes with normal medical procedures, rendering the contradictions between doctors and patients more acute and affecting the healthy development of the medical system. Can the state learn from the 'Mandatory Traffic Insurance' model, and require all medical institutions to apply for compulsory medical insurance? In case of disputes, the insurance company and the affected party will negotiate, and patients will no longer negotiate with hospitals. |

## Appendix G: Media Selection Criteria

Retrieval of Media Reports

Media contents are derived from two electronic sources: 1) China Knowledge Resource Integrated Database (CNKI), primarily for official newspapers, and 2) Duxiu, for popular and business outlets. Media reports are identified through search for the following terms: 'Healthcare Reform' (yigai), 'Medical'(yiliao), 'Health'(weisheng), 'Medical Insurance'(yibao), and 'Medicine and Pharmaceuticals' (yiyao).

**Newspaper Selection Criteria**

Official newspapers (People's Daily and China Youth Daily: a total of 35 reports). These media are under the direct supervision of the Party and state organs either at the national or local level, or under government institutions (Stockmann, 2013). Official newspapers, which are circulated within government units through mandatory subscription, are intended for instructional purposes, i.e., to furnish officials with guidelines on how to carry out state directives (Qin et al., 2016). The People's Daily was selected for the sample because it is the mouthpiece of the CCP Central Committee and thus has the most authoritative voice with respect to the Party's position. In the context of healthcare reform, the People's Daily features interviews with elite medical doctors and administrators, such as directors and department heads at urban tertiary and military hospitals.

In contrast, the China Youth Daily (CYD), which is placed under the control of the comparatively politically liberal Communist Youth League, furnishes journalists with some level of autonomy to craft their own discourse on various policy issues (Stockmann, 2013), including health (Interview 11). Because CYD editorial also includes reporters who specialize in health issues, it is one of the most influential newspapers in the public debate over healthcare reform (Interview 11). In 2005, CYD published a very influential report by the State Council Research

and Development Center on the vulnerabilities of China's health sector, prompting the Chinese government to launch a new round of healthcare reforms (Thompson, 2009). In 2008, when online consultation took place, CYD featured interviews with Li Ling (Beijing University), who was the leading voice of opposition to marketization in China's health sector. CYD provided a platform for Li Ling because of practical rather than ideological considerations. In late 2008, Li was available for interviews by CYD, whereas her opponents were already committed to other newspapers (Interview 11).

Business and Finance Newspapers (Caijing and 21 Century Business Herald: a total of 29 reports). These newspapers, which command an authoritative voice in the discussions of social and economic policies (Zhao, 2008), follow a distinct editorial line in favor of market reforms (Interviews 14, 15). Typically, these outlets represent the positions of rising business elites and government officials working within the finance and economic administrations. In covering healthcare reform, finance newspapers reflected the interests of the pharmaceutical industry. I selected Caijing for the media sample because in 2008, this publication was the leading finance newspaper in the country. The sample also includes 21st Century Business Herald because it had specialized reporters dedicated to covering healthcare reform who produced influential reports on this policy (Interview 16). This outlet also featured opinion columns by Gu Xin, a professor from Beijing University who was, along with Li Ling, the most prominent intellectual participating in the public debate over healthcare reform (Interview 15; Kornreich et al., 2012).

Popular papers (Jinghua Shibao, Xinmin Wanbao, Yangzi Wanbao, and Nanfang Dushibao: a total of 57 reports). Catering to median public opinion of urban, middle class residents rather

than to political and economic elites, these outlets speak in a voice that is distinct from either the official or finance media (Stockmann, 2013). In reporting on the healthcare reform, popular media emphasize everyday concerns of urban residents, such as rising health costs and doctor–patient frictions. Even though these papers are published locally, the central government still pays attention to their contents because these outlets serve as an indispensable source for learning about the public opinions of urban dwellers on national issues, including social policies (Stockmann, 2013).

There is variation in the level of political openness and editorial freedom across these newspapers. Popular media consists of two categories: commercialized metropolitan press (dushibao) and semi-official evening papers (wanbao). Both types of papers are subsidiaries of government-controlled press conglomerates but differ in their ownership and revenue structures. Whereas the dushibao derive revenues from private investment, sales, and advertisements, wanbao finance themselves through similar sources but are not allowed to sell shares to private investors. These structural differences can be translated into divergent levels of editorial freedom, as the more commercialized dushibao have a higher degree of independence from the Propaganda Department's directives than the semi-official wanbao (Stockmann, 2013). The sample contains both commercialized newspapers, such as Southern Metropolis Daily and Jinghua Shibao, and semi-official outlets, such as Xinmin Wanbao and Yangzi Wangbao. This selection design captures discursive variation across popular papers.

In addition to divergent degrees of editorial freedom, the criteria for selection of popular papers include sales statistics provided by Century Chinese International Media Consultation Inc. (CMCC, 2013), a private company specializing in the analysis of China's media market, and

World Association of Newspapers and News Publishers (2014). My assumption is that a larger readership is associated with a higher degree of government attention.

I analyze the contents of newspapers with the highest sales figures from the three largest media markets in China: the metropolises of Beijing, Shanghai and Guangzhou and their regions (e.g. Jiangsu and Guangdong Provinces) (CMCC, 2013). The premise is that because the papers are published in China's most vibrant media markets, they have a stronger discursive power than other locally-based outlets, and, thus, the central government pays the highest level of attention to their contents. In the case of Shanghai, I select two semi-official papers, Xinmin Evening News and Yangze Evening News. While Yangze Evening News is published in Nanjing, it is ranked third in terms of sales in Shanghai after New People Evening News and Shanghai Morning Post, respectively (CMCC, 2013), and it is the regionally-distributed, semi-official paper with the second highest magnitude of sales in China (World Newspaper Association, 2014), surpassing Shanghai Morning Post. For this reason, I selected this paper rather than Shanghai Morning Post. For Beijing, I selected Beijing Times, a commercialized newspaper ranked the third in terms of sales in the capital city. Two newspapers, Beijing Evening News and The Beijing News, that are ranked above this outlet, did not have any reports on the healthcare reform from the relevant period. In Guangzhou, both Guangzhou Daily and Yangcheng Evening News are ranked first and second, respectively. Yet, the first one is an official paper and therefore I exclude it. I selected Southern Metropolis Daily rather than Yangcheng Evening News because the former ranked the third in Guangzhou is a commercialized newspaper with the highest level of sales among all newspapers distributed in Guangdong Province (World Newspaper Association, 2014).

## Appendix H: Coding Procedures for Assigning Demographic Categories

I impute commenters' group identity based on the content of comments. Deploying this strategy, I divided the comments into six distinct demographic categories.

### Resemblance to Official Statistics

The results of my clustering, in which commenters are divided into six distinct social groups, are similar to the demographic details of the commenters reported in official statistics, which were based on information netizens' were required to provide before submitting their public comments (People.Com, 2008). Both my own analysis and published government figures show that 55% of the commenters are from the medical sector. In addition, 21% of my sample consists of grassroots groups, including migrants, laid-off workers, patients unable to afford medical care, and representatives of small pharmaceutical companies. This is more or less consistent with the government survey comprising 20% grassroots commenters. Moreover, in my sample and the government report, the proportion of participants from other demographic groups is 24% and 25%, respectively. The resemblance between my breakdown of the proportion of comments made by each of the demographic groups and government statistics could indicate that my analysis is representative of the actual demographic breakdown of participants as viewed by the Chinese government. For an elaboration on each of the imputed categories see below.

### Medical Staff

This category (55% of the sample) encompasses two typologies of comments. The first typology consists of comments expressing grievances about the inferior working conditions in low-tier medical facilities in China, such as low remuneration and lack of access to welfare provisions. These comments, which normally do not extend beyond a short paragraph, constitute 37.8% of the random sample. The second typology of comments includes policy recommendations on a wide range of topics pertaining to China's medical system, and 17.2% of the comments in the sample are subsumed under this typology.

I decided to collapse the two typologies—short passages on working conditions and lengthy comments on China's medical system—into one single category for two reasons. First, there is concrete evidence to establish that the Chinese government perceives medical personnel as a single group. In an analysis of netizens' input from a previous episode of online consultation on healthcare reform, which took place in September 2006, the Ministry of Health treats medical personnel as a unified category, instead of separating grassroots medical personnel from high-level medical doctors (MOH, 2007, pp. 182–185). Deploying the government's own demographic categories can capture government perceptions of these publics and thus its priorities in responding to this key stakeholder.

Second, as I mention earlier, there is a similarity between my coding scheme and Chinese government statistics (Wang & Fan, 2013, pp. 98-99). According to both government reports and my own calculations, 55% of commenters participating in the online consultation over the healthcare reform were medical personnel.

Triangulating government figures with my findings, I infer that the majority of commenters from my sample hail from the ranks of grassroots medical personnel. The Chinese government reports that the majority of commenters, 55%, were medical professionals, and 95% of all

commenters were of low-and middle income groups, earning less than 50,000 RMB per annum (Wang & Fan, 2013, pp. 98-99). Meanwhile, in 2009 the average salary of grassroots medical personnel in Beijing, where income is among the highest in the country, was 42,000 RMB per year (Fang F., 2010). The combination of these two income figures suggests that the majority of medical personnel participating in the consultation worked in grassroots medical facilities, where the staff were often underpaid.

Other figures from my data lend further credence to official statistics: 32% of all comments feature either complaints or recommendations regarding the treatment (daiyu) of medical personnel—a Chinese concept which encapsulates both income level and welfare provisions. The coding scheme provides an additional indicator of the identity of this demographic group. Among the comments containing policy recommendations on public hospitals (69% of all comments in the sample of comments), 38.9% refer to grassroots medical facilities (38.9%), whereas only 5.13% mention urban tertiary hospitals. Assuming that medical staff primarily invoke in comments problems that occur in their work units, we could infer that the majority of medical personnel participating in the online consultation were from grassroots medical facilities.

Meanwhile, there is evidence that that a minority of medical personnel were actually elite medical doctors. Government statistics imply that 5% of all commenters might have belonged to high income group. In addition, in a sample of 541 participants in the online consultation over the healthcare reform, Balla finds that elite, urban medical doctors took part in the online consultation process (Balla 2012, 2014; Balla & Liao 2013). However, as opposed to my sample, which is based on a random selection of comments, Balla's sample is unrepresentative of the

composition of participants, since only a self-selected group of participants agreed to take part in a follow-up survey to the online consultation carried out by Beijing University.

Because participating medical personnel did not directly divulge their income, I do not have sufficient empirical evidence to draw a sharp line between comments made by elites and non-elites. However, I believe that I have sufficient evidence to substantiate my claim that the majority of participants were grassroots medical professionals.

**Patients**

Patients (12% of sample) often complain about their personal challenges of accessing healthcare services. In most cases, the commenters plead with the government to either control medical fees or accommodate their special needs within existing health insurance schemes. Patients who are the most frequent users of the medical system, prominently those suffering from either chronic or catastrophic disease, tend to participate in the consultation procedure.

**Migrants**

Migrants (5% of sample) consist of two groups: 1) migrant workers hailing from rural areas and 2) retired migrants who settled outside of their place of household registration (huji) after retirement. Both types of migrant populations face arduous bureaucratic hurdles in applying for insurance compensation at their physical place of residence. Migrants participating in the online consultation recommend that the procedures for accessing health insurance in their current place of residence should be facilitated.

**Pharmaceutical Industry Insiders**

These netizens (2%) work in small pharmaceutical manufacturing companies. They complain about the difficulties that their companies face in navigating the brutally competitive Chinese pharmaceutical market and the heavy-handed bureaucratic intervention in pricing pharmaceuticals.

**Laid-off Workers**

Commenters from this group (2%) were laid off in the period of state-owned enterprises restructuring from the mid-1990s to mid-2000s. In 2008, a large number of laid-off workers did not have access to either pension or health insurance, so these netizens implore the government to provide them with access to medical insurance.

**Other**

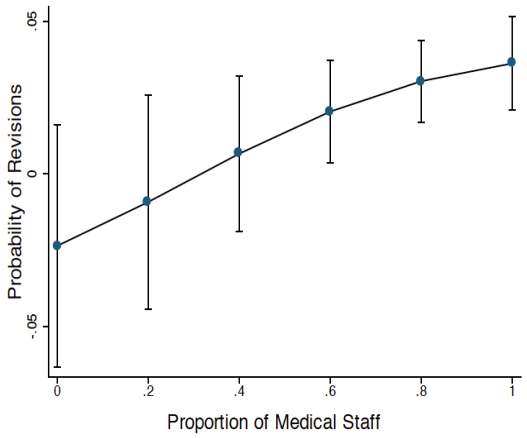
This classification (24%) captures commenters who do not easily fit within any of the other clusters.

## Appendix I: Conditional AME of Number of Comments on Policy Revisions in Interaction with PMP

To further explore the results in Model 4, I test the conditional average marginal effect (AME) of the number of comments—at different levels of PMP (proportion of medical personnel making the comments)—on the probability of policy revision. We can observe a general upward trend of an increase in the AME of number of comments on the probability of revisions as the PMP rises from 0 to 1 (Figure 4). When the PMP reaches above 0.6, the AME of an additional comment becomes both positive and statistically significant. These results show that the higher

the rate of participation by medical personnel, the greater the impact of the number of comments on the probability of policy revisions. Above the 0.6 level, the rise in the AME is relatively moderate. Possibly, after the PMP reaches a certain level, bureaucrats recognize that the issue is of strong concern to medical personnel and thus warrants a revision. Any increase in the PMP above this threshold may not substantially alter these bureaucrats' perception of the need to amend the policy.

**Figure 4. Average Marginal Effect of the Interaction on Policy Revisions**




## Appendix J: Bureaucratic Controversy

The decision to code these categories as 'Controversy' and 'No Controversy' is based on my knowledge of bureaucratic disputes over health policies. Drawing upon secondary literature (Thompson, 2009), government documents (MOH, 2007) and media reports (Wang S., 2009), I find that the four key health bureaucracies disagreed on three key issues: public hospitals, pharmaceuticals and medical insurance.

With respect to public hospitals, the Ministry of Health (MOH) was at loggerheads with three ministries on the issues of public hospital control and financing. Whereas the Ministry of Health (MOH) strove to maintain administrative control over public facilities, the Ministry of Finance (MOF) and National Development and Reform Commission (NDRC) supported structural reforms, such as privatization and the rendering of hospitals as independent legal entities. In addition, while the MOH vied for enhanced funding for public hospitals, the Ministry of Human Resources and Social Security (MOHRSS) resisted these arrangements on the grounds that the majority of funding should be channeled towards health insurance programs (MOH, 2007).

In the policy domain of pharmaceuticals, three ministries fought over control of essential medicine pricing. The MOH opted for having a centralized procurement procedure, in which the Ministry purchased essential medicine directly from designated manufacturers. The NDRC, however, insisted that decisions over pharmaceutical prices should be assigned to the Commission's Price Department. In opposition to these two bureaucracies, the MOHRSS argued that responsibilities should be delegated to medical insurance who would directly negotiate the pricing with pharmaceutical companies (Wang S, 2009).

In a fragmented medical insurance system, two bureaucracies fought over administrative control. The MOHRSS that was in charge of both the Urban Workers' Medical Insurance and Urban Residents' Insurance sought to gain jurisdiction over the management of the New Rural Cooperative Medical Scheme. Yet, the MOH who controlled the latter was reluctant to relinquish this administrative turf (Thompson, 2009).

Nonetheless, following the aftermath of the SARS epidemic that exposed the inadequacies of China's primary care and public health infrastructure (Thompson, 2009), there was an inter-bureaucratic consensus that enhanced investment in these areas was urgently needed.

## Appendix K: Interviews

During my fieldwork in China on both health and education reforms, I conducted a total of 80 interviews with experts, think tank researchers, representatives of pharmaceuticals associations, government officials, medical doctors and hospital directors. I discussed with the interviewees not only the online consultation procedure, but also other formal participatory outlets, notably expert consultation. For this paper, I primarily cite interviewees whose experience is directly relevant to this paper's content.

Officials. I conducted seven interviews with officials holding the ranks of Deputy Minister, Department Head (sizhang) and Bureau Head (chuzhang) from the Ministry of Health, Ministry of Human Resources and Social Security, National People's Congress (NPC) and China Insurance Regulatory Commission. The number of interviews was limited because of the difficulty to gain access to officials from China's central government. Among these seven officials, three had direct experience of participation in the drafting process of China's healthcare reform, and one official from the NPC was involved in handling online consultation at China's legislature. Out of these four informants, two officials, who held the rank of Bureau Head (Interviews 1, 2), were willing to discuss the administrative procedures for processing online input.

The four officials with direct experience in the processing of online consultation conceded that online comments have impact over policy revisions; none of these officials conceded that online comments do not shape policymaking.

Interviews with officials did not prove to be a good source for learning about the mechanism of responsiveness. While senior ranking officials, such as Department Heads and Deputy Ministers, make decisions over policy revisions, they often refrain from disclosing details on the inner-workings of the decision-making process within the Chinese bureaucracy. By comparison, less senior officials, notably Bureau Heads, are willing to openly discuss their work and the organizational procedures deployed for handling online comments. Yet, because they are excluded from the decision-making process, they lack direct information on the incentives of their superiors to revise policies. Therefore, I consult official documents to gauge the incentives for responsiveness.

Additional Interviews. In addition to officials, I also conducted interviews with health policy experts in order to assess the evolution of government policies towards grassroots medical staff, and the period when the government started to prioritize the improvement of this constituency's working conditions. I approached these experts for interviews because of their specialization in the field of grassroots medical services in China. Two of the interviewees are from the Public Health School at Beijing University (Interviews 8,9), and are recognized nationally as authorities in the study of grassroots medical services in China. Another interviewee is from the Social Development Department at the State Council Development Research Center (Interview 10), a key research institution in the health policy research since the mid-2000s (Wang & Fan, 2013).

My interviewees also included journalists whose experience was most pertinent to the drafting process of the healthcare reform. Having followed the Chinese media coverage of health issues for several years, I have become familiar with the newspapers that shaped the public discourse on health. I conducted four interviews with health journalists from *Caijing* and *21st Century Business Herald*` (Interviews 12, 14, 15, 16), two media outlets which are the most vocal advocators of marketization of health services. I also interviewed another journalist from *China Youth Daily* (CYD) (Interview 11), a paper that published consequential reports in opposition to marketization.

Health journalists also proved to be a reliable source for learning about the level of censorship in this policy arena. The journalists who discussed censorship with me represented relatively wide spectrum of China's media. One journalist previously worked as a health reporter in the central government news agency, *Xinhua*, and, later, covered health issues in outlets specializing in health policies, such as *China Hospital CEOs*, and *Jiankang jie.cn* (Interview 13). Another journalist is from *China Youth Daily*, an official outlet that is more politically liberal than the orthodox *Xinhua* (Interview 11). A third informant is from the commercialized newspaper *21st Century Business Herald* (Interview 12). Because each of these individuals had been covering health issue for more than ten years, they were in a position to assess the degree of censorship in this policy domain.

To understand the impact of interest groups, such as pharmaceutical associations and tertiary hospitals (*sanjia yiyuan*), I rely on interviews with informants who were directly involved in lobbying the government to revise health policies. One of the interviewees is a CEO of a consulting company that specializes in the pharmaceutical market. Concomitantly, this individual also holds the title of a deputy head of a national pharmaceutical association. In this

capacity, this informant engaged in numerous lobbying activities vis-à-vis the government (Interview 4). Another interviewer is a high level administrator at a tertiary hospital. He successfully leveraged both personal connections with officials and public advocacy efforts via the media to promote a distinct vision of the healthcare reform (Interview 6). A third interviewee was a Bureau Head in the Ministry of Health Policy & Regulations Department, which is responsible for drafting policy documents such as the healthcare blueprint. In the capacity of a drafter, this official witnessed the impact of interest groups on policymaking (Interview 7). My research has greatly benefited from the invaluable insight of these individuals who are highly qualified to discuss the impact of elite groups on China's healthcare reform.

## List of Interviews

1. Official, Beijing, July, 2016.
2. Official, Beijing, November, 2015.
3. Researcher at a think tank, Beijing, December, 2013.
4. Deputy Head of a National Pharmaceutical Association, Beijing, January, 2014.
5. Researcher, Beijing, February, 2014.
6. Hospital administrator, Beijing, July, 2016.
7. Official, Beijing, July, 2010.
8. Public Health Expert, Beijing, November, 2015.
9. Public Health Expert, Beijing, December, 2015.
10. Health Policy Expert, Beijing, November, 2015.
11. Journalist, Beijing, July, 2016.
12. Journalist, Beijing, March, 2014.

13. Journalist, Beijing, December, 2013.

14. Journalist at Caijing, Beijing, 14 February, 2014.

15. Journalist at 21st Century Business Herald, Beijing, February 18, 2014.

16. Journalist at 21st Century Business Herald, Beijing, July, 2016.

17. Professor of Education, Beijing Normal University, Beijing, December, 2013.

18. Professor of Education, Beijing University, Beijing, December, 2013.

19. Professor, Qinghua University, Beijing, December, 2013.

20. Professor of Education, Renmin University, Beijing, December, 2013.

21. Researcher, Research Institute Affiliated with the MOH, Beijing December, 2013.

22. Professor of Education, Qinghua University, Beijing, January, 2014.

23. Advisor to a Pharmaceutical Association, Beijing, January 2014.

24. Professor, Renmin University, Beijing, January, 2014.

25. Health Journalist, Beijing, January, 2014.

26. Professor, Tsinghua University, February, 2014.

27. Editor, Peking Medical Union Press, Beijing, February, 2014.

28. Researcher, CASS, Beijing, February, 2014.

29. Researcher, National Center for Education Development, February, 2014.

30. Journalist, Media Outlet Specializing in Health, Beijing, February, 2014.

31. Professor, Tsinghua University, Beijing, February, 2014.

32. Researcher, Central Party School, March, 2014.

33. Researcher, Central Party School, Beijing, March 2014.

34. Assistant to Tertiary Hospital Director, Beijing, March 2014.

35. Researcher, CASS, Beijing, March, 2014.

36. Researcher, CASS, Beijing, March, 2014.

37. Professor, Beijing University, Beijing, March, 2014.

38. Professor, Beijing Medical University, March, 2014.

39. Former Deputy Minister, MOH, Beijing, March, 2014.

40. Professor of Public Health, Zhongshan University, Guangzhou, May, 2016.

41. Professor of Public Health, Zhongshan University, Guangzhou, May, 2016.

42. Professor of Public Health, Zhongshan University, Guangzhou, May, 2016.

43. Professor, Zhongshan University, Guangzhou, May, 2016.

44. Professor, Fudan University, Shanghai, July, 2016.

45. Researcher, Shanghai Academy of Education Sciences, Shanghai, July, 2016.

46. Professor, Fudan University, Shanghai, July, 2016.

47. Researcher, Shanghai Academy of Education Sciences, Shanghai, July, 2016.

48. Researcher, National Institute of Education Sciences, Beijing, July, 2016.

49. Head of a Think Tank, Beijing, July, 2016.

50. Former Department Head, MOH, Beijing, July, 2016.

48. Deputy Department Head, State Insurance Regulatory Commission, July, 2016.

49. Former University President, Beijing, July, 2016.

50. Professor, Beijing Technology University, July, 2016.

51. Researcher, Key Think Tank, Beijing, July, 2016.

52. Professor of Education, Beijing Normal University, Beijing July, 2016.

53. Researcher, 21st Century Education Institute, Beijing, July, 2016.

54. Professor of Education, Beijing Normal University, Beijing, July, 2016.

55. Professor of Education, Beijing Normal University, Beijing, July, 2016.

56. Deputy Leader, China Private Education Association, Beijing, July, 2016.

57. Bureau Head, MOH, Beijing, July, 2016.

58. Professor, Qinghua University, Beijing, July, 2016.

59. Deputy Head of a Private Education Association, Vancouver, August, 2016.

60. Researcher, Research Institute Affiliated with MOHRSS, November, 2015.

61. Researcher, Research Institute Affiliated with MOH, November, 2015.

62. Researcher, Think Tank Affiliated with State Council, Beijing, May, 2012.

63. Researcher, Think Tank Affiliated with State Council, Beijing, May, 2012.

64. Researcher, Central Party School, Beijing, May, 2012.

65. Researcher, Think Tank Affiliated with MOHRSS, Beijing, July, 2011.

66. Researcher, Think Tank Affiliated with NDRC, Beijing, July, 2011.

67. Medical Doctor and Former CPPCC Member, Beijing, July, 2011.

68. Professor, Beijing University, Beijing, July, 2011.

69. Journalist, Caixin, Beijing, July, 2011 .

70. Medical Personnel, People's Hospital, Zhongshan City (Guangdong), July, 2011.

71. Researcher, Research Institute Affiliated with the MOH, Beijing, July, 2010.

72. Researcher, Central Party School, Beijing, July, 2010.

73. Researcher, Think Tank Affiliated with State Council, Beijing, July, 2010.

74. Researcher, Qinghua University, Beijing, July, 2010.

75. Researcher, CASS, Beijing, July, 2010.

76. Professor, Renmin University, Beijing, July, 2010

77. Professor, Renmin University, Beijing, July, 2010.

78. Administrator, Renmin University, Beijing, July 2010.

79. Researcher, Think Tank affiliated with State Council, Beijing, July, 2010.

80. Medical Doctor, Public Hospital, Beijing, July, 2010.

Bibliography:

Balla, Steven J. (2012). Information Technology, Political Participation, and the Evolution of Chinese Policymaking. Journal of Contemporary China 21(76), 655–673.

———, & Zhou Liao. (2013). Online Consultation and Citizen Feedback in Chinese Policymaking. *Journal of Current Chinese Affairs 42*(3),101–120.

CMCC (Century Chinese International Media Consultation Inc.). (2013). China Newspaper Advertisement Value and Analysis Report: Distribution Monitoring Briefing. Beijing: CMCC.

Di Eugenio Barbara & Michael Glass. (2004). The Kappa Statistic: A Second Look. *Computational Linguistics 30*(1), 95–101.

Fang, Fang. (2010, July 12). Beijing Seeks to Raise the Salary of Medical Personnel to Be on Par with that of Public Servants and Teachers. Retrieved from http://www.gov.cn/gzdt/2010-07/12/content_1651685.htm.

Kornreich, Yoel, Ilan Vertinsky, & Pitman B. Potter. (2012). Consultation and Deliberation in China: The Making of China's Health-Care Reform. China Journal 68, 176–203.

MOH. (2009, April 9). What Are the Measure Taken to Improve the *Treatment* of Grassroots Medical Personnel? Retrieved from http://www.moh.gov.cn/mohzcfgs/s9664/200904/39969.shtml.

Qin, Bei, David Stromberg & Wu Yanhui. (2016). Media Bias in China. Retrieved from http://www-bcf.usc.edu/~yanhuiwu/MediaBias1.pdf.

Stockmann, Daniela. (2013). Media Commercialization and Authoritarian Rule in China. Cambridge: Cambridge University Press.

Syed, Moin & Sarah Nelson. (2015). Guidelines for Establishing Reliability When Coding Narrative Data. *Emerging Adulthood 3*(6), 375-387.

Thompson, Drew. (2009). China's Health Care Reform Redux. In Charles W. Freeman III and Xiaoqing Lu (eds.) China Capacity to Manage Infectious Disease: Global Implications (59-80). Retrieved from https://csis-prod.s3.amazonaws.com/s3fs-public/legacy_files/files/media/csis/pubs/090325_freeman_chinacapacity_web.pdf.

Wang, Shaoguang & Fan Peng. (2013). The Chinese Model of Consensus Decision-Making: A Case Study of the Healthcare Reform. Beijing: Renmin University Press.

World Association of Newspapers and News Publishers. (2014). World Press Trends. Retrieved from http://www.arpp.ru/images/123/51253_WAN-IFRA_WPT_2014.pdf.

Zhao, Yuezhi. (2008). Communication in China: Political Economy, Power, and Conflict. Lanham, MD: Rowman & Littlefield Publishers.

Zhou, Yuting & Fan Wei. (2009, April 7). Healthcare Reform Implementation Blueprint Decided on the Level of Pay for Grassroots Medical Personnel. Retrieved from http://politics.people.com.cn/GB/1026/9087149.html.