The impact of crises on social service provision in China
The state and society respond to SARS

Jonathan Schwartz

Introduction
In 2003, the severe acute respiratory syndrome (SARS) epidemic began its spread across China. This potentially devastating infectious disease constituted a crisis for which the Chinese government was unprepared. Assessments of China’s initial response to SARS pointed to numerous failures that were largely attributed to the inability of the state to provide sufficient public health support (Canadian Department of National Defense 2003). Perhaps unexpectedly, the negative assessments of China’s SARS response changed over time, reflecting China’s success in ultimately bringing under control a disease once expected to spread across the country, infecting millions. What enabled China to turn around what seemed to be a rapidly deteriorating disease control situation? Did non-state actors play an important role in China’s effective SARS response? If so, what does the SARS case teach us about the impact of crises on relations between the state and civil society organizations in the realm of social service provision?

I open the chapter with a review of definitions of civil society and crises. I then analyze the Chinese infectious disease control infrastructure, its capabilities and reach. Then, following a brief description of the genesis of the SARS outbreak, I evaluate the different roles played by state and non-state actors in response to the outbreak. I conclude that, in order to control SARS effectively, the state was forced to increase its investment in, and attention to, public health issues even as it turned to a variety of non-state actors for assistance in what reflects a shifting dynamic in state–society relations in China’s public health sphere.

Civil society and the non-state sector in China
As is noted in Chapter 1, many scholars argue that Chinese civil society is “state led,” cooperating with the state to achieve shared goals. Other scholars argue that civil society in China is increasingly confrontational – working to undermine the state by taking on goals that challenge state domination. The Chinese state’s view of civil society is that civil society is beneficial in terms of providing assistance and support to government initiatives at a time when state resources are in decline. However, the state also views with real concern the potential for civil
society organizations to challenge ongoing Party-state domination (Perry and Goldman 2007: 17). Indeed, as Economy explains, “the key [for the Party-state] is not how the government tries to control NGOs, but how it could instead be subverted by them” (Cooper 2003). Thus, civil society organizations are broadly perceived by both scholars and Chinese officials as supporting the state while at the same time potentially subverting it.

The literature is replete with analyses of the growing role played by civil society in all aspects of Chinese public life (Frolic 1997; Otsuka 2002; Turner and Wu 2001; Knup 1998). NGOs, a key component of civil society in China, are identified by scholars as playing roles in environmental protection, social welfare, poverty alleviation, and health care. In general, the number and reach of NGOs has been expanding under the watchful eye of the state (Young 2003). This expansion in NGO numbers and activities has occurred in large part because, as Croll notes, in the state’s efforts to compensate for its declining ability to provide social services, it views non-state actors as useful tools to supplement state funding, cushion hardship, and provide volunteer assistance to those in need. Thus, the state encourages NGOs to “fill gaps in vital welfare functions and respond to economic or physical hardship and natural disasters” where the state itself no longer has the capacity to do so (Croll 1999: 695).

In addition to the growing role of what Wang and Sun categorize as conventional social welfare or social service organizations to provide social services (see Chapter 1, and Wang and Sun 2002: 234–70), China has seen growth in what may be termed as non-conventional social service organizations. Important examples of non-conventional social service organizations are the residence committees (RCs) and their rural counterparts, the village committees (VCs). In 1954, China’s Residence Committee Law was enacted. RCs are defined as grassroots, self-governing mass organizations (Article 11, China’s constitution). Since the 1990s, the status of RCs as self-governing bodies has been established under Article 2 of the state’s Organic Law on Residents’ Committees (Wang 2002: 407). However, while described as self-governing bodies in the Chinese administrative structure, RCs are also dominated by it. In terms of the Chinese bureaucratic structure, RCs are appendages of sub-district offices, which in turn are subordinate to district and then municipal governments Figure 7.1 illustrates the administrative position of RCs.

The role of RCs includes responsibilities to the state such as providing local police with information about activities in the neighborhood, helping to maintain the hukou (residence permit) system, helping to implement the one-child policy, facilitating government programs, and conveying information to residents about new government laws and policies. In some cases, such as enforcement of the one-child policy, RCs are viewed negatively by the public. However, in addition to such activities on behalf on the state, RCs have become increasingly active on behalf of the public. Thus, for example, RCs mediate in disputes, lead charity drives, act as sounding boards for residents’ suggestions and complaints, and coordinate collective action in response to local problems (waste collection, inoculation drives, etc.) (Read and Chen 2008: 319–23; Wang 2002: 413). The
majority of activists who volunteer their services to RCs receive no payment from the state.

With the passage of time, RC responsibilities have grown as the state has increasingly turned to them to provide better-quality and more extensive social services. With regard to disease outbreak prevention, RC roles have expanded in offering community services such as health, medical treatment, and sanitation (Wang 2002: 399, 408). With growing responsibility has come a shift as RCs have come to be viewed less as antagonistic to society and increasingly as providing a positive contribution in terms of social service provision.¹

As with the case of RCs, in 1988 the National People’s Congress passed a 1987 draft law that established elected VCs. These too were defined under the law as “mass organizations of self-government at the grassroots” (Manion 1996: 737; Worden et al. 1987; Organic Law of the Urban Neighborhood Committees 1990). Members of the VCs are supposed to be elected by their neighbors (though by and large this is not the case; rather, the Party selects representatives). These committees are not part of the state bureaucracy and are, in principle, autonomous in local affairs, though under the supervision of township governments (O’Brien 2001: 422). VCs are perhaps best described as a form of quasi-independent organization under the close supervision of the Party-state (China Ministry of Civil Affairs 2006; O’Brien 2001: 416). The township may issue directives to VCs, which must then help with their implementation.

And yet, as with RCs, the relationship is not purely one of top-down leadership (lingdao guanxi), with VCs acting as transmission belts for state

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¹ Note: The relationship between RCs and VCs in terms of administrative hierarchy and day-to-day operations is complex and can vary significantly at the local level. The provided figure is a general representation and may not fully capture the nuances of the actual relationships and roles within Chinese cities at the time of writing.
policy. As in the case of RCs, the VCs enjoy limited autonomy of action, in particular in terms of welfare (Oi and Rozelle 2000: 522–3; O’Brien and Li 2006: chapters 3 and 6).  

While RCs and VCs share many similarities, in this chapter I focus largely on RCs. The number of RCs reflects their potential to play an important role in social service provision. Read and Chen estimate that there exist 90,000 RCs across China (2008: 315). In 1993 in Shanghai alone there were 2,400 RCs, each responsible for approximately 1,000 families (Worden et al. 1987).

RCs and their village counterparts are usefully described by Read as “straddler groups” – groups that bridge the divide between state and society (Read with Pekkanen 2009: chapter 1). These groups cannot be viewed as autonomous civil society organizations in the conventional Western sense, nor should they be dismissed as purely instruments of the state. Rather, as straddlers they serve a dual role that places them toward the “state” end of the state–society continuum described in Chapter 1.

**Crises defined**

As is noted in Chapter 1, I define crises as non-linear events that change existing patterns in a dramatic fashion. Crises are especially challenging to less developed countries (LDCs) since they often lack the resources to respond effectively. As a less developed country, China has faced a number of crises in the modern era. Among them, Zhong Kaibin identifies AIDS and the Songhua River disaster, and SARS as a classic example (Zhong 2007: 91). Thus, as is discussed in the section describing the SARS outbreak, SARS was a non-linear event that changed existing patterns in China. The outbreak took the Chinese Party-state by surprise at a time when it lacked the resources to respond effectively. I illustrate this lack of resources in the following section by evaluating China’s reform-era public health system.

**Transition and transformation of China’s public health system**

The capacity of a state to act effectively in one issue-area does not reflect its ability to do so in all issue-areas (Chung 1995: 487–508). Indeed, states tend to focus the majority of their resources on those sectors likely to produce the greatest rewards. In the case of China, this decision necessarily meant investment in sectors other than public health. In the reform era, the benefits of China’s widely acclaimed Maoist public health sector were viewed as long-term, diffuse, costly, and technically complex (Bloom and Gu 1997: 352; Liu 2004: 532–8; Ronaghy and Salter 1974: 1331–3). Reformers preferred to sacrifice investment in public health in favor of job creation and infrastructure development. Investing in the latter offered immediate and obvious benefits that contributed to the wealth of the country and, by extension, to the state’s legitimacy to rule (Banister 1998: 987; interview with Bekedam, June 2005). As the central
government withdrew support from the public health system, the system began to deteriorate rapidly, becoming, as Henk Bekedam, World Health Organization representative to China, notes, the “worst he has ever seen” (interview with Bekedam, June 2005).

In post-1980 China, responsibility for health services was shifted from the state to a market-driven, professionalized, and increasingly privatized system (Huang 2003: 10; Blumenthal and Hsiao 2005: 2). The center slashed funding for public health and medical care delivery while forcing local governments, enterprises, and individuals to pick up the costs. Reflecting the fragmented nature of the Chinese political system, having decentralized responsibility and slashed central government funding for public health, the state increasingly lost control over the quality and availability of health services (Kaufman 2006: 60; Zhong 2007: 91). Underlying and exacerbating the loss of central control over health care was the fact that the Health Ministry suffered from a bureaucratically inferior position vis-à-vis other central government ministries and provincial governments (Saich 2006: 93). As a result, local governments easily and often ignored numerous centrally mandated, yet unfunded, health regulations, instead focusing on locally identified priorities via horizontal interactions (Lieberthal 1992; Lieberthal and Oksenberg 1988).

Oksenberg’s model of state–local relations provides a useful structure for understanding the functioning of China’s new health care provision system. Oksenberg divides the political system into three: the core, intermediary institutions, and organizations in society and the economy (2002: 193–5).

The core is appropriately described within the context of the Fragmented Authoritarian model as enjoying enormous, yet shrinking, power that is concentrated in the hands of the Party-state’s military organizations. Core organizations exist at the central, provincial prefecture and township levels. They retain a Leninist structure, though this structure is also influenced by Nationalist, Confucian, and Western institutional structures. The core retains tremendous power, including much of the means of production and, importantly here, the ability to mobilize (dong yuan) the public (though not to the same extent as during the Mao-era mass campaigns).

Intermediary institutions are linkage organizations that act between the core and the international community. Their role is to ensure that the core is not “contaminated” by outsiders, while enabling it to exploit the world for needed resources. Examples of such institutions include the China International Trust and Investment Corporation and the China Travel Service. Each of these organizations facilitates interaction with the international community without requiring direct core involvement (Oksenberg 2001: 25–7).

Finally, organizations in society and the economy are legal, semi-legal, and illegal organizations and associations such as religious organizations (official and unofficial), secret societies, government-organized NGOs, professional organizations, and unregistered organizations such as those in the environmental (see Chapter 5) and health spheres (see the discussion later in the chapter). These organizations have arisen in the social space made available by the core’s shift...
to macro-control from its past micro-control of the Chinese system (Oksenberg 2001: 27–9; People’s Daily 4 August 2004).

In practice, the core’s shift has meant that the center assigns heavy responsibility for infrastructure provision, health services, and nearly all public services to governments at and below the prefecture levels (also members of the core). However, the transfer of responsibilities has not been accompanied by a transfer of adequate resources to fulfill the new responsibilities. Indeed, prefecture, county, and township governments are estimated to expend 55 percent of their budgets on health care and other public services, a percentage far exceeding the average for either LDCs (13 percent) or developed countries (35 percent) (World Bank 2005: 3).

Local officials are forced to grapple with seemingly contradictory expectations. On the one hand, they must adhere to central government directives (such as offering epidemic prevention services), while on the other they are expected to increase economic output and employment. Improvements in these latter spheres remain the key criterion for promotion. Not surprisingly, one encounters statements such as those by a virologist for the Guangdong Province Center for Disease Control, Bi Shengli, who notes that when faced with the SARS outbreak, local doctors were informed by local government officials that, owing to the economic threat of an epidemic, “[they] can only report two cases [of SARS] not twenty, or the local economy will be hurt,” thereby causing a decline in revenue needed to provide social services (Garrett 2003). Faced with growing demand for social services and declining central support, local officials have increasingly supplemented their own efforts with support from non-state actors, Oksenberg’s Organizations in Society and the Economy (interviews with Shapiro, May 2005; anonymous interviews in Shaanxi and Nanjing, June 2005).

To summarize, in the reform era local governments lacked the incentive and capacity to compensate for declining central government investment in public health, with the result that a notable decline occurred in the quality and quantity of health care services and coverage across the country (Blumenthal and Hsiao 2004: chapter 5). In the period leading up to the SARS outbreak, the condition of China’s public health system was poor. It suffered from long-term neglect by the core, bureaucratic weakness of its leading institutions, and insufficient funding. As a result, when SARS erupted, the Chinese leadership had at its disposal a weak public health system, one that was ill prepared to meet the challenges of a mysterious and contagious new and frightening disease.

**Genesis of SARS in China**

The first SARS case was documented by a local doctor in Foshan, Guangdong Province, on 16 November 2002. Following protocol, the doctor reported the infection case to a local epidemic prevention station (Kaufman 2006: 55–7). With some delays, information regarding the epidemic moved from the local epidemic prevention station to the provincial health bureau and from there to the provincial government and provincial Ministry of Health. By mid-December
2002, provincial and national Ministry of Health experts had diagnosed the disease as viral. The disease continued spreading to other regions, including Beijing, Shanxi, Inner Mongolia, Guangxi, Hunan, Sichuan, Fujian, Shanghai, Shaanxi, and Ningxia. By 31 March 2003, 1,190 SARS cases had been reported. The number of cases peaked on 23 May with 5,285 reported cumulative cases and 303 SARS-related deaths (Quarterly Chronicle 2003: 862–5). With no new cases reported for two consecutive incubation periods, the government and the World Health Organization declared the epidemic in China officially over on 4 June 2003 (Quarterly Chronicle 2003: 866).

At the time of the outbreak, SARS was variously described by government officials and the domestic and the international media as “a greater threat than both the Asian financial crisis of 1997 and the flood disaster of 1998” as well as “the biggest shock to the [Chinese] system since Tian Anmen” (People’s Daily 25 June 2003).

The state’s response

In the reform era, infectious disease control and, as noted, public health in general was given low priority by the state (interview with Lu, June 2005). This attitude changed dramatically as the leadership grew aware of the tremendous potential harm to China’s population and economy that SARS represented (interviews with Bekedam, May 2005, and Lu, June 2005). However, owing to the fragmented nature of the Chinese political system, the central government had little capacity to force actions on local health bureaus. The local health bureaus, dependent on local government for approximately 90 percent of their financing, were unlikely to act against the interests of the local governments (Saich 2006: 92–3; interview with Bekedam, May 2005). Local governments were mostly concerned with maintaining calm and ensuring ongoing economic growth. The result was that there was little incentive for local and provincial health officials to disclose negative developments, and at the outset of the crisis the central government had little recourse beyond public exhortations of local and provincial units to enforce epidemic control initiatives.

Given the weakness of central–local interaction on disease control, it was unsurprising that the central government was slow to recognize the seriousness of the challenge SARS represented. Nor was it surprising that little action was taken in the early months of the epidemic (Davis and Siu 2007). Yet in a fragmented system such as China’s, when an issue does become a priority, the state has the capacity to focus resources and direct pinpoint pressure to advance that priority. Numerous officials interviewed following the outbreak noted that SARS was not a public health issue, but rather a question of political will (interviews with Cheng, Li, Hong, and an anonymous Shaanxi provincial hospital physician, June 2005). When in mid-April the Minister of Health, Wu Yi, declared China’s decision to make SARS prevention and control a top priority, the state did in fact effectively mobilize both the Party and the state bureaucracies (interviews with Bekedam and Shapiro, May 2005). Was this initiative sufficient to combat SARS?
According to Dr. Craig Shapiro, Health and Human Services Attaché to the US embassy in Beijing, SARS was a catalyst in changing the way the Ministry of Health functions (interview with Shapiro, May 2005). In May 2003, the central government established a national SARS control headquarters that reported directly to the State Council (the Cabinet) (Saich 2006: 94–5). The State Council also dispatched epidemic control experts from the center to inspect, supervise, and advise provincial and local officials on SARS control efforts. However, at least at the outset of the outbreak the main responsibility for addressing SARS was in the hands of China’s new center for disease control (CDC) network. The CDC network functions as a subordinate component of the Ministry of Health bureaucracy that runs from the national level (the national CDC in Beijing) to the township level, as illustrated in Figure 7.2.6

The national CDC was established as a center of expertise to provide technical supervision and makes recommendations following the model of the US CDC. By contrast, local CDCs replaced what were once epidemic prevention stations in providing public health services under the bureaucratic control of the relevant level of the public health bureaucracy. Thus, local CDCs are distinct from the national CDC, meaning they are responsible to the local department of health at the relevant bureaucratic level, with the national CDC largely responsible for

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Figure 7.2 Structure of the Chinese center for disease control network.
providing guidance. Local CDC responsibilities include reporting disease outbreaks, taking disease control measures, conducting limited research, and providing limited health education services. During the SARS epidemic, local CDCs were responsible for interviewing SARS patients, visiting homes and workplaces of SARS victims, performing disinfection of locations where SARS victims resided, collecting and analyzing SARS surveillance data, staffing SARS hotlines and information websites, and training government staff in epidemic response (WHO Beijing 2003).

To support SARS-related CDC activities, the central government made special allocations of funds for disease control that extended beyond the national CDC to the localities (People’s Daily 29 August 2003). Among the results of this additional government funding were notable improvements to, and expansions of, infectious disease control facilities across the country. For example, DiTan hospital, one of two infectious disease hospitals in Beijing, had been slated for closure prior to the SARS epidemic. However, following SARS the closure was canceled, the hospital’s budget was increased, and the hospital was designated for transfer to a new, more advanced facility outside the city center. A tour of CDC facilities in Shaanxi, Jiangsu, Beijing, and Shanghai provided additional evidence of central government and local assertions that, following the SARS outbreak, the central government made significant new investments in disease control (interviews with Cheng, Hong, Li, Yin, Zheng, and an anonymous Xi’an CDC director, June 2005).

Also exemplifying the central government’s investment in improved disease control capacity, an extensive computerized reporting network was rapidly established to ensure that all potential cases of SARS would be efficiently and rapidly reported up the bureaucratic lines of control to the central government. The computerized system replaced the previous slower and far less efficient paper system in 75 percent of all township hospitals. According to Vice Health Minister Gao Qiang, a disease outbreak occurring anywhere across China will now be reported to the central government Ministry of Health within one day. This outcome is especially impressive given that many township-level hospitals lack other basic equipment, and in some cases even running water (interview with Shapiro, May 2005).

On 2 April 2003, the State Council established the Ministry of Health as lead agency to take control over the state response to the SARS epidemic (Quarterly Chronicle 2003: 866). The State Council also established provincial-level anti-SARS supervisory teams and crisis management mechanisms based on the “Plan for the Medical Circles Nationwide to Prevent the Epidemic of Severe Acute Respiratory Syndrome for the Year of 2003–2004” (People’s Daily 23 August 2003). The plan focused attention on prevention in areas most vulnerable to a recurrence of SARS (e.g. health care facilities, rural hospitals and schools, and cities with large migrant worker populations). It also strengthened health education, monitoring, and treatment efforts in rural areas. Within this framework, the Ministry of Public Health established national expert groups, which were required to make a definitive report within twenty-four hours of receiving notice.
of potential clinical SARS cases from provincial or local-level officials. Similar expert groups were established at the provincial level. They too were expected to draw definitive conclusions about the severity of an outbreak, but were required to do so within twelve hours.  

In addition, while in the past there were few or no regulations on numerous public health protocols, in the wake of the SARS outbreak a flurry of new protocols and policies were introduced and passed from the center through the provinces on down the public health bureaucracy. These protocols and policies were developed in concert with field physicians, professors, and doctors, and came under the aegis of the Ministry of Health and the specially formed State Council working group (discussed earlier). Numerous additional policies were developed and implemented to prevent, control, and treat SARS.  

Despite the above-described reconcentration of power in the central government’s hands (the core) and clear signals from the center to local governments to prioritize epidemic prevention in the face of the SARS outbreak, these initiatives of themselves proved insufficient. This is illustrated by the fact that in the midst of the response to the SARS epidemic, the central government removed the Chinese CDC from its leadership position because of its failure to control the outbreak effectively (interviews with Bekedam and Hu, May 2005). The key challenge proved to be implementation (Schwartz 2003; interviews with Bekedam and Shieh, May 2005). In order to supplement government efforts, the state recognized the need for, and received, considerable support from non-state actors (Oksenberg’s Organizations in Society and the Economy) (Wang 2003: 8). It is to the role of these actors that I now turn.

The non-state sector’s response

Drawing on the Eastern European example, some scholars argue that in times of crisis, civil society organizations will step forward to fill a void left by the state. Thus, as in the cases of Hungary and Poland, faced with its lack of capacity to provide services, the state withdraws from social space that is then filled by non-state actors. While often working cooperatively with the state to achieve shared goals, this initially cooperative relationship may become contested as civil society organizations gain additional social space that they will later be unwilling to relinquish.

At least in the short term, the Eastern European dynamic has not been replicated in China. The SARS outbreak did not provide an equivalent opportunity for non-state actors to fill social space left open by the state in the social service provision sphere. Rather, the state largely took control, initiating anti-SARS mass mobilization campaigns (dong yuan) and investing heavily to rebuild the public health emergency response capacity of the health sector (Greis and Rosen 2004: 17–19). Nonetheless, examples do exist of conventional NGOs (purely domestic ones as well as those working in concert with international NGOs) engaging in SARS-related activities. Assisting China’s SARS prevention and control efforts were organizations such as the Chinese Red Cross and a range of
voluntary Buddhist, Taoist, Catholic, Protestant, and Muslim groups. These
groups provided financial support as well as volunteers to local governments.
Other examples include China’s Family Planning Association (FPA), whose
members participated in education, information dissemination, and survey work
on the spread of SARS in rural areas. Also, members of the Huizeying Human
Service Center in Beijing focused on helping medical workers and their families
cope with the stress arising from work combating SARS (China Development
Brief 2004).

In another example, the international NGO Amity collaborated with nine other
Chinese NGOs (including the China Charity Federation) and the Asia Foundation
to cooperate with government, health workers, and hospitals to mobilize resources
(Amity).

In Shaanxi Province, the Research Association for Women, established in
1986, expanded its traditional focus on women’s issues to develop and imple-
ment SARS-related programs. These programs included establishing community
health education programs, creating a SARS prevention program for poverty-
stricken rural mountainous areas, and organizing a workshop entitled “Surveying
the Linkage of NGOs in China with Public Health after the Outbreak of SARS”
(Westwoman).

The China Association for NGO Cooperation (CANGO) initiated a Henan
Province-based project entitled “Promotion among Primary School Students on
Knowledge of SARS Prevention and Healthy Life (2003)” (CANGO). A program
aimed at migrant workers in the Beijing area was run by the Cultural Communi-
cation Center for Facilitators, and involved distributing disinfectant, face masks,
and hygiene education flyers among migrant workers. These workers were con-
sidered especially vulnerable to SARS because their unofficial status meant they
lacked access to the public health system (Oxfam).

According to Shannon Ellis, Civil Society Program coordinator of the Canada–
China Cooperation Support Unit, numerous community-level organizations incor-
porated SARS prevention into their regular work. For example, AIDS organizations
and those working with homosexuals drew on their experience in health training to
educate about SARS infection control (interview with Ellis, July 2004). While
additional cases of NGO contributions to tackling SARS exist, the relative paucity
of such examples largely supports Gries and Rosen, who argue that the SARS out-
break did not provide an opportunity for non-state actors to significantly engage in
social service provision (2004: 17–19). To a large extent, this reality reflects the
complexity of establishing civil society organizations in China, an outgrowth of
what Perry and Goldman describe as the Party-state’s fear of “the specter of the
former Soviet Union and its swift dismemberment in the wake of Gorbachev’s bold
political reforms” (2007: 17).

However, while only limited examples of conventional NGO engagement in
SARS control can be identified, the activities of RCs (jumin weiyuan hui) and
VCs (cunmin weiyuan hui) deserve attention. As previously discussed, while
these are not conventional civil society organizations, neither can they be viewed
as state organs.
During the SARS epidemic, there were numerous cases of these committees effectively implementing health regulations deriving from government officials. For example, in an effort to stop the spread of infection, state policies meant that between 20 percent and 30 percent of China’s population were required to stay in their homes or place of employment for between two and three weeks (geili). While such a policy represents an excellent means to contain the spread of infectious disease, its implementation was clearly beyond the government’s capacity. In order to implement the policy successfully, the state turned to RCs to keep track of all people entering or leaving their jurisdictions (interview with Bekedam, May 2005).

For example, when the Nantong city government declared a two-week isolation policy for all visitors from outside the city, enforcement was heavily dependent on residents’ small groups, outgrowths of RCs. These groups monitored the arrival of visitors, contacted the visitors shortly after their arrival, and asked that they report to local clinics to be checked for signs of possible infection (interview with Lu, June 2005). In other cases, RC volunteers were trained to identify potential cases of infection. The training, provided by district hospital staff, was essential to enabling the volunteers to identify any of their neighbors, and visitors to their neighborhood, who might show signs of infection. Because of the existence of RCs and their volunteer staff, it became possible to implement the state policy that everyone arriving from a region of the country where SARS was known to exist would be checked for symptoms. The RCs ensured ongoing temperature checks by distributing free thermometers. Committee volunteers also distributed masks, disinfectants, and leaflets about prevention and control. They also purchased and distributed daily necessities for those in quarantine. Volunteers also reported potential infection cases to the district hospital via designated hotlines (interview with the anonymous director of a Shaanxi provincial hospital, June 2005).

Minhang District, Shanghai, exemplifies this process. In Minhang, RCs gathered 6,800 volunteers. Relying on no monetary incentives, the committees turned to active people in their communities, asking whether they would be willing to undergo SARS-related training. The training was conducted by community doctors (at the district level), who were in turn trained by the district CDC (interviews with CDC and public health officials, Shanghai, June 2005).

Clearly, the role played by the committees was central to effectively identifying potentially infected people, tracking their movements, providing information to public health officials on suspected cases, and ensuring that people remained informed of developments and policies relating to the epidemic. The organizations worked closely with the state public health network to identify, control, and treat cases of infectious disease.

However, it would be incorrect to assert that the committees in general functioned solely at the bidding of government officials. Many cases were reported of the committees acting in contravention of state policies. Thus, for example, numerous committees participated in sealing off their communities with roadblocks to protect their residents from potentially infected persons. These actions
were widespread, reflecting the priority given by these committees to their own regions’ safety even at the expense of central government expectations (interviews with Hu, Wingfield-Hayes, and an anonymous Shaanxi provincial hospital physician, May 2005). Such activities point to the fact that while not wholly independent of the state, neither were these committees fully controlled by the state (Read with Pekkanen 2009: chapters 1 and 3).

Clearly, from the perspective of the committees the greater the perceived importance of directives from the state, the greater the likelihood that they would be implemented, reflecting the nature of these committees as closely tied to the state (Alpermann 2001: 46, 49–50, 67). However, as Wang notes, these committees have also been undergoing a process of transforming from intermediaries between the state and society into more fully non-governmental organizations, taking on activities in support of residents’ interests vis-à-vis the state (2002: 414).

Thus, in the case of SARS the state successfully recentralized power in its own hands through heavy investment of financial, political, and legislative resources. This effort was supplemented by conventional civil society organization initiatives and, most importantly, by RCs and their village counterparts. Illustrating this dynamic is the Xi’an District’s response to SARS.

**Shaanxi Province, Xi’an City case study**

Illustrating the combined effort involved in addressing the SARS outbreak is the response in Xi’an (interviews with an anonymous university hospital director, Xi’an city hospital, Shaanxi provincial CDC, June 2005). Shaanxi Province had twelve diagnosed SARS cases. Of these, only three originated within the province. Of the twelve cases, all but one were found in Xi’an City. These diagnosed cases combined with fifty-nine suspected cases for a total of seventy-one cases that required an epidemiological response.

During the course of the SARS outbreak, the central government Ministry of Health provided all provincial governments with guidelines on infectious disease reporting and control. The key documents were the 1998 Infectious Disease Law (revised in 2003), as well as the Food and Drug Safety Law and the PRC’s Regulations on Public Health Emergencies (2003). The central government also rapidly updated the 1989 Infectious Disease Law to include SARS as a reportable disease (Wang 2003–4). The standards arising from this initiative were provided to the provinces through two bureaucratic lines of control: the Ministry of Health and the provincial government. Protocols and guidelines for SARS response were faxed and emailed from Beijing. Having received the central government guidelines, the provincial Ministry of Health was responsible for developing compliant protocols and regulations. Sub-provincial governments then adapted the provincial protocols and regulations to their local conditions.

To comply with central government requirements, the Shaanxi provincial government, along with the sub-provincial governments, required that all public health authorities, hospital staff, and administrators read and study the protocols and guidelines. The same was required of all enterprise and school officials.
Local authorities developed a quarantine (jianyi) system whereby transmission of infection was controlled by confining potentially exposed individuals to their homes. To limit movement of such individuals across the province and to identify possible SARS-infected individuals, the various levels of government established fever checkpoints at airports, train stations, and bus terminals, and along highways. In addition, in compliance with Ministry of Health guidelines, SARS headquarters were established at all levels down to the township to supervise and enforce implementation of government regulations. Local CDCs were responsible for investigating any clusters of suspected cases within two to seven days of having received notification. If a SARS case was confirmed, the patient was transported to a designated SARS treatment hospital by ambulance. Confirmation of SARS infection was made in a BSL-3 laboratory at the provincial or central level. Any individual established as having had contact with a person diagnosed with SARS was placed under home isolation for twenty-one days.

A key method for informing the local SARS headquarters about suspected outbreaks was a twenty-four-hour telephone hotline. A person calling in had the option of identifying him- or herself or someone else as a potential case. To provide the public with information on how to identify potential SARS cases, the state relied on the mass media to saturate the airwaves with information on the disease.

During the SARS outbreak, all persons arriving at a hospital (for whatever reason) were checked for fever at a location outside the hospital proper. Anyone with a fever of 38 degrees Celsius or higher, without an obvious reason for the fever, was taken to an isolated fever clinic on the hospital grounds for further testing. Criteria for clinical diagnoses of SARS included a temperature exceeding 38.5 degrees Celsius, a positive X-ray finding of pneumonia, a decreased white blood cell count, antibiotic failure, and a history of exposure. Any people meeting these criteria were isolated. All patients exhibiting a fever and a history of exposure were isolated as well. Finally, all fever patients were kept under observation for twenty-one days.

While only the Xi’an Number Eight hospital was designated an infectious disease hospital (a new designation resulting from the SARS epidemic – previously it had been a tuberculosis hospital), other hospitals established infectious disease wards to accept patients. All hospitals accepted patients regardless of their ability to pay. According to interviewees, the hospitals received adequate compensation from the state for the patient care.

During periods when there are no ongoing epidemics, outbreaks of infectious diseases in Xi’an City are reported in compliance with the 1989 Infectious Disease Law. However, during an epidemic all potential infectious diseases are reported immediately, following procedures distinct from normal practices. “Barefoot doctors,” local VC/RC members, or individuals report by phone to relevant hospitals (i.e. township, or district, city, etc.). The hospitals fax daily reports on the number of patients seen and their diagnoses, along with certain syndromic findings, up the administrative chain of command to both government and health (hospital) administrators. The county hospital (in rural areas – in
urban areas the procedure is slightly different; refer to Figure 7.2) uploads the information into computers and forwards it to the provincial CDC and the township government (interviews with the director of Xi’an City hospital, June 2005). The reports are then forwarded daily to the central government Ministry of Health. These procedures were adhered to during the SARS epidemic, with the addition that daily reports were made even when no diagnosed fever patients existed. Every day by 4 p.m., the central government Ministry of Health received reports of the number of cases across the province (and the country) and posted this information on its website.

In order to protect patients and medical personnel from exposure, protocols on protective equipment use were implemented. All medical personnel wore masks (cotton, 12 layer, or, where available, N95S), hats, and gowns. Those working directly with potentially infected persons wore gloves, double masks, double gowns, goggles, and hats. Doctors and nurses assigned to infectious disease units were required to remain in the units for three months and were required to be available twenty-four hours a day. Their only contact with the outside was via telephone. After their three-month stint, they were quarantined in a hotel for an additional twenty-one days before returning home.

While acknowledging the importance of the procedures and regulations established by the CDC and Ministry of Health, all interviewees in the province emphasized the role played by non-government personnel in ensuring that cases of the disease were quickly identified and controlled. As was true elsewhere, interviewees in Shaanxi considered SARS a political problem requiring a political response. And while conventional NGOs played a role in the SARS response, VCs and RCs acting under the guidance and with the training of local CDCs and hospitals played an important role. The committee leadership designated and, with CDC assistance, trained committee members to take responsibility for identifying potential SARS cases. These members were responsible for monitoring their communities and notifying hospitals of people exhibiting indications of SARS. Because of the close ties within neighborhoods, the designated committee members were largely aware of all the comings and goings in their communities. Any person returning or visiting from an epidemic region would be checked by the committee members for symptoms. In addition, committee members conducted routine fever checks for all homes under their responsibility.

Xi’an International Studies University represented a microcosm of actions taken by the community to address the SARS epidemic. The university (main campus) is located in the center of metropolitan Xi’an. The campus is enclosed by a wall with guarded gates. During the SARS epidemic, at the behest of the municipal government the university clinic director established a leading group for SARS (similar to the SARS headquarters discussed earlier) under the university RC. The RC worked collaboratively with the university administration, establishing a leading group that included the clinic director, the university Party general secretary, and the university president. Additional members included heads of all departments and the campus security chief.
Drawing on central government Ministry of Health regulations and the Shaanxi provincial and Xi’an municipal guidelines, the campus leading group categorized infectious diseases into three levels: basic (yi-ban), mid-range (zhong-da), and severe (te-da). Basic diseases were to be reported within twenty-four hours, mid-range within twelve hours and severe diseases within six hours. Although SARS was classified as mid-range early in the epidemic, the central government required that reporting on potential SARS cases occur every six hours. The reports went to the Yanta District Public Health Department, which uploaded the reports to the internet and sent them forward to the city government.

A specific set of measures was implemented by the leading group to ensure that individuals potentially infected with SARS could not enter or leave the campus. Thus, during the time of the crisis no students or faculty were permitted to leave the campus. No student who departed the campus for any reason (for example, in order to visit family elsewhere) was allowed re-entry to the campus until after spending fourteen days isolated in a building adjacent to the campus. All such students were kept under surveillance by the campus medical staff and had their temperatures checked four times daily.

Residents of the dormitories were regularly checked for fever. Any student exhibiting fever was isolated in the university clinic designated fever center for the extent of the SARS incubation period. The clinic was sealed off from the remainder of the health center and staffed by fully gowned, hooded, masked, and goggled nurses. Quarantine (jianyi) buildings were established for the university’s fifty to sixty quarantined individuals. If after completing the quarantine period the individual exhibited no disease symptoms, he or she underwent a chest X-ray and, if the findings so warranted, was released to his or her dormitory. If, however, the patient’s condition deteriorated while under observation, the patient would be sent by ambulance to the city’s designated SARS hospital. Only one individual was ultimately suspected of having contracted SARS. As a general precaution, the entire campus was disinfected.

Conclusion

The Chinese response to SARS illustrates the impact of crises on the roles of state and non-state actors in social service provision. In the period leading to the outbreak of the SARS epidemic, China’s public health system was both weak and in decline. The Ministry of Health lacked influence, the CDC system had only just been established, the majority of China’s citizenry had little or no health coverage, and the government was in the process of slashing financial support for infectious disease facilities. However, as China had yet to face a public health crisis in the reform era, there was little sense of urgency in government or within the public. Indeed, little urgency regarding China’s epidemic prevention and control capacity was expressed at any level of government. Thus, the government’s capacity to respond effectively to an infectious disease outbreak was poor and untested.

The SARS outbreak was a crisis that focused the spotlight on China’s capacity to address the potential spread of a deadly infectious disease. Quite suddenly,
China’s leadership and the world discovered that the Chinese state was unprepared to handle the crisis. While significant efforts were made to recentralize power in the hands of the central government Ministry of Health, an additional key to the effective SARS response was the activities and responsibilities taken on by a variety of non-state actors.

The SARS case describes a situation where social space once assumed to be under state control proves to be weakly controlled. Notably, as the SARS crisis grew, non-state actors gained an increased role – expanding into those areas of service provision once assumed to be state controlled. While conventional non-state, civil society actors did play a limited role in responding to SARS, the main contributors to the state’s SARS control initiatives were the RCs and VCs – non-conventional non-state actors. These committees worked in close coordination with local CDCs and health bureaus to fulfill public health mandates beyond the capacity of state organs to independently fill. Ultimately, the result was a successful SARS response. The disease was limited in its geographical reach, brought under control, and eventually eradicated.

SARS represents a case where various non-state actors worked with the state to combat a crisis. This was a cooperative relationship that reflected efforts to achieve immediate shared goals. Post-SARS state initiatives to expand and enhance China’s emergency response capacity continue to draw on this relationship, reflecting the state’s ongoing effort to recentralize control over emergency health responses while also expanding its reliance on non-state organizations.

The SARS dynamic suggests that crisis situations enable non-state actors to increase their scope of activities. Unlike in the East European cases discussed earlier in this chapter, the SARS crisis has not as yet resulted in a contested relationship, but rather has brought a strengthening of the state’s capacity to respond to infectious disease crises. To further evaluate the impact of crisis situations on state–society relations and social service provision, we must study additional crisis response cases. Given the growing threat of infectious diseases pandemics, it seems likely that we will not be required to wait overly long. Indeed, as the next chapter (addressing the AIDS crisis) illustrates, crisis situations can have a direct impact on the balance between state and non-state actor social service provision. In responding to the AIDS crisis, the state drew lessons from the SARS crisis by expanding its relationship with non-state actors.

Notes
1 In 1999 the experimental Shequ were introduced. These have arisen instead of, and in parallel with, RCs. For a further discussion of Shequ, see Derleth and Koldyk (2004).
2 Especially in terms of services for the village such as welfare, culture, education, and public health. The extent of autonomy varies from village to village.
3 According to Bekedam, in his own pre-SARS outbreak discussions with Hu Jintao and Wen Jiabao he found that they recognized the existence of a funding shortage in public health, yet remained unconcerned.
4 Unfunded mandates are a key problem identified by public health officials across the country.
Epidemic prevention stations have been renamed centers for disease control. These are subordinate to the Ministry of Health bureaucracy. The epidemic prevention stations and now the CDCs are responsible for surveillance and other public health services.

The US Centers for Disease Control conduct epidemic investigations, research, training, and public education. However, they do not have institutions that spread from the center to the local level, nor do they provide medical care services, as is the case in China. Local Chinese CDCs fulfill many of the functions of US local health departments, and offices of epidemiology and infectious disease.

Three levels of epidemic severity are identified: Ordinary – reflecting a single SARS case within a reporting period; Serious – reflecting either a recurrent single case in one area or two or more cases within one prefecture or municipality; and Severe – reflecting two or more cases in one province, which will be seen as indicating that the disease is spreading.

The ministry designated SARS a contagious disease to be listed on the People’s Republic of China Contagious Disease Prevention and Treatment Code. Those suspected of or confirmed as having SARS could be quarantined. Public security bureaus were made available to public health authorities where necessary to enforce quarantines. Public health departments across China have been required by the State Ministry of Health to organize rapid reaction drills in preparation for possible epidemics.

The CDC network was established two years prior to the SARS outbreak. The original plan was that the CDCs would be responsible for policymaking and technical work. However, the central government viewed the CDC system as having failed to respond to SARS effectively, with the result that the leadership role in responding to the outbreak was transferred to the Ministry of Health.

Cases of roadblocks were described by officials in each province visited during our fieldwork.

BSL-3 is suitable for work with infectious agents that may cause serious or potentially lethal diseases as a result of exposure by the inhalation route. Examples of agents that should be manipulated at BSL-3 include *Mycobacterium tuberculosis* and *Coxiella burnetii*.

The length of quarantines changed as understanding of the SARS incubation period increased. Thus, while in the early stages quarantines lasted between ten and twenty-one days, they were eventually set at fourteen days.

The hotline existed before the SARS epidemic but was upgraded in response to SARS, with additional training for hotline workers. According to one township hospital official, during the epidemic the line was staffed by trained individuals who provided information and consultations, and took information regarding potential SARS cases. To illustrate its accessibility, the official successfully called the hotline during our interview.

Infectious diseases are categorized as A, B, C, with A being most severe and requiring reporting within six hours. B types must be reported within twelve hours and C types within twenty-four hours. Although SARS was originally categorized as a B-type infectious disease, reports of SARS were required within six hours.

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Impact of crises on social service provision


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