Public-Private-Partnerships (PPPs) in the Chinese healthcare field: A perspective on the state and market relations

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Statement of originality

This is to certify that, to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

Signature:

Qiuxian Cheng
28 June 2023

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Abstract

This thesis presents an empirical study of the Chinese healthcare sector, investigating the introduction of privatisation and Public-Private-Partnerships (PPPs) in the healthcare system and the experiences of associated social agents and healthcare professionals in the midst of these changes. While there have been many reviews of the policies of privatisation and PPPs around the world and of the social and financial effects of the shift from a publicly owned to a managed healthcare system, only a limited amount of work pays attention to the attitudes, perspectives, and practices of healthcare professionals and stakeholders who have experienced the reform. Even fewer studies have examined the situation in China, and theoretical explanations underpinning this policy process remain underdeveloped. This dissertation seeks to fill this gap. Bourdieu's conceptual framework of the state, field, capital, and habitus is employed to examine the Chinese healthcare system and the social practices therein, which the Orthodox economics perspective and Marxist analysis largely overlook. Bourdieu's theory also supports the analysis of the relations of power and the nature of contestations within the healthcare sector and in relation to the state and the general field of power. The thesis combines Bourdieu's conceptual framework with concepts of the professions and medical dominance to facilitate insight into the positions, dispositions, and stances of doctors, nurses, and hospital managers and the forms of capital they use in these contestations. The empirical research adopts a qualitative case study approach, with primary data sourced from thirty-three key informant interviews.

The empirical analysis reveals that the Chinese state operates as a bureaucratic field with embedded and conflicting interests and values, where the Health Ministry seeks to increase the health budget and advocates for an increased role for the state, while the Finance Ministry tends to rely on the market to finance and deliver health services. The conflicts between the ministries, particularly between the left and right hands of the state, imply a resonance in Western countries in which a transition from state-oriented to market-oriented health policies has occurred. This worldwide shift is also observable in China but in a slightly different form and with different timing. Under the guidance of neoliberalism and through administrative measures, the Chinese state has transformed the power dynamics within the healthcare field,

and the boundaries between the public and private sectors have become indistinct. This threatens the previous emphasis on universalism. These reconfigurations made possible – and likely – the historical emergence of hospital PPPs. Within the local healthcare field, where the PPP hospital investigated in this study is located, the experiences of public and private hospital presidents and managers with hospital PPPs are analysed in terms of struggles between the well-established public hospitals and the newcomer – the PPP hospital – for state recognition. Within the PPP hospital, the experiences of healthcare professionals are analysed as contestations between the traditional practices of medical professionals and the newly emerged managerial professionals over control of professional practices and the conditions of work. Rather than passively accept neoliberal changes in the healthcare field, our participants respond innovatively to the managerial ethos within the PPP hospital, where there are different understandings of the role of the state and its relations with the market regarding the financing, provision, and delivery of healthcare. This diversity in their responses is produced by their positions in the hierarchically structured healthcare field and their differing past experiences, which in combination, lead to diverse dispositions. The study has demonstrated how actors and their social practices play a crucial role in transforming the healthcare field. The conflicts between managers and clinicians exemplify the overall shift towards neoliberalism. These conflicts are not only a reflection of this transition but also a method of promoting neoliberalism and granting power to the right hand of the state. The implication is that rather than a closed system detached from external forces or a mere reflection of what happens in the political and economic field, the Chinese healthcare sector is an arena open to struggles both within and without.

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Abbreviations

AFGC CUFE	Academy for Governmental Credit at Central University of Finance and Economics
BLT	Build-lease-transfer
BOO	Build-own-operate
BOOT	Build-own-operate-transfer
BOT	Build-operate-transfer
CAN	Chinese Nursing Association
CMDA	Chinese Medical Doctor Association
CPC	Communist Party of China
CUFE	Central University of Finance and Economics Institute of Political Science and Information Technology
DB	Design-build
DBF	Design-build-finance
DBFM	Design-build-finance-maintain
DBFMO	Design-build-finance-maintain-operate
DBFO	Design-build-finance-operate
NAO	National Audit Office
NCMS	New Rural Cooperative Medical Scheme
NHC	National Health Commission
NHFPC	National Health and Family Planning Commission
NPM	New Public Management
OECD	Organisation for Economic Cooperation and Development
PHI	Private Health Insurance
PRC	People's Republic of China
PSCs	Public Sector Comparators
RCMS	Rural Cooperative Medical System
SC	The State Council

SOEs	State-owned Enterprises
URBMI	Urban Employee Basic Medical Insurance
URBMI	Urban Resident Basic Medical Insurance
WHO	World Health Organisation

Chapter One - Introduction

Since the 1980s, many countries have displayed shifts in policy towards the marketisation and privatisation of health services, which has transformed the financing and organisation of health care. Private-sector health services have experienced significant growth in both developing and developed countries and have been presented in various forms. The growth of private health services ranges from fully privately owned and operated health institutions, the transfer of public assets (such as public hospitals) or services to the private sector and contracting out certain services, such as clinical services, management services, cleaning, and security, to Public-Private-Partnerships (PPPs). PPPs vary from country to country but are loosely defined as a "contractual agreement" (typically of a long-term nature) between the public and private for-profit sectors for the construction of infrastructure (e.g., hospitals) and/or provision of social services. At the end of their contractual lives, the facilities may continue to be managed and owned by the private sector bodies, or transferred to the government (Collyer 2020, p. 278; Hodge & Greve 2007; 2017; Flinders 2006, p. 223). Britain is a leader in the use of PPPs (in the form of Private Finance Initiative, PFI) in the hospital system, where the private sector contracts with the public sector to design, finance, build and provide health services (H.M. Treasury 2008). This new healthcare delivery model has then been adapted for other contexts like Australia and China (Willis 2020, pp.1-2; Lai & Fei 2010).

Even though some sociological studies have paid attention to the profound effects of privatisation and neoliberalism in the healthcare field on the population therein, very few studies have investigated how people who work in the field experience hospital PPPs (with a few exceptions, see for example Collyer & Willis 2020; Smallon 2015; Zullo & Ness 2009). What is also missing from the literature is the practice of the state and its relations with the healthcare market in this policy process. An explanation of this relation in the PPPs process of the Chinese healthcare field constitutes the analytical focus of this thesis.

Statement of the academic problem

Privatisation, PPPs, NPM, and neoliberal trend in the Chinese healthcare field and the role of the state

The 1980s witnessed a global process within which private capital and market competition were introduced into public service provision while the state reduced its commitments to welfare in countries such as Britain, America, Australia, and China (see, for example, Meagher et al. 2009; Harvey 2005, pp. 1-4; Megginson & Netter 2003, pp. 31-3; Hirsch & Osborne 2000). This process has been taking place under the name of "neoliberalism", a set of ideas claiming that a free market is the best way to provide public services, such as healthcare and education. The idea of a "free market", where controls and restrictions on capital involvement and movement are loosened or even abolished, is a central component of neoliberalism. The private sector is believed to be more efficient and flexible and can increase consumer choice, which contrasts with the alleged inefficiency, red tape, and corruption of the public sector (Noordegraaf 2015, p. 1; Klikauer 2015, p. 1107; Jessop 2013; Meagher et al. 2009; Harvey 2005, p. 2). During the 1980s, there was a major shift (the first policy shift) in Chinese health policy from the state to the market. Guided by neoliberalism, the Chinese government cut its budget for healthcare, reduced the coverage for social health insurance and its subsidy for public health institutions. For example, before the first round of healthcare system reform in the 1980s, the state owned all health institutions and subsidised 50 to 60 per cent of their recurrent cost. However, the subsidy took up merely 10 per cent of their total revenues by the early 1990s (Mei & Kirkpatrick 2019; Yip & Hsiao 2008, p. 462). At the same time, user charges and drug mark-ups were encouraged to finance public health institutions. Another policy measure of the 1980s was permitting private practice and private practitioners. The Ministry of Health declared in 1985 that health institutions could have a variety of funding channels, from the state and the collective to private individuals (Bu 2017, p. 276). An orthodox economics perspective assumes the privatisation of healthcare since the 1980s has been a result of fiscal constraints. (see, for example, Yip et al. 2019; Yip & Hsiao 2014; Wang 2003; Hesketh & Wei 1997; Hesketh & Zhu 1997; Hillier & Shen 1996). There is, however, a contradiction in these economic arguments. It can be seen from the *China Statistic Yearbook* (National Bureau of Statistics PRC, 1999, 2009) that, in a 10-year-period from 1991 to 2000, the national government expenditure for medical and health care as a percentage of its total fiscal expenditure fell from 6.03 per cent to 4.47 per cent and continued

reducing to 4.12 per cent by 2002. On the contrary, the proportion of China's national administrative expenditure (as a percentage of the government's total fiscal expenditure) boosted from 9.8 per cent in 1991 to 25.7 per cent in 2000 and continued climbing to 26 per cent in 2002, with the amount sharply rising from 63.5 billion of 1991 to 499.3 billion of 2000 and continued growing to 672.0 billion of 2002, which had increased by nearly 11 times in 12 years. The economic argument for the first Chinese health policy shift toward the market from the 1980s is that this was a rational solution to the fiscal constraints. However, this fails to explain the surging national administrative spending in a time of fiscal constraint. This kind of economic understanding of what happened in the Chinese healthcare sector as a by-product of what happened in the economic sector falls into a functionalist thinking pattern. Functionalism assumes that to maintain the continuation and integration of the whole system, subsystems and their parts have to fulfil beneficial functions for the working of the whole (Münch 2001, pp. 5838-9). It conceives the Chinese healthcare system as a "functionally specialised" constituent part of the whole social system (please see Münch 2001, pp. 5838-9; Wenzel 2001, p. 5847 for the main characteristics of functionalist thinking, which originated from biology). In this study, explaining the privatisation phenomenon in the Chinese healthcare sector as a fulfilment of the economic needs of society is rejected, for it downplays the role of individuals in the field and takes the healthcare sector as merely "a static object" that performs an inevitable and correct role in the social system. The economic argument also leaves a fundamental question unanswered: why the social needs of "economic growth" and "fiscal burden relief" rather than "equity" and "social justice" are identified as the most pressing and urgent needs of Chinese society at the time of the 1980s and why "health equity" is subsequently re-identified and put on the political agenda at the beginning of the twenty-first century.

The second policy shift took place in 2009, with the government re-instating its principal role in health service provision and increasing public spending on healthcare from 481.6 billion to 836.6 billion Chinese yuan between 2009 and 2012 (Yip & Hsiao 2014, p. 806). This second round of reform focused its attention on improving basic health care and primary health services in China. However, the government continued reforming the hospital system by encouraging privatisation and introducing Public-Private Partnerships. China's Twelfth Five-year Plan announced that ward beds in private hospitals by 2015 should account for 20 per cent of the total available (Zhang 2016). In 2013, *The Opinions of the State Council on*

Promoting Development of the Healthcare Industries (No. 40 [2013] of the General Office of the State Council) recommended an expansion of the scale of the healthcare industry to over 8000 billion Chinese yuan by 2020 from 1650 billion Chinese yuan in 2013. Private sector involvement was to be the primary pathway to achieving this goal. In 2014, the Chinese government officially allowed joint ventures between public hospitals and private companies, with a central takeaway of encouraging private capital in building hospital infrastructures (Baru 2019, p. 81). In China, PPPs refer to contractual partnerships between the public and private sectors to develop infrastructure and provide public services, which were traditionally the state's responsibility (Savas 2000; Yang et al. 2013). PPPs are regarded as "new solutions" for private capital to deliver health services, which can combine the resources and advantages of both public and private sectors, such as the combination of the quality of service observable in the public sector with the strengths of the private sector regarding the design, construction, operation, and management of hospitals (Wu 2017; Cheng 2013; Wang et al. 2020, pp. 281-91; CUFE 2020, pp. 202-12). By the end of 2019, the Ministry of Finance data revealed that the number of healthcare PPP projects had reached 262, with a total investment of 21.3 billion Chinese yuan (AFGC CUFE 2020; Wang et al. 2020).

The implementation of this neoliberal principle in the healthcare sector is also ingrained in the management of public sectors, commonly called "New Public Management" (NPM). The NPM movement began in the late 1970s and early 1980s, led by pioneers in the United Kingdom under Prime Minister Margaret Thatcher and in municipal governments in the U.S. The emergence of the movement was a response to the contemporary economic recession and tax revolts, which particularly affected places like Sunnyvale, California (Gruening 2001, p. 2). The movement gained momentum in the New Zealand and Australian governments as well. Their apparent successes prompted most OECD countries and other nations to consider NPM administrative reforms (Gruening 2001; OECD 1995). Under the NPM reform, public health institutions and bureaucracies are managed with a business-like approach, with the use of "hands-on" managers who are responsible for cost control, balancing income and expenditure and applying measurable performance indicators and competitive tools like league tables (Meagher et al. 2009; Hood 1991, pp. 4-5). Under the competitive mechanism, which is the central focus of NPM, each part of a health institution is regarded as a constituent "microcosm" of the larger organisation. Each part is organised as a mini corporation to be held accountable for its performance and in fierce competition with other

units. In the Chinese context, when the second health policy shift towards the state side occurred in 2009 (described in more detail in chapter four), the Chinese government increased financial support for public hospitals while at the same time encouraging their corporate management, with a focus on efficiency improvement and performance assessment. The Chinese state also encouraged separation between ownership and regulation in the public hospital system, between government administration and hospital management (Yip & Hsiao 2014). This implies that public hospitals gained more autonomy in terms of decision-making and hospital management; some piloted hospitals were even officially permitted to distribute profits to hospital staff (Allen et al. 2014). These policy measures are compatible with the NPM agenda, which focuses on measured financial performances, and competition both within public hospitals, between public hospitals, and between public and private hospitals.

There is an inherent contradiction between the continuous privatisation and the introduction of PPPs proposed by the Chinese state and its goal of increasing access to care in the second round of health reform of 2009. . Economists generally argue this shift to be a rational response to the reported consequences (such as unequal healthcare access and soaring health expenditure) (Xiong et al. 2020, p. 2; Wang et al. 2019; Yip et al. 2019; Yip and Hsiao, 2014; Feng et al. 2017, pp. 14-8; CUFE 2020, pp. 202-12; Wang, 2003), yet this proves insufficient as a way of analysing this contradiction. The Chinese government has continued privatising health services by offering policy support for private capital to run medical services, including expanding land supply, relevant tax policies, supporting commercial health insurance, and removing policy obstacles for private capital from entering into medical care. Also, the state has promoted cooperation between the public and private sectors in healthcare delivery (such as PPPs). Even though the orthodox economic understanding of privatisation was at its peak and is still used to explain health policy shifts in the Chinese healthcare sector, alternative explanations have emerged, among which is a perspective from political economy. Hsiao (2007) argues for a stronger analysis of politics on health policymaking and its execution than mere economic or health factors. According to Hsiao, the second round of health reform to reduce medical impoverishment and ensure affordable and accessible health services for the general public, is an approach for the Chinese government to improve social and political stability. However, this kind of explanation still fails to explain the continuous privatisation in the hospital sector. In addition, as with the orthodox economic understanding,

this political economy perspective also falls into a functionalist thinking pattern. Following this logic, the Chinese healthcare system is a part of the whole social system, performing its roles and functioning as a bulwark against threats to society: such as financial constraints, low efficiency and social and political instability. Explanations of social phenomena have been criticised for many reasons, a fundamental one of which is its teleology – understanding the occurrence and development of social phenomena in terms of specific purposes, effects or consequences (see Collyer 2018, p. 113; Owens 2010; Wenzel 2001; Connell 1979, for the criticism of functionalism). As pointed out by Connell (1979, p. 13), this theoretical approach is inherently problematic. That is, to guarantee social stability, there must be a match between the needs of the whole society and the personality of individuals. In other words, the analysis of resistance, conflicts and struggles caused by external pressure is beyond the capacity of functionalism to adequately explain.

Impacts of neoliberal policies on the healthcare field and the practices of healthcare professionals

There are some scholars in the political and social sciences focusing on the impacts of privatisation and PPPs on the healthcare sector. Some studies point out hospital PPPs do not fulfil the promise of reducing public borrowing, risk transfer, and higher value for money compared to public procurement projects. Alternatively, hospital PPPs cases from Australia, Britain, Canada, and Spain present a negative financial outcome embodied in the seriously high-cost overrun, compounded by late delivery and poor performance regarding care quality (Comendeiro-Maaløe et al. 2019; Whiteside 2011; Hellowell & Pollock, 2009; Collyer 1997; Chung 2009) (These will be discussed in detail in chapter two). Flinders (2010, p. 115), Lai and Fei (2010) point out a "splinter logic" in the contractual relationship between the public and private sectors. As pointed out by Flinders (2010), the basic logic of the PPP rests upon two primary elements: first, market-like relationships are assumed to be paramount in all transactional situations; second, it takes economic output and efficiency as primary performance indicators. This baseline logic, however, argues Flinders, stands in contrast to the principles and value orientations within the public sphere and its public service ethos. Grand (in Flinders 2010, p. 119) draws an analogy of "knights instead of knaves" to show the high trust and commitment of the workforce within the public sphere. The implication is that the integration of market logic into public service provision is likely to restructure the public

service bargain where the traditional public service ethos is replaced by the economic profit motive. The point being made is that how can the profit-driven private sector be responsible for cost-efficient health services delivery for the general public (which should be the responsibility of the state) and simultaneously maximise the profit? Without further analysis, it remains unclear why the Chinese state continuously promotes privatisation and PPPs practices in the field of healthcare despite conclusive evidence about their higher health costs and the resultant health inequality caused by privatising health services, and without clear evidence of higher efficiency or value for money.

Besides the economic impact and health inequalities, a few sociologists also focus their attention on the social effects of privatisation and NPM on healthcare professionals (such as doctors, nurses, and managers) and the relations among these professionals. As argued by Hsiao (2007), medical professionals play a crucial role in health reform in the sense that medical knowledge and expertise are required to formulate and implement health policies. Additionally, doctors and nurses are the ones who deliver healthcare on a daily basis, and their actions or inactions can significantly impact the success of a policy. Therefore, considering the views of these front-line healthcare workers do matter. An argument has been made that medical professionals have lost their professional autonomy due to the market-driven changes in the healthcare system (please see: Calnan & Calnan 2020, pp. 25-8; Noodegraaf 2015; Nigam & Ocasio 2010; Meagher et al. 2009; Sawyer et al. 2009; Light 1993, p. 285). As described in the previously-mentioned literature, physicians and professionals traditionally occupy a central position in healthcare delivery, quality improvement is voluntary, and medical professionals set the standards of professional practice. After the insertion of the market principle in the healthcare system, another ethos of managers emerges where there is an emphasis on competition and cost control, the practice of the medical profession is open to external surveillance, and managers are actively involved in the standards-setting and performance assessments of medical professionals. A similar argument is raised by Alford (1975; see also Checkland et al. 2019), who identifies challenges faced by managers of the healthcare system in New York: the introduction of sophisticated technologies has led to rising costs in medical care, coupled with growing specialisation among physicians and increasing complexity of medical services. Managers of the system were then pressured to improve coordination between services and streamline bureaucratic management. This created a group known as “corporate rationalisers”, who

aimed to reduce the professional monopoly of physicians over the allocation of health resources.

In their empirical research in the U.K. with twenty practitioners, including two therapists and eighteen social workers (working with people with disability, mental health problems and sensory impairments), McDonald et al. (2007) found that in a context of growing neoliberalism and managerialism, participants tended to increasingly rely on a raft of bureaucratic rules and procedures rather than their professional knowledge to guide their practice. The term managerialism can be interpreted as an ideology that supports the use of managerial knowledge and skills in the administration of all types of organizations. It also promotes the idea of a new class of managers who can solve problems by adopting these managerial techniques (Klikauer 2015, p. 1105; Locke and Spender 2011, pp. 5-6). This implies that their professional practices have been transformed by the market-oriented context. A counter-argument is raised by Sawyer et al. (2009), who interviewed twenty-four Australian nurses and social workers involved in community care and found that participants exhibited a "strong sense of agency". Indeed, stimulated by the NPM and de-institutionalisation trend in human services, they expressed positive or critical rationality when negotiating the risk management policies of community care. Some participants positively integrated risk management rules into their daily professional practice and perceived these rules as fostering their accountability and responsibility in practice. Others, however, criticised these procedures and rules as contrary to what clients need, and thought risk management policies might cause new risks and reduce the quality of care. Both groups negotiated the risk management policies and the work environment rather than acting simply in accordance with the bureaucratic system.

Only a limited number of studies focus on how Chinese health reforms are perceived and experienced by healthcare professionals and other stakeholders. In their quantitative study, Degeling et al. (2006) surveyed 2,637 doctors, nurses and managers from not-for-profit hospitals and general hospitals based in urban areas of Australia, England, New Zealand and China. They explored the similarities and differences in attitudes and perspectives of clinicians and managers towards the managerial reforms in the hospitals of these countries.

Degeling et al. (2006) found that clinicians in the three Commonwealth countries interpreted efforts to systemise clinical work and emphasise resource constraints as threats to their clinical autonomy, while hospital managers strongly supported these reform initiatives. In China, however, clinicians were found to be more receptive to this managerial ethos. Degeling et al. (2006) traced these differences to some cultural and social factors, such as the centrality of the work units to Chinese medical professionals' careers and the fact that medicine has been considered a policy tool serving the state's interest since the establishment of New China. These findings imply that Chinese medical professionals in the selected hospitals accept the ethos of managerialism with little resistance; they are transformed by the changing context. However, Degeling et al.'s (2006) study fails to explore how doctors' and nurses' perspectives and experiences change with the environment and why they respond in a certain way rather than another. A more nuanced story is offered by Tu (2018), whose book-length study investigates how various actors in the Chinese healthcare sector negotiate health reform, which is characterised by a parallel process of increasing access to basic healthcare and encouraging private medical practice. Based on qualitative research involving eighty in-depth, semi-structured interviews with medical professionals, managers, administrators and officials in a county of Sichuan province, Tu found that different groups of participants responded differently to the changing system. Within the public hospitals, where there was significantly reduced state investment, and the hospitals were required to be financially self-sufficient, doctors were reported to confront a painful dilemma – "to save or let die" (Tu 2018, p. 42). More concretely, to avoid a situation under which patients tend to evade medical bills, hospital managers took as their focus the securing of up-front payments, and medical professionals ended up bearing the pressure. On the one hand, medical professionals would be responsible for the loss of the hospital if he or she saved a patient who did not have the money to pay; on the other hand, doctors and nurses would receive criticism from the patients' families and violate their professional ethics if they turned a blind eye to the poor patients. However, the focus of hospital managers in this study was to avoid the economic loss of the hospital and "to get the money to sustain this hospital expenditure" (Tu 2018, p. 43). Tu's study not only shows how the market transformation of the healthcare system shapes the operation of hospitals and the practice of doctors and nurses, but it also shows a glimpse of the way these doctors and nurses negotiate with and even resist market transformation. As one doctor says, "(he) would rather be a simple doctor, focusing on treatment only" (Tu 2018, p. 50). Tu's fieldwork was conducted more than ten years ago and is focused on public hospitals. Relatively little sociological attention has been paid to how

healthcare professionals and other healthcare stakeholders experience hospital PPPs in China, which is the focus of this study. An empirical study is needed to answer the question of whether there is a similar tension in the contemporary Chinese healthcare sector, whether the professional autonomy and status of medical professionals have been challenged with the introduction of PPPs, how healthcare professionals respond to the external changes associated with PPPs and neoliberalism, and to reveal the role of the Chinese state in this policy process.

Research questions and aims of the study

This study focuses on the experiences of healthcare professionals and associated social agents within hospital PPPs and seeks to locate their experience in a context of a broader argument about the state and market relations. It aims to understand the introduction of PPPs and PPPs policies in the Chinese healthcare system and gain insight into the conflicts and challenges PPPs present and why these changes have occurred.

The study is to address four main questions:

(1) How did the state introduce the Public-Private-Partnerships (PPPs) into the Chinese healthcare field?
(2) How do healthcare professionals experience hospital PPPs?
(3) How do associated political and market agents (or agencies) experience hospital PPPs?
(4) What will investigating the experiences of individuals in the PPPs tell us? How does this study add to sociological knowledge?

Theoretical framework and research design

A critical analysis of the approaches of orthodox economics, pluralism, and Marxism to privatisation and PPPs in the healthcare sector is provided in chapter two. It reveals a problematic locus - the way the state and the healthcare sector are theorised. The state is conceived as an agent of capital in Marxism, where the demands of the capitalist market structurally determine health policies; or, in orthodox economics, the state is a rational actor that best assists the private sector in undertaking its work by not interfering in the market.

Neither of these conceptions fully takes into account the political work of the state and the way policies are the outcome of actions by individuals within society over historical time in specific contexts. Nor do they consider China, where there seems to be a reverse situation between the state and the market. The comprehension of the Chinese healthcare sector, from orthodox economics and a political economy perspective, has been reduced to a mere reflection of external political-economic forces.

To remedy the problems highlighted above, Bourdieu's interlinked concepts of field, capital, habitus, practice and the state are introduced. The literature chapter proposes a Bourdieusian understanding of the Chinese healthcare sector and the state as two contested fields that are intertwined. Unlike the functionalist understanding, where the Chinese healthcare system is a constituent part of the broader social system that performs appropriate roles in society as well as functioning as a bulwark against societal threats like financial constraints and low efficiency, a Bourdieusian conceptualisation of the healthcare field is concerned with the power relations among field positions, the competition between field agents around domination and legitimacy, and transformations both within the field and in relation to the bureaucratic field and the field of power. Critical agents (agencies) associated with hospital PPPs in the Chinese healthcare field, as defined by this study, include, but are not limited to, the ministries responsible for health policy and health budget (the Ministry of Health and the Ministry of Finance, for instance), local governments responsible for health issues, public and private sector bodies in the contractual relationship, hospitals of various types according to their ownership, pharmaceutical and medical device companies, medical professionals (doctors and nurses mainly), and healthcare managers and administrators. To get a sense of their relationships, we can examine the hierarchy of the Chinese healthcare field, intersected by the bureaucratic field. According to Bourdieu, the field is profoundly hierarchised; there is a hierarchy of positions, ideas and practices within the healthcare field, with the dominant actors holding tremendous power (capital) and control to determine what occurs in the field (see Thomson 2014, p. 71-2; also see Collyer et al. 2017). There is also agency and transformation. For Bourdieu, actors within the field are:

> "not particles subject to mechanical forces, and acting under the constraint of causes: nor are they conscious and knowing subjects acting with full knowledge of the facts,

> as champions of rational action theory believe... (they are) active and knowing agents endowed with a practical sense that is an acquired system of preferences, of principles, of vision and... schemes of action."
>
> (Bourdieu 1988, p. 25)

Various actors are in constant struggles to appropriate the *doxa* and impose their ideas, perspectives and viewpoints as dominant within the field. Bourdieu uses *doxa* to represent a set of natural, fundamental and unquestioned beliefs and perceptions that are operating in the field – a decisive element of "take-for-granted" perceptions and practices – and this is realised through the habitus – the internalised sense of possibilities and limits – of field agents (Bourdieu 2000, pp. 10-1, pp. 15-6; see also Deer 2014, p. 115). In the healthcare field, in the latter half of the twentieth century, one unquestioned belief is that "free market forces" and "managerial techniques" are central elements of good quality and low-cost health service delivery (Noordegraaf 2015, p. 1; Klikauer 2015, p. 1107; Jessop 2013; Meagher et al. 2009). Since the 1980s, a process of the state liberalising the health service has been taking place in China: there has been an ongoing tension between agents or agencies perpetuating the idea of reducing the role of the state while opening the health services to private capital and market competition on the one hand, and those opposing this *doxa*, on the other. These various actors compete to transform or preserve the structure and *doxa* of the field, and they bring economic capital, cultural capital, symbolic capital and other types of capital into the competition. It is the volume and structure of capital available to these actors that define their relative positions in the field and, consequently, define their actions and strategies (Bourdieu 1998, pp. 40-1). Bourdieu (see Colyer et al. 2017, p. 98) also intends the idea of *habitus* to tell us that actors do not act according to their own interests and positions alone; their experiences, structured by past and present circumstances, also matter. Thus, the practices of actors result from "a relation between one's dispositions (habitus) and one's position in a field (capital), within the current state of play in that social space (field)" (Bourdieu & Wacquant 1992, p. 126; Maton 2014, p. 51-2).

This study aims to understand both the process of PPPs being introduced into the Chinese healthcare field and the experiences of those working in the system. Documentary analysis was employed to understand the process of PPPs being introduced as it assists with giving

background information and historical insights associated with privatisation and PPPs in the system. y using Bourdieu's work as a conceptual framework, the researcher also conducted this study by talking directly with people who work in PPP hospitals, as well as other stakeholders with useful knowledge and information about hospital PPPs. A qualitative case study (Hafiz 2008; Yin 2009, pp. 41-6) is selected because it is impossible to fully understand the healthcare professionals' experiences at PPP hospitals without considering the context of PPP hospitals and the political and economic conditions surrounding them. The main source of information for this study comes from key informant interviews and documentary analysis.

Significance of the study

PPPs, as cooperative arrangements between the public and private sectors, have been widely and globally used in infrastructure programs. Also, they have recently been gaining popularity in social programs, the delivery of health services, for example. PPPs, however, have been presenting continuous conflicts and challenges in the hospital systems of Western countries, such as seriously high-cost overruns, late delivery and poor performance regarding care quality (Comendeiro-Maaløe et al. 2019; Whiteside 2011; Flinders 2010; Lai & Fei 2010; Hellowell & Pollock 2009; Chung 2009; Collyer 1997). In the face of empirical evidence and no clear evidence of the acclaimed strength (for example, reduced public borrowing, risk transfer and higher value for money), the Chinese government has nevertheless continuously encouraged hospital PPPs. What is the reasoning behind these conflicts and challenges? How did the Chinese state introduce hospital PPPs? How do healthcare professionals and associated political and market agents experience hospital PPP? What are the characteristics of the state and market relations within PPPs in healthcare? How these questions are understood can influence policymaking and implementation of PPP and influence the Chinese government's response to the conflicts.

As explained earlier in this chapter, healthcare professionals have been central players in health service delivery, engaging in policy debate and influencing policy implementation. Learning about their experiences with hospital PPPs in the policy process can shed light on the attitudes, concerns and requirements of healthcare professionals. This knowledge can, in turn, provide useful insights for policymakers and other stakeholders. Knowledge about

stakeholders' experience with hospital PPPs is also useful for understanding the healthcare market and policy environment where PPP hospitals are placed. For all these reasons, a study of PPP in the Chinese healthcare field from a perspective of state and market relations is a significant task.

Overview of the thesis

In this chapter, the general background of the thesis is outlined, as are the research questions that motivate the empirical investigation, which aims to explain how the state introduced public-private partnership (PPP) schemes into the Chinese healthcare sector and how healthcare professionals and associated political and market agents experience PPP schemes in hospitals in China. The second chapter of this thesis examines the research literature that addresses relevant questions with a specific focus on the theoretical explanations offered therein and their shortcomings. In doing so, it reveals the problematic locus of existing literature, specifically the way the state and the healthcare sector are theorised. According to Marxism, the state serves the interests of capital, which leads to the health policies of the state being determined by the demands of the capitalist market. According to orthodox economic theory, the state is a rational actor that enables the private sector to perform its function by not interfering with it. In these explanations, the healthcare sector has been depicted as merely a reflection of external political and economic forces. As criticised in chapter two, both state and societal agents or agencies in the policy process have been ignored. The relations between the social structure and agents or agencies also remain unexplored. The thesis addresses these limitations by introducing Bourdieu's theory of the state, field, capital, and habitus in chapter two, which aims to bridge the theoretical gap between the social structure and the individual agents and to give a Bourdieusian understanding of the phenomena of privatisation and Public-Private Partnerships in the Chinese healthcare sector. The second chapter argues for the need to examine privatisation and PPPs in hospital settings as a process of both state and societal actors in action. Applications of Bourdieu's conceptual framework reveal that the Chinese healthcare sector should be understood as a relatively autonomous field open to struggles among actors both within and beyond the sector, especially actors from the bureaucratic field. These various actors, whether they are from the state or other parts of society, act in a certain way that is a result of their positions (capital) within the field and the structuring of their habitus

by past and present circumstances. Importantly, these various actors struggle to impose their perspectives and their "principles of vision and division of the social world" as dominant and legitimate in the symbolic order where the state, the "holder of the monopoly of legitimate symbolic violence", plays a central role (Bourdieu 1985, pp. 731-5). Based upon the research questions and the theoretical framework described in chapters one and two, chapter three details the research design employed in the study. As a methodology for conducting this research, Bourdieu's three-level field analysis is described, followed by a discussion about the qualitative case-centred method used for the empirical examination, ways of collecting data through interviews and documentary review, and the method of analysing data through thematic analysis. Following this, the strategies used to improve the study's validity are explained, emphasising the need for reflexivity within the context of the social conditions imposed on the researcher-researched relationship by the researcher's lived experience and educational background.

Chapters four to six present the findings of the study and the result of data analysis. Chapter Four focuses on the research question of how the Chinese state introduced PPPs into the healthcare field, more specifically, how the practice of the state reshaped the power relations within the healthcare field and how this kind of reconfiguration provided the possibility for the introduction of hospital PPPs. Through an analysis of the conflicting points of view of the Health Ministry and the Finance Ministry towards the way healthcare should be financed, provided and organised, this chapter argues that the Chinese state operates as a relatively autonomous bureaucratic field embedded with contested ideas, practices, interests and actions. It also highlights the significant contribution of the state to reshaping the healthcare field. Under the guidance of neoliberalism, a series of administrative measures of the state strengthened the position of private capital. The traditional principle of equity has come under threat from neoliberalism, NPM, and managerialism. The boundaries between the public and private sectors have been muddled and blurred, with private capital entering more areas of services and enjoying more policy benefits that were traditionally within the limits of the public sector. All these changes have made it possible for the historical emergence of hospital PPPs. This chapter also pays attention to Chinese medical professionals in the context of privatisation and NPM. It focuses on how the power relationships between the Chinese government, medical institutions, medical professionals and patients are altered and

how the autonomy of medical professionals has been affected by the health reform since the 1980s.

Chapters five and six empirically analyse the experiences of healthcare professionals and associated social actors within hospital PPPs. Within a broader discussion of the relationship between the state and the market, these experiences are examined. In chapter five, an analysis of the field-specific capital possessed by the PPP hospital investigated in this thesis and a public hospital group in the same area reveals that the public hospital group is in a dominant position. In contrast, the PPP hospital is in a subordinate position as a newcomer and a challenger in the local healthcare field. The local healthcare field is analysed as a field of struggles between the established public hospital group and the new PPP hospital. Opposing strategies and attitudes towards hospital PPPs and the role of the state in health service provision and delivery are found among participants. This chapter argues that these opposing position-takings reflect their dominant/ dominated, public/ private place within the healthcare field. For example, public hospital managers show resistance to the development of the hospital PPP and think that the involvement of private capital can potentially result in health inequality, and insist that the state should take the responsibility of financing and providing healthcare to the public. While the PPP/private hospital managers claim several benefits associated with hospital PPPs, such as creating job opportunities and relieving the state's financial burden, they argue that the state should leave the work of allocating health resources to the market by not interfering in it. This chapter also underlines the stakes in the struggle – state recognition and the state's symbolic power – which is institutionalised through qualifications, licenses, and titles but is also subjectively present through the classification principles imposed on agents in a universal manner.

In chapter six, the differing experiences of healthcare professionals working with hospital PPPs are analysed. The analysis reveals struggles between the traditional medical professionals and the newly emerged managerial professionals over the control and dominance of work conditions and professional practice. Both medical capital and managerial capital brought into the competition are analysed as symbolic capital as, in accordance with Bourdieusian theory, they are disguised and don't appear as a type of economic exchange. In

addition, medical and managerial professionals in this study are analysed as agents in a changing contextual field, which presents a shift from the functionalist explanation of the medical profession to an account emphasising the relationship between a changing context and individual agents. The findings show that participants innovatively respond to the managerial ethos in the PPP hospital, which is characterised by a severe level of pressure toward revenue generation, data-based evaluation, a distinctive patient management approach, and a purchasing procedure based on market monopoly: each of which is at odds with the practices in the public hospitals. Some participants show compliance with the managerial ethos, while others resist it. This chapter argues that rather than a mere reflection of their past experiences and socialisation, the practice of compliance and resistance of participants results from an encounter between their historically structured habitus, their field position and the current state of play of the healthcare field.

The final chapter of this thesis discusses the findings of this study in relation to the research questions. It reiterates the importance of investigating the hospital PPP phenomenon in China as a process of both state and societal actors in action. Also, it re-emphasises the idea that the Chinese state and the healthcare field should be understood as two contested, intertwined fields. This study demonstrates that the Chinese state, under the guidance of neoliberalism and managerialism, has significantly reshaped the healthcare field. This reconfiguration has enabled the historical emergence of hospital PPPs. During this policy process, the symbolic power of the state is not only objectified in legal permits and credentials but also functions to impose these legitimate classifications upon social agents. The experiences of associated social agents and healthcare professionals within hospital PPPs are analysed in terms of a struggle between the dominant public hospital group and the new PPP hospital, and a struggle between the traditional medical professionals and the managerial professionals. The stake in these struggles, as highlighted in this study, is the state's symbolic power, which can offer legitimate classifications and impose the recognised principle of visions and divisions upon the social world. This final chapter also points out that Bourdieu's theoretical framework (field, capital, habitus, the state), combined with concepts of the professions and medical dominance, carries significant implications for analysing these struggles both within the healthcare field and in relation to other more or less powerful fields, the bureaucratic field in

particular. It also assists with mapping out positions, dispositions, and position-takings assumed by various actors.

Chapter Two - Theory and Literature

Introduction

This study investigates how the state introduces the Public-Private-Partnerships (PPPs) into the Chinese healthcare field and how healthcare professionals and associated political and market agents experience hospital PPPs. The previous chapter outlined the background of the thesis and the research questions driving the empirical study. This chapter critically reviews the theoretical and empirical literature relevant to these research questions, with a specific focus on the weaknesses of the theoretical explanations offered therein. The chapter begins with theories of the professions, from the trait and functionalist theories of the professions to subsequent Weberian and Marxist explanations. The conclusion of this section is that the understanding of the medical profession and its professional autonomy should be transferred from the traditional approach focusing on the characteristics and functions inherent in the profession to a more relational manner linking professional authority with the division of labour on one side, and the broader societal context concerning class relations and the state power, on the other. To understand whether medical power might be as dominant as it once was in the changing context of privatisation and marketisation, section three reviews a debate for or against "medical dominance". The debate focuses on the base of medical power and the boundary of the working class, from which it also presents a divide between Weberian and Marxism schools.

The fourth section critically discusses a range of theorisations of privatisation, together with the empirical evidence upon which these arguments have been established. Importantly, it exposes the weakness of each theorisation, from Rationalism and Pluralism to Marxism and Neo-Marxism. This is followed by section five: an analysis of the new delivery models of Public-Private-Partnerships, focusing on hospital PPPs. It then criticises the justification of hospital PPPs in rationalist theories - an argument supported by empirical evidences. The aim of this section is to lead readers to a fundamental question: How the phenomena of privatisation and PPPs should be understood in the context of a much broader argument of the state's role and its relations with the market?

Section six is concerned with how healthcare professionals and other healthcare stakeholders experience the neoliberal change in the healthcare system. A gap identified from the literature is how healthcare professionals and other healthcare stakeholders experience and perceive hospital PPPs. By revisiting the weakness of Marxist and Pluralist explanations of privatisation and PPPs, in section seven, a theoretical gap is identified between the social structure and the individual agents when understanding the phenomena of health privatisation and hospital PPPs. Section eight introduces Bourdieu's theory of the state, field, capital, and habitus to fill the theoretical gap between the social structure and individual agents and to give a Bourdieusian understanding of the phenomena of privatisation and PPPs in the Chinese healthcare field. This chapter concludes with the importance of investigating privatisation and the hospital PPP phenomenon as a process of both state and societal agents in practice.

Theorising the medical profession

Trait theory and Functionalism

The profession, a key term in this study, has a history of theorisation from the early trait and functionalist theories originating from the Durkheim tradition (1957) and subsequently appearing in a different form within the Marxist and Weberian traditions represented by scholars such as Freidson (1970a), Johnson (1972, 1977) and Navarro (1976, 1986). These theories are, however, contradictory. Early trait approaches to the professions focus on the common characteristics that distinguish the professions from non-professions, such as a body of systematic knowledge, the codes of ethics, and the orientation of altruism (Greenwood 1957). The professions, as stressed by Durkheim (1957, p. 31, 42-3) and Parsons (1938, 2013 [1951]), have a primary role as a moral bulwark against risks to the social order. Both trait and functionalist theories view the professions as functioning to oppose the increasing bureaucratisation and rationalism of modern society (Willis 1983, p. 9). The later Marxist and Weberian theories inevitably criticise both trait and functionalist theories for their failure to link professional authority with the structure of class on the one side; and their failure to locate the power of the professions with the power of the state on the other, as Willis (1983, pp. 9-10) has pointed out.

Weberian theory

Freidson, who is well known for his criticisms of trait and functionalist explanations of the professions, sees legitimate and recognised autonomy as the most strategic distinction of professions. Medicine, a typical profession, argues Freidon (1970a, pp. 72-3, 82-3), achieves its legitimate autonomy from esoteric knowledge itself as well as the support of the state and the elites in society. Through political actions favouring the medical profession, state patronage secures its exclusive right to control its work, immune from the intervention of other occupational groups and the lay world. By structurally linking professional autonomy with political and economic power, Freidson puts the profession in its broader social context and within the societal division of labour rather than taking it as a consequence of its functional attributes. In this sense, Freidson's analysis of the medical profession falls into a Weberian approach focusing on the competition between different occupational groups for higher professional status. In other words, the profession is regarded as having successfully persuaded society that their work is of particular value and deserves self-regulated autonomy.

Johnson (1972), at almost the same time as Freidson (1970b), similarly argues that professions and professionalism primarily concern issues of power and control. Johnson focuses his attention on client-professional relations and points out that professionalism should be viewed as a form of occupational control instead of the inherent nature of a specific occupation (Johnson 1972, pp. 45). Professionalism concerns the producers' power to define the need of clients and how that need is to be filled. The other two types of control – Patronage and Mediation – respectively, exist when clients and a thirty party, the state, for example, define both the need and the way it is to be met (Johnson 1972, pp. 46-7). Johnson, in his later work (2015 [1977] pp. 93-5, 105-7), however, recognised his failure to analyse what contributes to the types of control in client-professional relations and to locate occupational control within a more fundamental base of power concerning class relations, the dominant mode of production and the requirements of capital. In this manner, Johnson's analysis goes further than Freidson's, which merely links the medical profession with the division of labour.

Neo-Marxism

Later Neo-Marxist writers reveal that Freidson's explanation does not address a number of questions, such as the identity of the strategic societal elites, the nature of the relations between the state, doctors, and the elites, and the basis of the class interests behind doctors' professionalisation (McKinlay 1977, pp. 465-6; Johnson 2015 [1977]; Navarro 1976, 1986). The Weberian approach, argues Coburn (2006, pp. 433-4), focuses merely on the struggles between occupational groups rather than the significance of the context within which the struggles occur. Applying the "closure" logic to medicine assumes that competition alone determines the power relations or hierarchies in health care between different health occupations**.** This analytical perspective is an obvious limitation when understanding the dynamics of medical power within recent decades. There is a need for alternative analyses to understand the debate about whether medical power is as dominant now as it once was and what forms of external power may have contributed to this shift.

An alternative perspective is proposed by Navarro (1976, 1986), who is renowned for his critical analysis of health issues in Anglo-American nations in the change from a state-oriented system of welfare in the postwar era to market-driven politics since the 1980s (Coburn 2015, pp. 405-12). Navarro's explanation is based on an analysis of class relations and class struggles**.** The class owning the means of production – capital in a capitalist society, exploits the middle and working classes, and this exploitative relation of classes, according to Navarro, is more important than other factors that influence the population's health, such as socioeconomic and social status, as emphasised in the Weberian approach (Navarro 1988, p. 397). In other words, from Navarro's Marxist perspective, the economic base – the ownership of private property – determines the social life in civil society, including medicine and medical power.

Medical dominance in the global context of privatisation

The 1980s have witnessed a fundamental alteration of how healthcare is financed and organised globally**,** and the immediate cause for this is state policy in the marketisation and privatisation of healthcare. In the U.S., the provision of healthcare has a long tradition of marketisation. In 1968, the Hospital Corporation of America (HCA) was established, and it

was the first hospital corporation in America. By 1983, 13 per cent of American non-Federal, acute care hospitals belonged to for-profit chains of hospitals (Light 1986). A Medical-Industrial Complex (MIC) also emerged in America, referring to "a large and growing network of private corporations engaged in the business of supplying healthcare services to patients for a profit – services heretofore provided by nonprofit institutions or individual practitioners" (Relman 1980). These for-profit health services and some other related services created a gross income of 35 to 40 billion dollars from 1979 to 1980 in the U.S. (Relman 1980). The growth of HMOs (Health Maintenance Organizations) in America, which provide prepaid comprehensive health services to patients by a group of doctors and other medical personnel, was stimulated by the *Health Maintenance Organization Act of 1973* (Light 1986, 2004; Relman 1980). This program combined the finance from insurance companies and the delivery of health services for members, and it pioneered the American managed care system, aiming at controlling the cost of for-profit health care and improving the quality of care (other types of managed care include Preferred Provider Organization and Private Fee-For-Service, etc.). Examining all these new phenomena in the American healthcare system provoked considerable debate about whether physicians still maintain their dominant position**.**

"Medical dominance" versus "proletarianisation"

In the U.S., where the new Medical-Industrial Complex emerged, HMOs subcontracted and replaced the traditional profession-centred medical practice. Physicians, in these cases, found their clinical decision-making dictated by economic judgments, and these economic categories limited their treatment options. Examining these new phenomena gave rise to a strengthened political economy argument – these market-based and bureaucratic services inevitably reduced the medical professions to an exploited class that serves the capitalist class to gain wages (Mckinlay & Arches 1985). An opposing view has been made that the corporate influence exerted on the medical field could result in doctors losing some autonomy, and they may need to adapt their thinking patterns and professional practice to fit the corporate 'management's outlook (Starr 1982, pp. 446-8). Nevertheless, physicians still have some authority as the corporations remain heavily dependent on the physicians to make profits, generate revenues, or control hospitalisations and overall costs (Starr 1982, p. 446). In this sense, Starr still seems to put great weight on the medical profession's power even in the

late twentieth century. Starr's "medical dominance" position is likely to emanate from his Weberian approach when locating the essence of medical power – the widespread support outside of the physician group, such as the support from the state and the patients.

"Medical dominance" was introduced from a Weberian representative in Eliot Freidson's work (1970a, b; see also Freidson 1994, pp. 30-2), where the status and power of medical professionals are considered to lie in their control over their professional work and other occupational groups. Also following a Weberian approach, Willis (1983) gives his understanding of "medical dominance" using a book-length analysis. He argues against the technological determinist explanation of medical dominance, where the dominance by medicine is attributed to the amounts of medical knowledge and technology possessed by different occupational group members. Instead, he draws on a historical and social process within the division of health labour and proposes three modes of domination by which "medical dominance" has been achieved: the subordination, limitation and exclusion of other health workers. Willis then moves from the autonomy of the work itself and the authority over other health workers to the broader social and economic environment to explain especially the critical role of the capitalist state and the demand from industrial and financial capital in the process of "medical dominance" (characterised as sovereignty). In this strong sense, Willis appears to speak for Marx by pointing out that "medical dominance" heavily rests upon the compatibility of medical knowledge and technology with dominant class interests. Following this three-level analysis of "medical dominance" – autonomy, authority, and sovereignty, Willis (1983) argues for a decline of medical power since its peak in the mid-twentieth century, and the state support for Medicare, which means a somewhat corporatised and privatised Australian healthcare system is at the heart of the state-level analysis. It is noteworthy that even though Willis has given class factors a critical place in his analysis of "medical dominance", he also realises the inadequacy of the Marxist approach in investigating specific historical events and the process in which "medical dominance" is achieved or threatened, and the struggles between different occupations within this process.

Neither "medical dominance" nor "proletarianisation"

Navarro, however, critiques both sides of the "medical dominance" and "proletarianisation" theses (1988). He points out that two key questions in Freidson's "medical dominance" position remain unanswered – one is the relations between the societal elites and the state; the other is the source of state power. From Navarro's perspective, Starr also ignores class politics when analysing corporate medicine's growth in the United States. From Navarro's viewpoint, these Weberian writers did not consider the capitalist class's overwhelming influence over the state and the American working class's limited power in policymaking. These failures, from his perspective, result in the "medical dominance" standpoint – medical power has been, is, and will be dominant despite the ever-changing context of the late twentieth century. The starting point of his critique of the "proletarianisation" position is the boundary of the working class. In the Marxian tradition, the working class or proletariat are wage labours who do not own the means of production (Marx & Engels 1848). Navarro does not deny that the medical profession's autonomy has declined with regard to the "material means of production" of medicine, such as funding, hospitals and medical devices (1988). However, a crucial difference between manual labourers and the medical profession, as Navarro mentions, is that the medical profession's knowledge and skills must be credentialed by the state. Alternatively, the medical profession fulfils a somewhat dominating function of the state, explaining why the medical profession is not to be proletarianised. In sum, Navarro admits the medical profession's power has somewhat declined with corporate medicine and the growth of the medical-industrial complex, but medical power, from his perspective, is never the ultimate power in medicine. Instead, it is always under the control of the ruling class. These theories about the medical profession and medical dominance were generated at a particular time and in Western countries. There might be an alternative understanding from Chinese political and social contexts. This will be discussed later in this thesis (please see chapters four and six).

Theorising privatisation of health services

Orthodox economics perspective

The previous section has revealed sociologists' efforts to theorise the medical profession and contribute to the debate for or against "medical dominance" in the context of privatisation and marketisation of health care. Privatisation as a social phenomenon has been discussed in various contexts and defined by scholars in various disciplines, and these definitions and theorisations of "privatisation" are sometimes contentious. A prevailing orthodoxy in economics is to view privatisation as an economic and fiscal solution used to improve the performance (efficiency, accountability, service provision and the like) of the public sector through increasingly exposing the public sector to market forces (Domberger & Piggott 1986, pp. 145-6). Related practices broadly include corporatisation, contracting out, and Public-Private-Partnerships, by which public assets, goods or services are transferred from the public to the private sectors (Collyer 2019, pp. 279-81). The rise of privatisation can be traced back to the pre-war era. In the early 1950s, Britain's Churchill government denationalised the steel industry, an example of the early privatisation programme. In Germany, the government partly privatised Volkswagen in the 1960s, with 60 per cent of its stock sold to the public (Megginson & Netter 2003, pp. 31-3). There have also been some early privatisations in the USA and Canada. Privatisation in the U.S. typically includes assets divestitures and contracting out services and activities, such as ambulance services, high-way construction, facility building, and maintenance. Some State-owned Enterprises (SOEs) were transferred to the private sector through sale or gift in Canada. For instance, the British Columbia Resources Investment Corporation was given away to the residents in free shares (Boardman et al. 2003, 129-31, 148-50; Hirsch & Osborne 2000). A similar movement towards an increased role for the private sector and the imposition of a market solution in service delivery has also taken place amongst Australian SOEs since the 1970s. Australian Post, for example, has been restructured into a government corporation to provide some services for profit and is subject to market competition. Other regions like Latin America, Central and Eastern Europe and Central Asia have also been active in the "privatisation" movement, with public enterprises sold off (Cook & Kirkpatrick 2003).

In public administration, the traditional public administration stresses elements such as (1) the dominance of rules governing public staff and activities, (2) incremental state budgets, and (3) the central roles of the professions in service delivery. However, traditional public administration lost its cutting-edge in the 1980s (Hood 1991, pp. 3-4; Dunleavy & Hood 1994, pp. 9-10; Osborne 2006, p. 378). We have seen the growth of "New Public

Management (NPM)", which adopts business-like methods to manage the public sector. These methods include using "hands-on" managers, measurable performance indicators, output controls, and the adoption of competitive approaches in the public sector (Hood 1991, pp. 4-5). New Public Management movements have also moved from developed countries to some transitional and developing economies and from central administration to local governments. For instance, the 'NPM' reform initially occurred in the United Kingdom under Margaret Thatcher's government and in the municipal government of Sunnyvale, California, U.S. (Gruening 2001). The fundamental shift of these reforms, as identified by academics, might be that a profit-making corporation is promoted as an ideal model for managing the public sector (see, for example, Meagher et al. 2009, p. 334; Hood 1991; Stewart & Walsh 1992).

The economic argument views "privatisation" and "NPM" as rational solutions to social problems such as inefficiency and the high cost of the public sector, economic recessions and budgetary deficits, and high levels of bureaucracy and red tape. This kind of argument has several assumptions. First, it assumes that each country is confronted with the same social problems of similar priority and urgency and ignores the political and cultural differences between them. Second, it takes privatisation as a magic 'cure-all' fitting into all contexts. Third, there is seldom evidence of any improvement in cost efficiency, service quality and greater equality. Some evidence even stands contrary to the asserted functions of privatisation *(*Collyer 1996, 2003; Collyer & White 2011; Martin & Parker 1997; Goodman & Loveman 1991*)*. For example, in their empirical study, Martin and Parker (1997) measured eleven organisations' performance from the nationalisation period to the post-privatisation period and the latest period in the U.K. They compared performances between different periods, concluding that no significant performance improvement was shown before or after the privatisation. International Financial Service London (IFSL) Research (2008) reported 694 PFI/ PPPs projects throughout Europe between 2001 and 2007, with a total of € 73 821 million. Within the U.K. PPP projects, the health sector constituted 23.2 per cent of total expenditure between 1987 and 2006 (Hodge et al. 2010, p. 7, 14). The "rational solution" argument fails to explain privatisation's growing popularity in the face of conclusive evidence against its cost efficiency.

The economics perspective inevitably falls into a functionalist tradition as it leaves a fundamental question unanswered: Why the problems of "low efficiency" and "high cost" rather than "poverty" and "health inequality", to name a few, are identified and recognised as the most acute and significant "social problems" and put on the policy agenda. As Edelman (1988, pp. 12-36) has pointed out, and Samson (1994, p. 80) and Collyer (2003) have underlined, "social problems" are socially and ideologically constructed rather than fixed assets in society. In other words, to understand the construction of a "social problem", it is essential to learn the meaning of the context from which it is identified and recognise and examine the consequences of the "social problem". Importantly, there is a need to bring to light the ideological stance behind the political management of the "social problem" and the silence of other more troubling issues. In some other way, silence is meaningful because what appears as a problem to some people at the same time benefits others. In this sense, privatisation is a solution to a series of socially and ideologically constructed "social problems" rather than a politically neutral and rational technique (Edelman 1988, pp. 12-36). These identified "social problems", in turn, as Edelman (1988, pp. 12-36) has argued, are used to justify the solution and further justify the ideological stance underpinning the solution.

Pluralism

Social and political scientists make sense of what privatisation is and the impacts of privatisation in varying ways. Henig et al. (1988) adopt a pluralist approach, seeing privatisation as a political strategy and an outcome of political struggles between parties and interest groups according to their objectives. As Henig et al. have suggested, in Britain, France, and the USA, privatisation is an electoral strategy for attracting votes to the conservatives (Henig et al. 1988, p. 463-4). This pluralist perspective attempts to limit the explanation of privatisation to the sphere of production, focusing on the agents within the state. Saunders and Harris (1990) seek to remedy this shortcoming by emphasising the implications of privatisation for the relations between producers and consumers. In the United Kingdom, for instance, a shift in financing patterns from the medical professionals to the patients has resulted in doctors' massive protests against the government (Saunders & Harris 1990, p. 73). Thus, privatisation in the pluralist perspective is argued to have the potential to alter the power relations between different groups, such as the medical

professions, consumers, government, and unions (Henig et al. 1988, p. 463; Saunders & Harris 1990).

Marxism and Neo-Marxism

However, the pluralist explanation is criticised for ignoring the influence of collective forces and social structures on the power struggles and for reducing the "privatisation" phenomena to an outcome of actions between individuals and groups (Luke 1974; Samson 1994, 79-84; Collyer 2003). Starting from the socially and ideologically structured "social problem" argument by Edelman (1988, pp. 12-36) and applying Lukes' theory of power (1974), Samson (1994) offers a more relational explanation. He makes an effort to reveal the "meaningful silence" behind the traditional definition of privatisation – the transfer of power and control from the public to the private sector and points out some hidden processes associated with privatisation, especially public sector cuts. Cuts can be achieved financially and through the elimination of services, such as reducing subsidies for welfare programmes and some public institutions like hospitals, and it can also be realised by setting more stringent criteria in eligibility for state benefits. According to the House of Commons, in Britain, the NHS was underfunded by £1,896 million between 1981/2 and 1987/8 (House of Commons 1987-88. xix). A similar case happened in Australia; a survey of Australian health economics by Richardson and Wallace (1983, p. 125) illustrates that the Commonwealth contribution to the total health expenditure had remained at the same level as it had in the 1970s, in sharp contrast to the rising demand for health care, and that a 30 per cent increase should have been made in social security and welfare payments. The U.S. also cut some welfare programmes budget, such as *Child Nutrition* (by 27.7 per cent) during the fiscal years of 1982 and 1985 (Katz 1986, p. 288).

Public sector cuts in health finance and service provision cannot be fully explained through pluralist theories. This paradigm's major weakness is that it fails to explain why state policies continuously favour specific groups over others, as Marxist representative Navarro (1976, p. 439) has already argued. In Australia and the U.S., for instance, both political parties support the introduction of "free market" forces into the health sector and, at the same time, a reduced role for the state in this area, despite the citizens' preference for a state-financed and owned

healthcare system (Navarro 1976, p. 445). More importantly, the pluralists' argument of agents' actions and willingness to determine the nature of the competition surrounding privatisation fails to explain the construction of their willingness and motivation and their relations with the dominant class's interests and broader social arrangements. "Public sector cuts" proposed by Samson (1994, pp. 87-9) as unspoken agendas within the conception of privatisation bring to light privatisation's negative impacts on those who formerly relied on health benefits provided by the state. After the "cuts", the access to and quality of health services come to be primarily determined by consumers' economic conditions, and this whole process is likely to result in increased health inequality, which has been well documented (e.g., Kokkinen et al. 2015; Navarro et al. 2006; Samson 1990).

Rather than regarding "privatisation" as an outcome of political struggles between different interest groups, Samson (1994, pp. 91-2) views "privatisation" as a "hegemonic project" where the state imposes *sets of ideas about "privatisation"* on people through a series of policy changes (both the introduction of market forces and the reduction of the state role) and ideological means. A primary means of the ideological construction by the state, as pointed out by Samson (1994, pp. 91-2), is through establishing a watershed dividing the private sector from the public sector and associating the private sector with efficiency, liberty, independence and increased consumer choice, and the public sector with inefficiency, overstaffing and corruption. These "faiths" claimed by the Reagan and Thatcher governments fit into the ethos of neoliberalism, where managerialism has also reigned. That is, the logic of "free market" and "managerial techniques" are believed to produce good-quality and low-cost goods or services both in public and private organisations (Noordegraaf 2015, p. 1; Klikauer 2015, p. 1107; Jessop 2013; Meagher et al. 2009). From Samson's perspective, privatisation is justified at a philosophical level. Thus, a package of ideas and political programmes – free market forces, individual freedom, privatisation, deregulation of markets, opening up new markets, loosening of state regulations, social welfare cuts and the like, are extended and consolidated. Seen from Samson's lens, privatisation is, in turn, subordinate to a hegemonic project, which is justified by neoliberal ideology. Managerialism shares certain affinities with neoliberalism regarding competition advantages, efficiency orientation, cost consciousness, etc. According to Klikauer (2015, p. 1105), Locke and Spender (2011, pp. 5-6), managerialism could also be understood in an ideological sense, where it justifies, on the one hand, the use of managerial knowledge and skills in running all organisations ranging

from hospitals and colleges to oil rigs and advertising companies (based on a principle of cost-efficiency); and a new class of managers to solve problems by adopting these managerial techniques, on the other.

Nevertheless, both neoliberalism and managerialism have evoked worldwide political debates and resistance, indicating that these seemingly "value-neutral" concepts adopted "for the general good" conceal the hunger for the profit of the so-called "free market" and, more practically, capital (e.g., Klikauer 2015; Jessop 2013; Meagher et al., 2009; Samson 1994; Navarro 1976). Marxists regard this set of neoliberal and managerialist ideas (such as privatisation and NPM) within a specific theoretical framework about the class nature of the state and its apparatus and seek to address how class relations might be altered under a series of political and ideological programmes of privatisation. In contrast, pluralist theories cannot answer these questions because their focus is limited to interest groups, with no attention devoted to class and ideology. Converting health services previously provided by the state into commodities to be exchanged in the market, from the Marxist perspective, is consistent with the ideology of capitalism, for the role of the state in this whole policy process is to adapt to the interests of the ruling class – the capitalist class - and to increase capitalist profit (Navarro 1976, pp. 444-6, 450). From the Marxist perspective, the fundamental logic for this is that the state and its policies are heavily dependent on the state of the capitalist economies. A growing body of literature concerns the rising cost of health services, unnecessary high-tech and sophisticated medicine, and high hospitalisation rates and attributes the negative performance of healthcare systems to the pursuit of profits in the private market. From a Marxist perspective, the state legitimises the for-profit behaviours in the healthcare market and regards the medical profession - the providers of healthcare - as serving the interests of capital (Navarro 1976, pp. 447, 450).

Theorising Public-Private-Partnerships in the hospital field

Loose definition, delivery models and general background

Associated with the increasing worldwide prevalence of privatisation has been the phenomenon of Public-Private Partnerships (PPPs). These have been loosely defined as contractual agreements between the public and the for-profit private sector to build new infrastructure and/or provide social services, typically of a long-term nature (Hodge & Greve 2007; 2017; Flinders 2006, p. 223). PPPs are located between direct state provision and pure privatisation or divesture, under which public assets or services are fully transferred to the private sector (please see Figure 1). In PPPs, however, the private sector may take various roles in a continuum ranging from designing, financing, building, operating, and maintaining infrastructures; and at the end of the contract life, private bodies may either continue to operate the facilities and retain the ownership or transfer the facilities to the government (Roehrich et al. 2014; Torchia et al. 2015; Duffield 2010, pp. 188-90).

Delivery model	Identify needs (infrastructures or services)	proposal	Design	financing	building	operation	maintenance	Ownership	Concession
Direct state provision	Public sector								
Contracting out	Public sectors pay another party to fulfil their function (such as services and management) and do not involve in the job under the contract.								
Scope of PPPs									
Design-build (D.B.)	Public sector		Private sector	Public sector	Private sector	Public sector			No
Design-build-finance (DBF)			Private sector			Public sector			
Design-build-finance-maintain (DBFM)			Private sector			Public sector	Private sector	Public sector	
Design-build-finance-operate (DBFO)			Private sector				Public sector		
Design-build-finance-maintain-operate (DBFMO)			Private sector					Public sector	
Build-operate-transfer (BOT)			Private sector					Public sector	Temporary
Build-lease-transfer (BLT)			Private sector			Public sector	Private sector		
Build-own-operate-transfer (BOOT)			Private sector						
Build-own-operate (BOO)			Private sector						Yes
Pure privatisation or divesture	Public assets, goods or services are fully transferred from the public to private sectors.								

Degree of private sector engagement

Separation of ownership

Figure One Delivery models of PPPs

(Source: Adapted from Duffield 2010, pp. 188-90; Roehrich et al. 2014)

Since the mid-1990s, governments around the world have introduced PPPs into the health field and used this "new solution" to build hospitals and provide health services. In the U.K., which is a leader in the use of health PPPs, John Major's Conservative government legitimised the use of the Private Financial Initiative (PFI) in 1992, though limited PFI to arrangements where the private sector takes responsibility for the design, financing, build and service provision phase of the projects (H.M. Treasury 2008). During the ten years between April 1997 and April 2008, the NHS signed 97 hospital PFI projects out of 127 contract projects, with an additional 21 PFIs at the proposal or procurement stage. During this period, the capital value of the PFIs was around £10.49 billion, taking up about 90 per cent of the total value of hospital-building programmes (Hellowell & Pollock 2009). In the Canadian healthcare system, which has long claimed to be based on the principle of universality and accessibility, PPPs have also been used to build hospitals, clinics, and primary health centres. In that country, the most common delivery models adopted are BOOT (Build-Own-Operate-Transfer), DBFO (Design-Build-Finance-Operate) and Design-Build-Operate (DBO). By 2011, there were 14 health PPP projects, with another 34 projects at various stages of development (Whiteside 2011). The same trend has occurred in Australia. By 2016, there were 9 PPP hospitals, with another one owned by a for-profit private company added to this list in 2018 (Collyer et al. 2020, pp. 37-52). The popular form of PPPs used in the Spanish National Health System is known as an Administrative Concession, and this form experienced growth, especially between 2007 and 2011, before final discontinuation in 2018 (Comendeiro-Maaløe et al. 2019). Some developing countries, India and China, for example, have also introduced PPPs as an alternative to direct public care provision and expect to integrate the claimed strength of the private sector (such as new technology, management, high efficiency and good quality care) into the existing healthcare system and to achieve the shared goals jointly.

Rationalism: PPPs as New Public Management and New Public Governance Agendas

Even though PPPs' have been widely used across the world for public service delivery, the justification for PPPs is fiercely debated both in theory and practice. As they do with privatisation, rationalist theories regard PPPs as conforming to the NPM agenda by arguing that the use of market and quasi-market mechanisms potentially improves efficiency and

achieves Value for Money (VfM). By this, they mean the achievement of optimum coordination of costs and quality of goods or services to meet users' requirements over the project's life circle (OECD 2008, p. 21). According to the NPM, there should be a separation between policymaking and policy implementation, and the state should focus its attention on policymaking and the regulation of policy delivery (Bovaird 2010, pp. 54-5; Klijin 2010, pp. 71-2). Thus, the private sector is encouraged to take over projects or services that do not interest the public sector for such reasons as they are non-essential or would be more efficient and productive if provided by the private sector (Willis et al. 2019). The state ends up controlling the implementation by employing performance indicators or leaving it to the market, the latter of which has a strong emphasis in the NPM (Hood 1991). There are some different ways PPPs are defined. Nao (2002) and Greve (2007) mention that outsourcing and tendering are also forms of PPPs as they all emphasise the strength of market logic in public service delivery. A tendency also exists in the literature that regards PPPs as a "malleable form" of privatisation as they are both principal elements of NPM which emphasise the involvement of private capital and efficiency improvement. Moreover, some scholars argue that PPPs are by no means new solutions but a "softer" expression of privatisation in the public service area to make it less confrontational to those ideologically opposed. (e.g., Savas 2000; Bovaird 2010, pp. 55).

Evidence on the insufficiency of rationalist explanation

However, arguments have been made that it is insufficient to use the NPM agenda to justify PPPs as they are distinct from pure privatisation in terms of their focus on long-term contractual relationships (usually spanning a period of 25 to 30 years) (Bovaird 2010, pp. 60-3). Around the middle 1990s, a New Public Governance (NPG) paradigm emerged and became a tool for advocates to speak in defence of PPPs, from which PPPs are viewed as either a continuation or a break with the NPM agenda. In contrast to the NPM regime, where policy delivery is through a set of independent organisations in competition with one another, NPG is concerned with the interdependence between actors, including both state and societal actors, to deliver public services (Osborne 2010, pp. 8-9; Rhodes 2007, 1997). Actors in this network exchange resources to reach a negotiated goal, and the base of their interaction is trust and shared values (Rhodes 2007). The NPG agenda seems to provide reasonable

grounds for PPPs. Hospital PFI might be an example. Public and private bodies negotiate a contract covering the Design, Build, Finance and Operation of a hospital. Private financing of the hospital is believed to be a measure to reduce public debt while increasing public infrastructure investment (Hellowell & Pollock 2009, pp. 13-4; Chung 2009). The public bodies play a bigger role in this relation than pure privatisation and might make more sophisticated use of the resources of private bodies during the Design and Build phase, such as an innovative hospital building design. At this stage, the risk of poor design would be transferred from the public to the private sector; simultaneously, the private sector would achieve potential efficiency gain due to the intelligent design. At the later stage of the contract, private sector bodies would also carry at least part of the risks associated with service delivery. The government purchases a stream of health services produced with the asset, in compliance with specific quality and quantity at an agreed price, which should ideally achieve the Value for Money (OECD 2008, pp. 20-1). This is also a significant reason for the public sector entering the contractual relationship, and the private sector is, of course, interested in the "substantive added value" attached to the PPP project (Klijin 2010, pp. 71-2).

In practice, however, hospital PPPs are not making good on their promise of risk transfer, limiting the size of public borrowing, or higher Value for Money than public procurement projects. First, private finance, as Hellowell and Pollock (2009) and Whiteside (2011) have suggested, is of an "off-balance-sheet" nature, which means that PPP projects are paid during the whole lease arrangement rather than paid up front as the traditional procurement projects. This implies that the state obligation associated with the hospital PPP is "invisible" but still exists. Two PPP schemes from the U.K. provide empirical evidence for this argument. Considering the interest rate, the cash value of the return on private capital is around twice the capital invested in the hospital building by private bodies (Hellowell & Pollock 2009). There might be an argument that the higher financial cost is simply a reflection of the risk adopted in the form of an agreed price when the contract is signed. However, this claim masks the fact that the real motivation for private bodies to enter the contractual relationship is the anticipated return on investment in the form of a higher profit margin. It is moreover noteworthy that private bodies could also absorb the risk translated into the price in the form of profit due to their expertise and experience (Cohn 2004; Hodge 2004; Gaffney et al. 1999).

In this sense, the hospital PPPs are one project with "two profits", which tends to explain the high cost of private finance. Some other empirical records disapprove of the assumed cost-efficiency of hospital PPPs. One Canadian hospital PPP in the form of DBFO ended with costs over-running by 68 per cent compared to an estimated $CAN 211 million in 2011, partly because of an alteration in infrastructure design, which resulted in a delay in service delivery. Additionally, a high transaction fee covering administrative, legal and consultant fees is present with this hospital PPP (Whiteside 2011, pp. 263-4).

In a more comprehensive study of Spanish hospital PPPs in the model of the Administration Concession, besides cost and efficiency indicators, there also includes some performance indicators concerning the quality of care, such as care of low value and unnecessary hospitalisation, the result shows that the PPP case does not outperform the traditional public hospital (Comendeiro-Maaløe et al. 2019). Similar analyses are raised by Collyer (1997) and Chung (2009, pp. 82-3). In their case studies of the very first Australian hospital PPP (privately built, operated and owned), Collyer (1997) and Chung (2009) conclude that the hospital PPP, compared to its Public Sector Comparators (PSCs), cost the state 30 per cent more to operate, while its performance in terms of waiting time and the waiting list was far from satisfactory in comparison with its PSCs. These examples illustrate a negative financial outcome of PPPs embodied in the seriously high-cost overrun, compounded by the late delivery and poor performance regarding care quality.

The justification of PPPs as a New Public Management and governance arrangement based on rational choice, institutional, and network theory is thus insufficient to explain the continuous popularity of the PPP phenomenon. According to network theory, the fundamental assumption of the partnership between public and private bodies is the shared value between network members (Rhodes 2007, p. 1246). However, the primary motivation for the private bodies entering the contractual relationship is the pursuit of profit rather than to share advanced technology, information, and expertise with the public bodies, which might undermine their competitive advantage in the marketplace. In this sense, how can the for-profit market actors be responsible for delivering cost-efficient public services for the common good (which should be the responsibility of the state) and at the same time secure

their profits to the maximum? How can the state agents continuously introduce this market logic into public service delivery, knowing that a "splintered logic", as Flinders (2010, p. 115) terms it, exists in this relationship?

The potential answers to these questions are linked back to the previously discussed political debate about privatisation based on the Pluralist and Marxist traditions. PPPs, as a phenomenon, share the same logic of the so-called "free market" with other marketisation forms such as privatisation and New Public Management. Beyond the economics of PPPs, Collyer (1997) firstly makes sense of the Australian hospital PPP as a political strategy for the state to get rid of health finance and provision responsibility, leave the administration work for the hospital, and expose the medical professionals to the private market. This strategy is likely to change "the political landscape" among different interest groups (such as the unions, financial interest groups and the medical profession). To further make sense of the belief in the "free market" being able to allocate resources efficiently, Collyer then theorises Australian hospital PPPs as a "powerful discourse" used to maintain inequality in health resources allocation and benefit the class with capital. In this sense, Collyer's theorisation represents a shift from the pluralist perspective focusing on power struggles between interest groups to a Marxist tradition which offers a broader view of the relations of PPPs and class interests, class relations and wider social arrangements (please see the previously discussed political debate of privatisation for details). Aligned with the Marxist tradition, Whiteside (2011) understands Canadian hospital PPPs as a form of "accumulation by dispossession", through which the state seeks to create conditions for capital accumulation. In other words, integrating the market logic of the private sector into a long-term contractual relationship in the public domain helps to carve a path for future revenue generation in the sector where the state traditionally takes the leading role. Following this logic, both PPPs and privatisation are argued to be subordinate to a more hegemonic project, justified by "the philosophy of neoliberalism" (Whiteside 2011). Consequently, the boundaries between the public and private sectors and between the state and market are inevitably increasingly blurred. These evolving debates of privatisation and PPPs lead us to a fundamental question: How should we understand the phenomena of privatisation and PPPs in the context of a much broader argument about the state's role and its relations with the market?

Effects of Privatisation and Public-Private-Partnerships on healthcare professionals

Sociologists also focus on how privatisation and the insertion of market logic impact the medical profession, nurses, other health workers, and their relationships. Medical professionals have been argued to lose their position of autonomy and even their monopoly to various extents, and this is fundamentally caused by the change of organisational environment from the public to mixed ownership and by the transformation of the broader cultural and socio-economic context (Sofritti 2020; Calnan & Calnan 2020, pp. 25-8; Naqvi et al. 2019; Bryce et al. 2018; Benoit et al. 2010; Meagher et al. 2009, p. 334). Light (1993, p. 285) and Nigam and Ocasio (2010) emphasise a logical conflict between the traditional ethos of the medical profession centring on the role of physicians in guiding service delivery and the commercialism ethos of management which focuses on efficiency improvement and cost reduction. The rise of this new profession in the health services sector – medical managers, according to Navarro (1976, pp. 452-3) and Samson (1994, p. 90), is a direct result of privatisation bringing about a shift in the relations of power. This occurs because the state develops a passionate interest in relying on cost-conscious managers to save capital and limit the power of the medical profession, through which clinical work becomes "cheaper". In his book-length contribution, Noodegraaf (2015, pp. 186-8) argues that hospitals are not standard production organisations, and some complicated work, such as "Open Heart Surgery", are difficult to standardise and measure, in which case the medical profession requires more autonomy. This implies that it is hard to literally apply the managerial logic with standardised codes and norms to the hospital setting and the medical services themselves, and it helps to partly explain the conflict between managers and medical professionals.

Some quantitative studies reveal a correlation between healthcare workers' perception of privatisation and demographic factors, gender, age, educational level, type of profession, and year of employment, to name a few. Ulusoy and Oflaz (2016) surveyed 220 physicians and nurses who work in a public hospital system in Turkey to assess their perception of strategies under the "Health Transformation Program" (HTP) introduced by the Ministry of Health. HTP is a privatisation project employing a Public-Private Partnership, a pay system based on performance and the hiring of contract workers in the healthcare system, among other strategies. The result shows that physicians do not exhibit a positive perception of

privatisation, while nurses hold a negative perception of privatisation, especially its effects on their clinical practice. However, it is noteworthy that the younger generation of doctors seems to be more compliant with the market logic of these transformations in the healthcare system, according to Pillay's (2008) quantitative study of physicians working in the private health sector in South Africa.

Various studies apply qualitative methods to examine how healthcare workers experience market-oriented changes in their work environment and how their attitudes, professional practice and career choices are altered with the ethos of neoliberalism and managerialism. In his qualitative study, Smallon (2015) interviews 31 clinical and non-clinical staff working in a public health organisation in New Zealand and finds that the transition phase under New Public Management practice significantly increases their stress and job insecurity. This is mainly because the cost pressures on the government lead to the use of part-time and short-term contract jobs and demand a heavier workload with inadequate resources and support.

A more recent book edited by Collyer and Willis (2020) focuses explicitly on the question of how a mixed public and private healthcare system in the developed and less developed world is experienced by individuals working within it, patients in need of the health services, and by policymakers who have some agency to shape the system. In their chapter, Rudge and Toffoli (2020, pp. 157-80) highlight the way nurses working in a private hospital in Australia confront the tension between their value of "quality and safety" in nursing care and the hospital's market-oriented strategies. In this case, tension occurs particularly around the shifting of nurses between units according to supply-demand conditions: a strategy that allows the hospital to increase the number of patients without increasing labour costs. Collyer (2020, pp. 107-30) points out a similar issue faced by gatekeepers in the Australian healthcare system, arguing that some General Practitioners also resist commercial imperatives to stimulate demand, and other studies have also found that some healthcare staff prefer to work in a public system for this reason (Rudge & Toffoli 2020, pp. 157-80; Collyer 2020, p. 282; Zullo & Ness, 2009). While a qualitative study by Waring and Bishop (2011) illustrates that some NHS clinicians previously working in the public sector have transformed into an independent sector where there exists the ethos of private ownership, some of them take the

change as an opportunity to learn new things while others seek to resist and still rely on the traditional ethos of the public sector. However, while these qualitative studies have investigated how healthcare professionals and other healthcare stakeholders experience the market-oriented change in the healthcare system, few studies have paid attention to their experience and perceptions of hospital PPPs in the context of a much broader argument of the state's role and its relations with the market. Even fewer studies have examined the impact of privatisation and PPPs on Chinese healthcare workers and stakeholders. This study seeks to theorise the experiences of healthcare professionals and stakeholders with hospital PPP in China to fill this gap.

Need for bridging the social structure and the individual agents

A coherent theory that considers both the changing social structure and the relationship between the state and the market is needed to explain the phenomena of health privatisation and hospital PPPs in China from the perspective of the state's role and the experience of actors. The Marxist approach takes the state as merely *an agent of capital* and the capitalist class. This is an economic determinist approach, where *the economic base* structurally determines the ideological system and all social life in society, including that of the medical professionals, managerial professionals and the relations between the state and market actors (see, for example, Collyer 2020). The worldwide popularity of privatisation and PPPs, from this "structural causality" perspective, follows the logic of capital accumulation, and both the state agents and market actors, in this explanation, play little part in this policy process. Marxism is seriously challenged by the Pluralist approach, which regards privatisation and PPPs in healthcare as outcomes of actions between the state actors according to their interests. It views the dominance of the medical profession as a result of a power struggle between different occupational groups in the marketplace. Another weakness inherent in Marxist class analysis, as suggested by Willis (1983, p. 13), is that the class location of the medical profession has been problematic as the group is heterogeneous, which means the class analysis inevitably conflates the notion of professional groups with the concept of class. To remedy this shortcoming, Pluralists take individuals and groups as the focus of analysis and Marxism, in turn, criticises the pluralist approach for ignoring the influence of the broader social arrangements in the social actions between actors within the

state and society. Therefore, a more coherent theory is needed to bridge the social structure and the social agents; to explain a dynamic policy process more fully in relation to broader social arrangements; to demonstrate how market actors *experience* this shift; and how their relations are altered with this changing context.

Re-theorising Public-Private-Partnerships using Bourdieu

Field, capital, habitus and practice

Identify the Chinese healthcare field

Bourdieu's theories of the state, field, capital, habitus and their relationality might facilitate our analysis of the relations between the state and the market, between the social structure and individual agents in the healthcare area. It is noteworthy that these concepts should not be used statically and independently but understood in a dynamic and relational sense (Collyer et al. 2015; Maton 2014). According to Bourdieu (in Bourdieu & Wacquant 1992, p. 107), the notion of field is of primary significance in sociological research, and it is the objective relations between players that matter in the field rather than the individual agents or agencies. By definition, a field is:

> "a network, or a configuration, of objective relations between positions. These positions are objectively defined in their existence and in the determinations they impose upon their occupants, agents or institutions by their present or potential situation in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology, etc.)."
>
> (Bourdieu & Wacquant 1992, p. 97)

Following Bourdieu's logic (in Bourdieu & Wacquant 1992, p. 97), our analysis should begin by identifying the key players and map out "the objective relations between positions" occupied by these players within the healthcare area. Participants in the Chinese healthcare

field, which is the field in question of this study, include healthcare professionals (doctors, nurses and managers mainly), patients, public and private hospitals, PPP hospitals, pharmaceutical companies, government ministries, medical universities, medical associations and other stakeholders. All are linked by objective and historically structured relations. Figure 1 depicts the Chinese health governance system under which medical and pharmaceutical service is administrated. The health administration field of China is longitudinally a five-layer hierarchy (national level, provincial level, city level, county level and township level), with interdependent players taking varied positions and fulfilling different responsibilities (see Meng et al. 2015). It synchronically comprises central and local government, national and local health commissions, medical security organisations, health inspecting organisations and other related bodies. Organisations at the national level are the policy-makers and provide guidance to the lower administrative level. The central and local governments take the lead in managing the health administrative organisations at the same level. Accordingly, some key players exist in the Chinese healthcare field (health administrators, healthcare providers and healthcare consumers), and these also display a set of objective relations (subordination, business management, business guidance and coordination, etc.) between the players. These dynamic relations, as described by Bourdieu, have effects on each other and thus potentially alter the structure and challenge the boundaries of the field (Bourdieu & Wacquant 1992, 107; Rhynas 2005).

Capital

The positions taken by these actors, according to Bourdieu, are fundamentally based on the distribution of the forms of capital**,** which are dependent on one another: *economic capital,* which refers to material property and provides for the possibility of transformation into other forms of capital; *cultural capital*, which can take an objectified state (as with books and paintings) or an institutionalised state (as academic qualifications and degrees), or an embodied state (as value, skills and knowledge); *social capital*, which concerns the aggregated resources "linked to possession of a durable network of mutual acquaintance and recognition"; *symbolic capital*, which includes all the other forms of capital with a symbolic dimension (such as linguistic capital or scientific capital, depending on the field in which they are located) (Bourdieu 2011, pp. 79-92; also see Abel & Frohlich, 2012; Moore 2014, pp. 101-2). Bourdieu's forms of capital indicate his broadening of Marx's concept of

economic capital and his echoing of Weber's ideas about the difference between material and non-material forms of capital. In the Chinese healthcare field, differences exist between the assignment of capital to various government ministries, different types of hospitals, and also to different individuals. The Ministry of Finance, for instance, will usually have more opportunities for making decisions about where to use the financial budget, thus increasing its power to influence its positions. In China, public hospitals receive more government subsidies than private hospitals, which potentially enhances their situation. Patients with high incomes will generally have more choices about their care than the poor, which may benefit their quality of life. These examples help to make it clear why we can use Bourdieu's concept of capital to more fully explain the relations between positions in the Chinese healthcare field, as they improve our understanding of agents' day-to-day practice.

Habitus

In order to investigate the logic of the practice of agents in the Chinese healthcare field, one might need to deploy Bourdieu's conception of *habitus* in relation to *field* and *capital*. The concept of *habitus*, argues Bourdieu, aims to resolve the question of how agents' practice is regulated without necessarily being "the product of obedience to rules" (Bourdieu 1990, p. 65). From this perspective, Bourdieu is opposed to the rational choice explanation of privatisation and PPPs, which assumes that the action of agents is based on an accurate calculation and conscious choice and that the agents in policy-making are armed with a god-like knowledge of what the healthcare field is like and the full consequences of their actions (Maton 2014, p. 54-5). Instead, Bourdieu intends *habitus* to link the social structure and individual agency, the *outer* and *inner*, objectivity and subjectivity, and to transcend these *dichotomies*. He posits the notion of *habitus*, a "systematically ordered" structure (a system of dispositions) that is "structured by one's past and present circumstances" such as family upbringing, educational and working experiences; and that "also helps to shape one's present and future practices" (Bourdieu 2000, p. 170; see also Maton 2014, pp. 51-2). Thus, the notion of *habitus* not only brings together the social structure and individual agency but also bridges past, present and future circumstances. The study of *habitus* requires a prolonged immersion in the field in question at different times. A relational sense of structure and agent and different circumstances over time is required when examining how healthcare professionals experience the market atmosphere of their work environment and how their professional practice is altered with the market-led change. In other words, how the "outer"

circumstances regulate the "inner" world of healthcare workers over time and how this "inner" world, in turn, generates regular and regulated strategies and practices which aim to maximise their positions in the field in question.

Practice

Habitus does not act alone. For Bourdieu, practice results from a dynamic relation between field and habitus, more specifically, from "a relation between one's dispositions (habitus) and one's position in a field (capital), within the current state of play in that social space (field)" (Bourdieu & Wacquant 1992, p. 126; Maton 2014, p. 51-2). This relation is encapsulated in an equation (see Maton 2014, p. 51-2):

$$[(\text{habitus})(\text{capital})] + \text{field} = \text{practice}$$

Practice as the locus of these "double relations", as Bourdieu suggests (in Wacquant 1989, p. 42), can neither be reduced to the subjectivism of elevating agents' consciousness in pursuing maximum utility through rational computation, nor to objectivism where there are no actors. Instead, Bourdieu intends the idea that the practice of agents or agencies is shaped in a "field of possible" (Emirbayer & Johnson 2008; Townley 2014, pp. 47-9). Concretely speaking, a field is also structured by past experiences – choices of beliefs and actions, historical events, and practices – and field agents or agencies are faced in the current context with a range of options available and visible to them as viable. For example, the everyday practice of healthcare professionals might have a significant modifying effect on the power relations within health organisations and the rules and constraints of the healthcare field. This evolving field, in turn, shapes future possibilities – field agents or agencies tend to further practice in some way rather than others. Simply put, from a Bourdieusian sense, the healthcare field and practice within the field shape each other. Hence, to understand the perception of healthcare professionals towards hospital PPPs and their professional practices within the PPP hospital, it is a must to understand the ongoing and evolving healthcare field and subfield in which their everyday practice takes place, and the durable and transposable habitus that engages them with the field of action. These concepts will assist in explaining such questions as how healthcare professionals respond to the influx of market logic in the

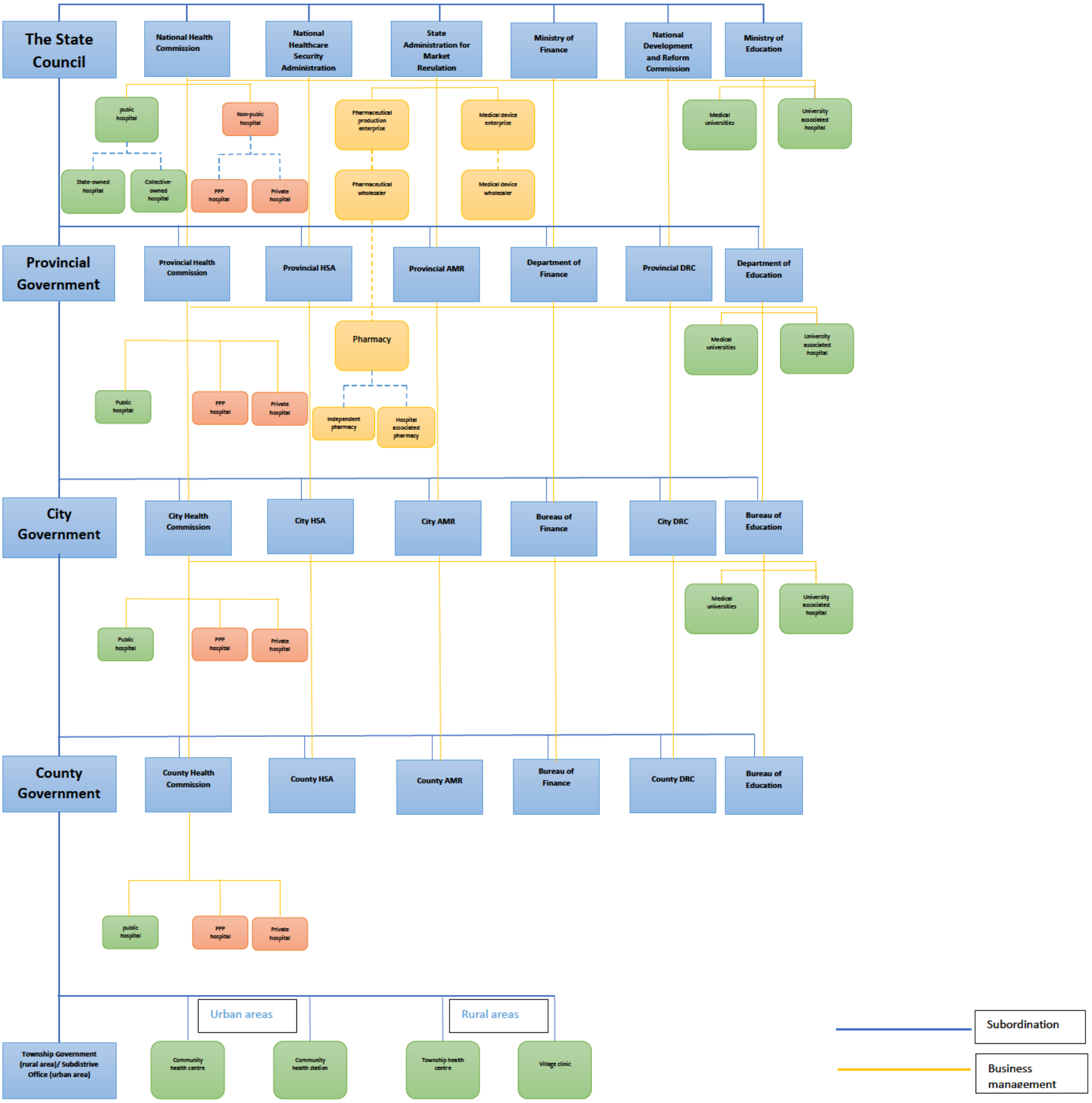
healthcare field and how their professional practice and professional autonomy are altered in this evolving field of market orientation. These questions inspire us to use Bourdieu's interlinked thinking tools (field, capital, habitus) in combination with the concepts of the medical profession, professional autonomy, and medical dominance to investigate how healthcare professionals experience measures to reduce their autonomy and increase control and surveillance under neoliberalism.

According to Bourdieu (Bourdieu & Wacquant 1992, p. 101), the field is also "a field of struggles" where agents or agencies act to preserve or transform the *current structure of the field*. The distribution of capital constitutes the very structure of the field. Some agents or agencies occupy positions that come attached with a higher level of types of capital than others and thus are positioned dominantly. For instance, some hospitals have outstanding service capability, advanced medical technology and equipment, and are research-intensive, internationally recognised and with many medical talents; these hospitals occupy the dominant positions in the Chinese hospital field. In contrast, some hospitals are poorly resourced and are only recognised in a small area. Thus, they are positioned as subordinate. Contestations mainly occur between fractions aiming to dominate, such as between the new health institutions and well-established health institutions and between the new and traditional professions. The substantial stake in contestation, according to Bourdieu, is *the dominant principle of hierarchies.* More specifically, these field agents or agencies compete for legitimate authority to define the dominant order and preserve or transform the field's current state of play (Bourdieu 1993, pp. 40-2; Thomson 2014, pp. 75-6). It is essential to mention here that the hospital as an institution should also be understood as *a space of struggles* within *the healthcare field* from a Bourdieu-inspired approach. This kind of conceptual thinking overcomes the shortcomings of the orthodox economic perspective of an institution as "a single unified actor" (Emirbayer & Johnson 2008, p. 23; Davis 2010, pp. 478-502). The understanding of the hospital as a single actor fails to consider the intra-hospital contestations between agents holding different species of capital over the legitimate principle of domination or, to put it another way, over whether this or that type of capital is to be more highly recognised and esteemed. Likewise, this approach makes it challenging to analyse such inter-organisational practices as PPPs, outsourcing, and alliances, which increasingly blur the boundaries of individual hospitals.

If we take the Chinese healthcare sector as *a hierarchically organised space of struggles,* then what *positions* do these agents occupy, and what defines *the orientation of their practices*? All the species of power individuals or institutions bring into competition within the field define their relative positions and their *strategies* in the struggle (Thomson 2014, pp. 74-5). Bourdieu uses the term *strategy* to signify the *orientation of practices* which is also referred to as "*position-takings*". From this logic, the spaces of positions and position-takings (or stances), i.e., "the structured system of practices and expressions of agents" (in Bourdieu & Wacquant 1992, p. 105), are inseparable from each other and must be analysed together. To borrow Spinoza's expression, it is like "two translations of the same sentence" (Bourdieu & Wacquant 1992, p. 105). For example, there should be a "fit" between the objective position (determined by the volume and structure of capital at their deposal) of hospital managers and the related financial and managerial strategies they adopt. The source of this homologous and mutually constitutive relation between the two spaces, argues Bourdieu, is *habitus* (Emirbayer & Johnson 2008, pp. 26-7; Bourdieu 1977, pp. 78-80). Another question is then raised concerning how habitus helps shape one's position-takings and how habitus operates within the hospital. As mentioned in the section immediately above, habitus is "a system of dispositions" structured by past experiences and life trajectories (Maton 2014, pp. 51-2). The traditional medical and new managerial professions unconsciously produce their habitus through their social origins, educational backgrounds, career trajectories and the fields they are engaged in. This differently structured habitus gives rise to varying possible position-takings by the professions, thus to the previously mentioned "field of possible". Field agents embodied with similar habitus tend to take certain position-takings as possible and consider as more desirable of this position-taking rather than an alternative position-taking. In different types of hospitals, holders of diverse species of capital, such as doctors and managers, are continuously engaged in different and sometimes opposing position-takings. As suggested in some work, doctors are usually oriented towards increasing their professional autonomy, especially in their clinical practice, while managers tend to use measurable indicators to control doctors' professional practices (Noordegraaf 2015). Understanding these contestations in the healthcare field thus requires an analysis of the positions agents occupy (capital), the habitus embodied in them, and the strategies (position-takings) they deploy.

In these struggles, according to Bourdieu (Bourdieu & Wacquant 1992, p. 101), agents or agencies generally utilise two opposing action strategies – conservation or subversion

strategies. On the one hand, dominant agents or agencies usually adopt conservation strategies to maintain the existing dominant order and to secure their dominant position in the healthcare field; subordinated agents or agencies often seek to transform the current state of power relations and the "rules of the game" to their benefit and to improve their position in the field in question. The weapons they deploy in this *field of struggle* are the species of capital in their hands. These different kinds of resources are also stakes, among the most significant of which is the capital of capacity to determine the *exchange rate* between species of capital, such as the *relative value* of economic capital as opposed to cultural capital, thereby exercising influence over the power relations of differently positioned occupants and the recognition of the legitimacy of this power distribution among them (Bourdieu 1994, pp. 4-5; Emirbayer & Johnson 2008, p. 13). This kind of capital is what Bourdieu terms "*statist capital*", which emerges through "the culmination of a process of concentration of different species of capital" within the field of the state (Bourdieu 1994, p. 4).



HRSS= Human Resources and Social Security

SAMR= State Administration for Market Regulation

DRC= Development and Reform Commission

Figure Two Chinese health administrative structure

(source: adapted from Meng et al. 2015)

The debate over state autonomy

A debate about whether the state is "dependent" or "autonomous" has constituted a dilemma facing social and political scientists (Bourdieu & Wacquant 1992, p. 111; Loyal 2017, p. 43). Marx and Engels claim that "the executive of the modern state is [nothing] but a committee for managing the common affairs of the whole bourgeoisie" (1948 [1848], p. 11). For Marx, the significant role of the state is the maintenance of the social order and in doing this, it consolidates the domination of the bourgeoisie – namely, "the owners of the means of social production and employers of wage labour" (Marx & Engels 1948 [1848], p. 46). In this sense, the state is an instrument of the materially dominant class and is without autonomy from this class. This instrumental view is further highlighted in Marx's argument, which posits that the state, together with the dominant ideology, the law, the religion and some other conceptions of the historical epoch, are part of the "superstructure" which is established upon the economic base of human society – modes of production – which is also termed as "infrastructure" (Marx & Engels 1972 [1895]). Accordingly, Marx (1970 [1846], pp. 82-7, 92-6; also see Camic 2001, 8143-4) points out that the state is designed to serve the interests of the ruling class and thus maintains and promotes the system of domination. The class with the means of material production, argues Marx (1970 [1846], 92-6), takes control over the production of ideology so that their class interests are secured. Hence, the primary function of the ideology of the state, from a Marxist perspective, is to disguise the fundamental interest of the dominant class based on an "upside-down" distortion of the truth. From the Marxist explanation, the neoliberal ideology, with its emphasis on the "free market", conceals the fundamental interests of *the bourgeoisie* and is used to justify the integration of private capital into the health sector, thus serving the interests of capitalists and the for-profit nature of capital.

Compared to Marx's interpretation, Weber's theory of the state is that it is totally autonomous. He views the state as a closed system where power struggles among parties and interest groups occur. He also claims that the state has its own administrative bureaucracies, legal systems, religious organisations, and, most importantly, the military (Weber 2004 p. li-lx). The state, argues Weber, is the only association in the contemporary context to successfully claim a monopoly over legitimate physical violence to exercise its ultimate control and maintain its rules and orders, which makes it substantially different from any

other association (Weber 2004, p. xlix). In contrast, Bourdieu does not reduce the state to a mere instrument serving the interests of the materially dominant class, as Marx does, nor does he consider the state as a closed system with absolute autonomy and a clear, well-defined boundary as Weber does. Bourdieu, however, clearly points out that:

> "What we encounter, concretely, is an ensemble of administrative or bureaucratic fields (they often take the empirical form of commissions, bureaus and boards) within which agents and categories of agents, governmental and non-governmental, struggle over this peculiar form of authority consisting of the power to rule via legislation, regulations, administrative measures (subsidies, authorisations, restrictions, etc)."
>
> (Bourdieu & Wacquant 1992, p. 111)

Bourdieu (2014, pp. 5-6) claims the Marxist tradition defines the state by what it does and what functions it fulfils; and argues this kind of functionalist interpretation of the state fails to pose the problem of the structure of the state or the mechanism of the state for fulfilling its functions –namely, the existence of the state itself. Another weakness of this interpretation lies in the way it downplays the positions and position-takings of both the state and societal agents and agencies, such as government ministries and their relations of inequality both within the state and in the general field of power. Weber has an interest in the function of symbolic systems – unlike Marx. Instead, Weber examines the producers (or agents) of symbolic products (such as religious messages in the religious field) and the interactions and struggles between these agents, as well as the interests that drive them and strategies deployed in the struggle (in Bourdieu 1994, pp. 15-6). As for the state, Bourdieu (2014, p. 4) borrows Max Weber's definition of the state as "[the] monopoly of legitimate violence" and develops the symbolic aspect of the state more strongly (Bouridue 2014, p. 128; also see Bourdieu 1994, pp. 15-6), and defines the state as holding "the monopoly of [the] legitimate use of physical and symbolic violence over a definite territory and over the totality of the corresponding population" (Bourdieu 2014, p. 4). Bourdieu argues that "Domination, even when based on naked force, that of arms or money, always has a symbolic dimension" (Bourdieu 2000, p. 172). This argument does not lead Bourdieu to deny the use of physical power; alternately, it reminds us of both the state's material and symbolic aspects. The state, according to Bourdieu, undertakes a process of accumulation and concentration of forms of capital, such as military capital (the armed and police forces), economic capital (taxation and a series of infrastructure purchased by taxation), information capital (census data, yearbook,

archive material in different areas), and more importantly, symbolic capital, which can be objectified in codification, nomination, delegation by the state and can be any species of capital that is both socially and legally recognized, in other words, it is recognized and valued by officials and all social agents. In the Chinese state, one point to show the interdependence between physical and symbolic power, physical violence is disguised in the symbolic form (legitimate form) to prevent disqualified doctors from practising medicine and also permit qualified doctors to practice in two or more medical institutions, an edict which was issued by health administrative departments. The state, therefore, structures the social order not only through "the rites of the institution" but also through the "mental structures" with which social orders are perceived (Bourdieu 2014, p. 183).

By using the concept of the bureaucratic field and the symbolic effect of the state, Bourdieu encourages us to focus on the *struggles, power relations* and *transformations* in day-to-day practices, the specific positions (functions in particular) and position-takings (stances) of both bureaucratic and nonbureaucratic agents or agencies (Bourdieu 1992, p. 111; Bourdieu 2014, pp. 10–12, 95, 269-70, 288). Both state and non-state agents may access the bureaucratic field, which is determined by the forms of capital they hold. In sum, Bourdieu's state theory leads to a "process-oriented" analysis of actors in action when trying to understand the privatisation and PPPs in the healthcare field.

In the case of Chinese health policy, it is historically formulated in a certain period and located in a particular situation, and it can change from space to space and over time. It has undergone a pendulum-like movement between the public and private sectors in funding and the provision of health services since the 1980s. These changes have emerged along with the tension between the government-oriented and the market-oriented policies of the Chinese state. As shown in the transitions of China's health policy since the 1980s (this has been explained in the Introductory chapter), the state health policy area appears as a site of continuous struggle between powers possessed both by the private sector (pharmaceutical companies, private and Public-Private-Partnership hospitals, insurance companies, etc.) and the public sector (health-related ministries, local governments, public hospitals, etc.). More than conflicts and struggles, these healthcare spaces of force relations between positions also present in the form of more or fewer coalitions and cooperation. The private actors, for instance, may establish alignment with other bureaucratic actors of similar preference in the

policy orientation, working to direct the state health policy, which is according to their interests, values, and resources. Above all, the state is not an isolated and monolithic system apart from society. The state in the healthcare field is more than the constituent organisations and actors involved. The privatisation and PPPs in the Chinese healthcare field should be understood as a process of both state and societal agents in practice – a process of negotiation, contest and collusion changing with specific time and space. Our analysis of this process then needs to be served with Bourdieu's theory of practice, accompanied by his theory of the state.

Summary of the chapter

This chapter has pointed out the importance of investigating privatisation and hospital PPP phenomenon as a process of both state and societal agents in practice rather than rational choices, Marxism's economic determinism or Weberian action outcomes. Rationalist theory has proven to be insufficient to explain the worldwide and continuous popularity of hospital PPPs in the face of conclusive evidence, which is followed by "a splintered logic" – a logic for the public good and a free market logic for maximum profit – between public and private bodies in the contractual relationship. This argument leads us to a transition from the "economics of PPPs" to the "politics of PPPs", focusing on the role of the policy-maker – the state and its relations with the market. Unlike Marxism, where the state is merely a superstructure and without autonomy, or the Weberian explanation, where the state is a well-defined entity with a clear boundary and absolute autonomy, Bourdieu's conception of the state is a relatively autonomous and open field, which not only shapes social actions but is also shaped by the practice within the field and in interaction with other more or less powerful fields. Bourdieu's conceptualisation overcomes the weakness of existing theorisation of privatisation and PPPs – the dichotomy between objectivity and subjectivity, between the social structure and individual agency. Following Bourdieu's logic, market-oriented change in the Chinese healthcare field could be internalised in healthcare professionals and other healthcare stakeholders through habitus. In turn, these market-oriented norms and values are externalised in the healthcare field and a broader social structure, as these market logics, together with other forms of capital, are deployed by agents to maximise their positions, and, thus, relations of power within the field are altered. This

also enlightens us to make sense of professional autonomy and medical dominance as a dynamic process of both state and societal agents in action.

Overall, through a critical examination of the perspectives of orthodox economics, pluralism and Marxism, the chapter reveals the problematic locus of existing literature, specifically, the way it narrows the focus to either the structural context of privatisation and PPPs or the actions or inactions of the state and societal actors within the policymaking sphere. Even though Bourdieu's work was developed in the French context, its suitability in the Chinese state and the Chinese healthcare field needs to be examined. Bourdieu's inspiration of "relation between…" leads us to some questions that remain to be explored: First, what relationships have there been between the bureaucracies, the political arms of government, and the healthcare field over time in China; second, how has the Chinese state introduced PPPs into the Chinese healthcare field; third, how do healthcare professionals and other healthcare stakeholders perceive and experience hospital PPPs; fourth, how have the practices of societal agents shaped the healthcare system itself. Two key areas of research in this study are neoliberal changes in the state and the resonance between these changes and the everyday world of those in the healthcare system. These changes, in some way, have created a new managerial profession. The attention is then focused on the distinction between the traditional medical profession and the new managerial profession and how their interaction is influenced by the overall policy shift. An empirical study needs to be conducted to address these questions. Chapters four, five, and six are devoted to addressing these questions. The next chapter will discuss the methodological approach used to conduct the empirical study.

Chapter Three - The Study

Introduction

Chapter two offers an analysis of theoretical explanations underpinning the worldwide policy shift towards the privatisation and PPPs in health services and proposes a theoretical explanation for this policy process. It argues that existing literature presents a problematic locus – the way the state and the healthcare sector are conceptualised. Bourdieu's interlinked concepts of field, habitus, capital, practice, and the state are introduced to bridge these problems. The chapter points out questions that remain unanswered – how the Chinese state introduced PPPs into the healthcare sector and how healthcare professionals and associated political and market agents perceive and experience hospital PPPs. It concludes with an argument for an empirical study to address these questions, that is, for an examination of the privatisation and hospital PPP phenomenon in China as a dynamic process of state and societal agents in action.

This chapter details the research design employed in the study to address the above needs and the research questions. The second section explains Bourdieu's three-level field analysis as a methodology for guiding the research. This is followed by section three - a description of the qualitative case study approach selected for the empirical examination and of the choice of interviews and documentary analysis for data collection. Section four gives an account of the method of thematic analysis developed for this research, with a focus on the three stages of coding, categorising, and thematic identification. In the fifth section, strategies used to enhance the study's validity are explained. The emphasis is on the requirement of reflexivity within the context of the social conditions imposed on the researcher-researched relationship by the researcher's lived and educational experiences.

According to Bourdieu's three-level field analysis, the researcher first uses documentary analysis to trace the historical development of the Chinese healthcare field with regard to hospital PPPs, with a focus on the practice of the state in this policy process and its effects on

the power relations within the healthcare field. The researcher conducted this study by talking directly with people who work in hospital PPPs, as well as other stakeholders with relevant information and knowledge about hospital PPPs, to understand the way in which hospital PPPs impact health professionals and other societal agents, how those arrangements shape their ideas and actions, and how those actions reconfigure the healthcare field itself. A qualitative case study was chosen since it is impossible to fully comprehend the healthcare professionals' experiences at PPP hospitals without considering their context and surrounding political and economic conditions (Hafiz 2008; Yin 2009b, pp. 41-6). The main source of information for this study came from semi-structured key informant interviews. The positions of various actors, the dispositions they assume, and the stances and strategies they adopt were analysed and compared. The data were analysed to show the nature of the competitions between these actors, the various types of capital in action, and the interests and stakes within the contestations.

Methodology

Bourdieu recommends as a first step to map out the field in question. As described in chapter two, there are historically and hierarchically structured relations between positions occupied by various actors in the Chinese healthcare field. The various systems of dispositions of these agents (or agencies) should be analysed along with their field positions, the field structures they are or were located in, and their degree of affinity to or distance from the dominant pole of the field of power. Their habitus might match or mismatch with the dominant "rule of the game" in the field. In this study, this kind of "playing" back and forth between field and habitus allows more attention to be paid to such elements as the medical profession's biography, training trajectory, and working experience with respect to the underlying logic of their practice within the field (Grenfell & Lebaron 2014, p. 26). The Chinese healthcare field should also be examined through a focus on the competition between field agents over the legitimate authority that defines the *dominant principle of hierarchies* within the field, according to Bourdieu's approach (Grenfell & Lebaron 2014, p. 25-6). An examination of the Chinese healthcare field as *a field of struggles* enables an insight into the resources (volume and configuration of forms of capital) that the field agents bring into the struggles, the strategies (a manifestation of the orientation of practices, also referred to as position-takings) they deploy, and the interests and stakes in the contestation. These individuals or institutions

compete for distinction and domination by pursuing a specific form of capital that is most recognised and valued according to the defining principle in the field in question. This in-depth investigation of struggles helps reveal the objective structure and the nature of a specific field (Bourdieu 2000, pp. 152-3).

In sum, by adapting Bourdieu's (in Bourdieu & Wacquant 1992, pp. 104-7) three necessary steps for researching a particular field into this study, the examination of the PPP phenomenon in the Chinese healthcare field follows three levels: (1) analyse the position of the Chinese healthcare field vis-à-vis the field of power, the field of the Chinese state in particular; (2) map out the objective structures of the relations between the positions occupied by the medical profession, healthcare managers, public and private/ PPP hospitals and other associated political and market agents (or institutions) which compete for the legitimate form of specific authority of which the Chinese healthcare field is the site; and (3) analyse the habitus of healthcare professionals and associated political and market agents in relation to the changing healthcare field with the emergence of the hospital PPP phenomenon.

Data collection

Why a qualitative study?

Bourdieu's three-level field analysis emphasises relations between the objective social structures and the lived experience of individual agents, between spaces of positions and position-takings (Bourdieu & Wacquant, 1992, p. 11). Swanborn (2010) roughly divides strategies to study social phenomena into "extensive approaches," such as a quantitative variable-centred approach, and "intensive approaches," such as a qualitative case-centred study. In an extensive approach, a large set of instances of the phenomenon are used to explain the phenomenon and ground the conclusions in forms of, say, distributions of frequency or relations between variables. Alternatively, in an intensive approach, a specific instance or a handful of instances provide in-depth information about the phenomenon (also see Creswell 2013, p. 47-8). This study employs a qualitative approach as it offers an in-depth understanding of privatisation in the Chinese healthcare field and the hospital PPP phenomenon. Qualitative research, according to Sandelowski (2004, p. 893), encompasses a wide range of approaches to, and strategies for, conducting inquiries and uncovering how human beings comprehend, perceive, interpret and create social reality. Qualitative

approaches usually focus on words over numbers in the collection and analysis of data (Bryman 2008, p. 366). In order to explore how healthcare professionals and associated political and market agents experience hospital PPPs; how this new arrangement shapes their ideas and actions; and how their actions reshape the healthcare field itself; the investigation engages directly with the people working in PPP hospitals and others with useful knowledge and information about hospital PPPs. These details cannot be accurately measured or acquired from the existing literature. Moreover, the qualitative approach enables the investigator to gain insight into how people engaging in hospital PPPs make sense of this phenomenon and provides details of what is happening in the healthcare field surrounding hospital PPPs.

Documentary analysis

Over time, in the Chinese healthcare field, agents in hierarchically structured positions displayed or are displaying an ensemble of dispositions and orientations when playing the game, whether governmental officials, public or private doctors, nurses, or managers. Thus, the changes that emerged in the Chinese healthcare field over time have everything to do with the historically formulated structure of the field, and documentary analysis provides a detailed description of background information, policy shifts, past events and historical insights associated with the hospital PPP phenomenon. In other words, it traces the historical trajectory of the Chinese healthcare field where hospital PPPs emerged. In Merriam's (1988, p. 118; also see Bowen 2009, p. 29) words, "documents of all types can help the researcher uncover meaning, develop understanding and discover insights relevant to the research problem". Unlike interviews, documentary evidence is stable and outside the influence of the researchers (Yin, 2009a). These documentary materials allow the researchers to show how multiple sources of evidence integrate into one case study and present a coherent or conflicting picture. Integrating multiple sources of evidence is a general principle for qualitative studies known as "triangulation" (Yin 2009a; Maxwell 2009). This is also a strategy to better assess validity by reducing the limitation of only one information source (Maxwell 2009).

This study adopted the READ approach for documentary analysis by preparing the materials, extracting data, analysing data, and distilling the findings (Daglish et al., 2020). First, based

on the research questions, inclusion and exclusion criteria were established. The key decision being made here was to include national health policy on privatisation and PPPs and to exclude policy documents in specific regions or provinces as the latter vary from province to province and were less likely to represent the overall policy process. These documents were divided into two categories: (1) Policy or official documents on privatisation or PPPs since 1978. (2) Official documents or news reports on changes caused by privatisation in the system. The main sites selected for searching were: WHO, www.gov.cn, nhc.gov.cn, stats.gov.cn, and People's Daily. There was a follow-up on references to other documents when available.

Inclusion criteria

- Health policies or official documents on privatisation or PPPs published since 1978.
- Official documents or news reports concerning changes after privatisation in the health system.

Exclusion criteria

- Policy documents restricted to specific areas or provinces.
- Policy documents issued before 1978.
- Document content not relevant to privatisation or PPPs in the health system even though it may contain the "key words".

Documents used in this study mainly include health policies regarding Chinese Health Reform, focusing on privatisation and PPPs in the healthcare field, and news reports concerning changes occurring in the Chinese healthcare field, especially changes in the relationship between various actors. Particularly useful are official reports and statements by health ministers, and the distribution of health institutions of different types published in the *China Health Yearbook* over time, as well as data concerning the distribution of government expenditure of different periods published in the *China Statistic Yearbook.* The third step was developing a data extraction form to *capture* (1) the basic data of the document, such as the issuing agency of the document, date and title; (2) the content of the document relevant to privatisation or PPPs, such as whether privatisation or PPP is encouraged and associated policy approaches (please see Appendix H for an example of a data extraction form).

Thematic analysis was chosen as the method for analysing these documents. Thematic analysis refers to:

> "A method for identifying, analysing and interpreting patterns of meaning (themes) within qualitative data [...] Thematic analysis (TA) can be applied across a range of theoretical frameworks and indeed research paradigms."
>
> (Clarke and Braun 2015)

Thematic analysis, argue Braun and Clarke (2006), can be seen as an "essentialist or realist" approach, which aims to report the reality, experiences and meanings of study participants. Second, it can also be a "constructionist" approach, which examines how various discourses in society shape experiences, meanings, realities, events, etc. A third understanding of thematic analysis, according to Braun and Clarke (2006), is a "contextualist" approach, which falls between essentialism and constructionism. Theories such as critical realism fall into this category; it acknowledges how individuals make sense of their experiences and how these interpretations are affected by the broader social context. This approach focuses attention on the opportunities and constraints of reality. In this thesis, selecting thematic analysis for the analysis of relevant documents such as health policies, news reports, and statistical data can facilitate our understanding of the process through which privatisation and PPPs are introduced in the health system. Moreover, thematic analysis focuses its attention on how a range of ideologies or discourses operating in society impinge on the process and how individuals interpret this process, all of which are the foci of this thesis.

Document data were analysed thematically. Like the analysis of the interview data (which will be discussed below), the analysis of the documents can be summarised in three phases: (1) become acquainted with the data at hand; (2) create initial codes; (3) and identify theoretical themes (Braun & Clarke 2006). In the first phase, the researcher familiarised herself with the entire data set and noted down some initial observations and interesting patterns. The second phase involved generating preliminary codes from the data. Codes refer to "the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon", as defined by Boyatzis (1998). In this phase, the researcher organised the data in a meaningful way. Figure three demonstrates how codes were applied to a segment of data from a health policy issued by the State Council in 2009.

After all data had been coded and collated, the researcher began to sort different codes into potential themes and organise relevant data extracts into these themes. In essence, it is a process of considering how various codes could combine to form a broader and overarching theme. It is also a process of bridging codes of data and the theories relevant to this study. Specifically, searching for themes helps to explain the policy process in a theoretical and structured manner. By way of an example, the codes "the Health Ministry campaigned to increase the health budget", "the Finance Ministry sought to cut health finance and encourage private capital to enter the health sector" were analysed as debates between two ministries and between left and right hands of the state. The struggle is between different interests and different perspectives on what the problem is and how it should be solved. The Chinese state is then comprehended as a bureaucratic field with embedded and conflicting interests and values.

Data extract	Code
Pilot the reform of public hospitals: increase financial input in the public hospitals and improve corporate management of public hospitals; separate ownership from regulation, separate government administration from hospital management, separate drug sales from hospital revenues, and separate for-profit from not-for-profit; increase the market share of private hospitals to 20 per cent. (The State Council 2009b)	Restate the role of the state in public hospitals; Restate the not-for-profit nature of public hospitals; Further increase the autonomy of public hospitals; Further encourage the growth of private hospitals.

Figure three: an example of data extract, with codes applied.

Case studies

A case study is an intensive approach used to investigate "a real-life, contemporary bounded system or multiple bounded systems over time" (Creswell 2013, p. 97; Yin 2009a). Stake (2005, p. 444) also points out boundedness and certain patterns of activities as two significant elements for specifying a case. Thus, certain features of a specific case can be found within the limits, while other features can be found outside the boundaries. Coming to understand how healthcare professionals and associated political and market agents experience hospital PPPs requires a thorough examination of how practices developed and were conducted in PPP hospitals and how associated agents made sense of these happenings. Compared to multiple-case studies, a single-case study is more advantageous in investigating a phenomenon at a "fine-grained level" of detail (Ozcan et al. 2017; Gerring 2004). In other words, it offers an in-depth analysis of a specific phenomenon, which pertains to the level of detail, richness, wholeness, and extent of variation an explanation covers. In contrast, cross-unit analysis, argues Gerring (2004), is more likely to explain a portion of the variance regarding a given result. A similar argument is raised by Eisenhardt and Graebner:

> "Somewhat surprisingly, single cases can enable the creation of more complicated theories than multiple cases, because single-case researchers can fit their theory exactly to the many details of a particular case. In contrast, multiple-case researchers retain only the relationships that are replicated across most or all of the cases."
>
> (Eisenhardt & Graebner 2007, p. 30)

To investigate the hospital PPP phenomenon in China as a social process of both state and societal agents in action, we need to investigate the daily practice and interactions between individuals within the PPP hospital. Equally important in this study is learning the context within which the PPP hospital is situated, how the PPP hospital responds to external policy change, how the PPP phenomenon historically emerged in the healthcare field, and how it changed and developed. To answer all these questions, we need an in-depth analysis of the PPP phenomenon in China. Thus, a single-case study approach was adopted.

This study examined one PPP hospital in Y City, China. Hospital X is a general hospital under mixed ownership in Y City, which started up in 2016. It is a non-profit, new, mixed-

ownership hospital, with full capital investment from X Medical Equipment Co., Ltd. and XX University through promotion by the Y city Government in the construction form of BOO (Building-Owning-Operation). BOO is one of the most common delivery modes of hospital PPPs. The hospital is equipped with more than 1,000 programmed beds, and serves residents both in the local area and from other provinces. As of December 2019, there had been more than 1.5 million outpatient and emergency visits, around 100,000 discharged patients, and nearly 30,000 inpatient operations. Also, the hospital performs both teaching and research tasks and was rated as a tertiary first-class general hospital in 2020. In spite of its large size, the hospital is still positioned subordinately in the local healthcare field when compared to the local public hospital group, which is evidenced by the number of inpatients and outpatients and the number of senior medical professionals (this will be discussed in more detail in chapter five). The hospital, implementing the president responsibility system[1] under the leadership of the Council, integrates the functions of prevention, health care, medical treatment, teaching, and scientific research (Li 2019, p. 12). X Medical Equipment Co., Ltd. participates in the resolutions of the Council, while XX University is responsible for the overall management and operation of the hospital. The hospital implements a full-employment system. As of the end of December 2018, the total number of employees has reached more than 1,000, all of whom are full-time employees.

At the time of the study, this PPP hospital was in the initial stages of operation and had attracted some concerns about its ownership from academics, media commentators and the general public (Li 2019; Yan 2019). In his survey of employee satisfaction towards the performance appraisal system in hospital X, Yan (2019, pp. 22-9) found that one-third of respondents (n=80) expressed dissatisfaction towards the performance assessment in hospital X, with 49 per cent of respondents considering the performance indicators as unreasonable, vague and general. A similar quantitative study was conducted by Li (2019, pp. 20-6), with a focus on the post setting management in hospital X. She surveyed 491 employees in hospital X and concluded that the average satisfaction score towards post-setting was 2.57±0.771 (out of 5), which was the lowest among six indicators (the other five indicators were hospital management, work duty, work environment, career development, salary and welfare). Li

[1] President responsibility system: Under the leadership of the Party Committee of the hospital, the president is fully responsible for the hospital's medical, teaching, scientific research and administrative management. (Hu 2017; see also Li et al., 2021)

(2019) points out that due to the extreme lack of talent among those with intermediate and senior professional titles in the newly established hospital, the personnel with junior professional titles undertake a large amount of additional work, which was the major reason for the dissatisfaction. Nevertheless, both studies lack a sufficient explanation of the reasons underpinning employees' dissatisfaction and lack an explanation for the different responses among different groups. In social media, Hospital X has been claimed to charge higher fees than public hospitals and to be, as a matter of fact, a for-profit private hospital in the clothing of a not-for-profit PPP hospital (Baidu Zhidao 2020; Sougou Wenwen 2017; BBS.DXY.CN 2022). These debates surrounding its mixed ownership, the nature of not-for-profit and employee dissatisfaction towards certain aspects led the researcher to investigate this "special" case hospital empirically. Studying what transpired in the case hospital as well as how the involved agents perceived what was happening, contributes to a better understanding of the hospital PPP phenomenon in the Chinese context.

Interviews

To build the case study, the researcher drew on interviews and followed the principle of "triangulation" to enhance validity. Key informant interviews were the primary data collection method for this project as they generated rich information about "lived experience and meaning" (Barriball & While 1994; Fontana & Frey 2005, p. 642, 695). In this study, key informant interviews assisted in making sense of how healthcare professionals and associated stakeholders experienced and perceived hospital PPPs and how their attitudes, professional practices and choices were altered with the emergence and popularity of PPPs in the Chinese healthcare field. By playing back and forth between the social space where interviewees were located and their making sense of what was happening in this social space, key informant interviews also align with Bourdieu's fundamental principle for qualitative and ethnographic research: to escape from the dichotomy between objectivism and subjectivism (Grenfell & Lebaron 2014, p. 27, 29; Bourdieu 1977; Bourdieu et al. 1999). Instead of fully structured interviews, this study adopted a semi-structured key informant interview mode for two primary reasons. First, although interviewees were provided with general directions and an elementary framework of questions, semi-structured interviews allowed the investigator to explore the ideas and opinions of interviewees regarding some areas of research interest, some contentious, complicated, and sometimes sensitive issues – some of which could not

have been foreseen by the researcher. The researcher was also able to probe for more useful information, clarify the answers through this interview process, and modify questions for subsequent interviews. Second, informants were purposefully selected to include participants who held various positions and from different professions (doctors, nurses, managers, administrators, for example) in different institutions (PPP hospitals, public hospitals, and government departments, for example). As a consequence, it was inappropriate to use a one-size-fits-all interview schedule for these informants (Barriball & While 1994).

Sampling strategy, Sample size and demographics

This study employed *purposeful sampling* (Creswell 2013, pp. 154-7), mixed with *passive snowball sampling* (Noy 2008), to select thirty-three participants in the Chinese healthcare field. This ensured a diverse range of insights into PPPs and, thus, a theoretical richness of the data, and assisted in securing access to some elite informants, such as clinical informants. Between May 2020 and Jan 2021, the investigator interviewed thirty-three participants who occupied various positions in both public and private institutions, ranging from doctors and nurses to managers, hospital presidents and government officials. According to the different social spaces within which the participants were located (within the PPP hospital or in the broader market and policy community), participants were divided into two groups:

Participant Group One: twenty-two participants in the PPP hospital were selected for their working experience with PPPs, among which nine were doctors, six were nurses (including three matrons), three were administrators, three were senior managers, and one was vice president. Within a PPP hospital, directors, managers, doctors, and nurses hold first-hand experience of a PPP in the hospital system. Including them in this investigation assists in revealing some of the conflicts and challenges a PPP may present in the hospital system. It is noteworthy that an essential selection criterion for group one participants was that they should have working experiences both in public hospitals and the selected PPP hospital. This criterion was introduced to compare participants' feelings and experiences working in different types of hospitals and explore how their thinking patterns and actions were altered with the changing work environment. Each type of hospital has its own 'rules of the game'.

For example, privately owned hospitals (including PPP hospitals) generally have higher profit-generation pressure (Tang et al. 2014) than public hospitals. Seen from Bourdieu's perspective (Grenfell 2014, pp. 50-1), the habitus of participants is structured by their past and present circumstances. In other words, their habitus is structured by their past experiences in public hospitals, and they carry within them their history to the current circumstance and practice in certain ways rather than others. Therefore, to understand how participants think and act in the PPP hospital, it is important to understand their habitus in relation to the fields they were and are engaged in. The years of employment in public hospitals ranged from one to thirty years, and that of the PPP hospital from half a year to four years. Three of the participants had left the PPP hospital for positions in public institutions, and one worked in a private hospital at the time of the interview. Group One participants were also selected from different departments and positions in the PPP hospital to maximise sampling variety. This type of approach is argued by Creswell to increase the likelihood of different perspectives associated with different positions being included in a study (Creswell 2013, pp. 156-7).

Participant Group Two: eleven participants were selected from the broader healthcare market and policy community for their knowledge, information, and perspectives towards hospital PPPs. Participants were healthcare professionals in public and private hospitals and were public or private doctors, senior managers, hospital presidents, government officials in the health departments, academics or experts from medical universities, and policy think tanks. There was one private hospital manager, one public hospital president, one senior manager, one administrator, three public doctors from four different public hospitals at the tertiary level, two government officials from the local Health Commission and the local Food and Drug Administration, respectively, one official from the local government, and one staff member from the local Centre for Disease Control and Prevention. It was worth mentioning that participant 13 was a CEO of a newly-built for-profit private hospital at the time of the interview. Before joining the private hospital, he had worked as a senior manager in the (case) PPP hospital for three years and as a professional manager in a private medical investment company for five years. Participant 17 was an expert advisor for The Health Commission of the local area and a public hospital manager at the time of the interview; before this, he was involved in the building and early operation stages of the case PPP hospital. Thus, these two participants in Group One overlapped with Group Two. These

participants were interviewed because they were or had been particularly active in the space of the healthcare market or health policy or associated areas and were able to discuss hospital PPPs and the policy environment from the basis of their experience. Participants in group two also had a good knowledge of the selected hospital PPP so that the objective relations between these positions occupied by the public or private agents or agencies and the PPP hospital could be explored.

In the context of this study, there were only a very limited number of potential participants who had experience and knowledge of hospital PPPs. In addition, healthcare professionals were usually overloaded with clinical work, especially in the time of the COVID-19 outbreak in China (2020). Therefore, the likelihood of direct interview invitations for potential participants was significantly reduced. To gain access to the PPP hospital and potential participants, the investigator thus mainly used a personal network to find appropriate gatekeepers for each group. Gatekeepers, as defined by Kawulich (2011, p. 58), are "individuals who have some power over the research location and have the ability to control access to a research site and contacts with potential study participants". In this study, the researcher selected two gatekeepers for Participant Group One: an administrator working in the PPP hospital (gatekeeper one) and a retired professor from xx Medical University (gatekeeper two), the public sector body in the contractual relationship. These two gatekeepers used to work or are working with potential participants in Group One, thus have direct connections with potential participants and are very knowledgeable about the potential participants and the positions they occupied in the PPP hospital. This also facilitated the sampling variability of the study. For Participant Group Two, the researcher selected a public hospital president (gatekeeper three), a public hospital administrator (gatekeeper four), and an administrator working in the district-level health commission of the local area (gatekeeper five). These three gatekeepers were selected to gain access to public and private hospital doctors and nurses, managers and presidents (public hospital managers and presidents were mainly accessed through gatekeeper three), and participants in the policy community. It is noteworthy that gatekeepers two and three worked for both groups as they had worked in the local healthcare system for more than twenty years (gatekeeper two was also a member of the think tank of the local health commission), thus having established connections among hospitals and the policy community.

The gatekeepers assisted with identifying the potential participants within and outside the PPP hospital according to the criteria stated above. Gatekeepers were not in direct supervision relations with potential participants, which meant they had no absolute power over potential participants, thus guaranteeing their voluntary participation. Passive snowball sampling was used, in which the researcher did not ask gatekeepers for a potential participant's identity or contact information. This process was replaced with the investigator providing recruitment information directly to the gatekeepers, who in turn provided it to their networks or possible participants. Once interested, these potential participants could contact the investigators directly. This was to protect the potential participants' identity/confidentiality and promote voluntary recruitment. It was essential to realise that gatekeepers may have their own preferences and agendas; the investigator, therefore, did not let the gatekeepers decide who would finally be interviewed (Chaudhuri 2017; Devers & Frankel 2000).

Table one: Demographic information of participants

Num	Occupation and department	Years of employment as of 2020 (public hospital/ PPP hospital)
Group one		
2	Administrator, Science and education department	1/3
3	Administrator, Hospital Infection-control Department	2/5
4	Head nurse, Rehabilitation Department	5/3
5	Nurse, Rehabilitation Department	1/3
8	Deputy Director (doctor), Pharmacy Department	4/4
9	Doctor, Orthopaedics Department	1.5/4
10	Doctor, Rheumatology and Immunology Department	7/3
11	Nurse, Nursing Department	9/3
12	Administrator, Medical Administration Department	1/4
13	Director (senior manager), Hospital Infection-control Department; for-profit private hospital CEO	5/3 (4 years in a private hospital)
16	doctor, Hospital Infection-control Department	15/1
17	Senior manager; expert advisor for The Health Commission of the local area	30/5
18	Head nurse, Hematology Department	7/5
19	doctor, Emergency Department	3/2
22	Nurse, Thoracic Surgery Department	15/3
23	Head nurse, Cardiology Department	14/4
24	Senior manager of the PPP hospital	24/5
25	Doctor, thoracic surgery department	2/4
26	Doctor, hepatological surgery department	13/4
27	Doctor, ophthalmology department	1/3
28	Doctor, urinary surgery department	10/3

31	Vice president	31/5
Num	**occupation and institution**	**Years of employment as of 2020**
Group two		
1	Public hospital administrator	4
6	Staff in the Centre for Disease Control and Prevention	2
7	Public hospital doctor	6
14	Official in local Health Commission	10
15	Deputy director in a public medical university; public hospital president	18/5
20	Public hospital senior manager	15
21	Public hospital doctor	3
29	Official in local government	6
30	Public hospital president; an official in local Health Commission and local Food and Drug Administration	21 /4 /12
32	Private hospital manager	8
33	Public hospital doctor	1

Implementation of interviews

Following approval by the Human Research Ethics Committee at the University of Sydney, semi-structured, in-depth interviews were conducted with thirty-three key informants between May 2020 and Jan 2021. These interviews aimed to capture the views and experiences of participants with PPPs in the Chinese hospital system and the problems or challenges PPPs present. For Participant Group One, interview topics included their experiences with PPPs in the selected hospital, perceptions of PPPs, especially compared to that of the public hospitals, challenges or conflicts PPPs present and advice on the problems. For Participant Group Two, interview topics mainly included their understanding of PPPs (especially the selected hospital), the market and policy environment hospital PPPs face, and their views on how *the mixed-ownership hospital system is funded and organised*. The interviews were open-ended to allow the pursuit of interesting ideas generated during the process. Due to the diverse circumstances of the participants, an interview guide was prepared and customised for each one before the interviews. The guide detailed the time and place of the interview, the interviewer, the interviewee, the position, and the institution of the interviewee. The most crucial component of the guide was vital topics to be discussed in the specific interview. For instance, when discussing doctors' experiences working with hospital PPPs, the investigator focused more attention on their experiences with receiving and treating patients and their relations with nurses, administrators, and managers in the working context. While for managers, especially senior managers in hospitals, besides their working relations with other healthcare professionals such as clinical staff, the investigator also sought to bring to light their ideas and perceptions of how the hospital was operated, financially organised and how personnel were managed. The guide helped display a logical flow of interview questions and sub-questions to discuss. Some relevant topics identified in earlier interviews and the preliminary data analysis were included in later interviews. Interviews lasted approximately one hour and were conducted by the investigator over WeChat video or audio. Online interviews facilitated access to participants who were based overseas and were alternative methods in a time of COVID-19; the investigator was in Australia and unable to return to China for face-to-face interviews during COVID-19 as a result of the travel ban and safety considerations**.** With participants' consent, the interviews were recorded using a digital audio recorder or field notes to ensure accuracy. The audio was fully transcribed, and participants were asked to review and approve that transcription before analysis**.**

Ethics consideration

To ensure the research was conducted ethically, this study first sought and obtained approval from The University of Sydney Human Research Ethics Committee (HREC) (Project No.: 2019/1013, please see Appendix A). The HREC reviewed the research proposal, mainly outlining the theoretical and empirical basis, background evidence, the research aims and questions, sampling and recruitment strategies, interview topics and safety protocols. In accordance with the approval letter, written permission was obtained from the selected PPP hospital to conduct interviews within the hospital, and the approval letter from The University of Sydney HREC, which detailed the project title, authorised personnel, approval period and conditions of approval was also submitted to the PPP hospital for their information and archiving. In order to avoid real or perceived coercion, this study made initial contact with potential participants using WeChat to ascertain participants' willingness. The invitations were accompanied by a Participant Information Statement (Group 1 and Group 2; please see Appendix B to E) and a Participant Consent Form (Appendix F and G) approved by the ethics committee. The Participant Information Statement showed potential participants the aim and scope of the research, why they were invited to this study, what the study would involve, and their freedom to withdraw from the study at any time during the research. Importantly, the principle of voluntary participation was emphasised at the beginning of the information statement and applied in the fieldwork process. After reading the Participant Information Statement, two potential participants selected for Group Two outside the PPP hospital declined to engage in the research due to the political sensitivity of the topic. The investigator thanked them for their interest in this study and welcomed their potential participation if they changed their minds. Before the interviews, participants who agreed to take part in the study were asked to sign a Participant Consent Form or provide consent through audio recording or field notes for the interview to record, transcription, and their willingness to be contacted for further studies.

Ensuring the confidentiality of participants' information and identities was crucial. Some of the interview topics discussed and material used in this study were sensitive, and a breach of this confidentiality might place participants in a disadvantageous position in terms of employment. Therefore, identifiable information about participants, institutions, and geographical locations has been removed. Instead, pseudonyms were employed for individuals (in the form of

participant numbers), and anonymous descriptors were used for their occupations (e.g., doctors, nurses, managers, hospital presidents, government officials) and types of institutions they were in (e.g., public hospitals, PPP hospitals, private hospitals, private companies, government departments such as the local health commission). For example, the descriptor (participant 1, doctor, PPP hospital) refers to a participant who was a doctor working or had worked in a PPP hospital. The specific locations and institutions involved in this study are represented anonymously (X company, Y city).

Data analysis

Data were analysed thematically. As indicated above, preliminary data analysis was conducted after each interview using listening, reading and memos. Listening and reading helped obtain a sense of the tape recordings and the interview transcript, especially the interview context, including silences, hesitations and the tones of the interviewees' voices. Memos facilitated by OneNote software were used to identify organising ideas and gaps, which could guide subsequent interviews (Agar 1980, p. 103; Creswell 2013, p. 183). Initial analysis towards the end of data collection also helped to indicate whether theoretical saturation had been reached. Saturation means that no additional data are being found whereby the sociologist can develop properties of the category (Glaser & Strauss 1967, p. 61). When similar instances were observed repeatedly, for example, instances of "managerial capital acquired by managerial professionals" (such as "high administrative efficiency", "communication skills", "grant application tools", and "care for employees" in the PPP hospital) were observed over and over again, the researcher gained confidence that the category was saturated. If the instance revealed a new property of the category, it was added to the memos and integrated into the theory (for a detailed discussion of the application of theory saturation in qualitative analysis, please see Glaser & Strauss 2017, pp. 60-2, 112-3; also see Nascimento et al. 2018). This process of preliminary data analysis and immersion in the data enabled the researcher to gain a relational sense of the "full picture" of the evidence and matters to be examined by connecting disjointed parts of interviews played by the interviewer and interviewees from various positions and institutions. Additionally, the researcher could avoid an overwhelming situation where she had to confront voluminous interview data at the end of data collection (Creswell 2013, pp. 182-3; Green et al. 2007, p. 547).

The next step consisted of coding data into themes. A coding framework was established upon the data and relevant studies. Codes and themes were revisited and revised during the process of data collection and data analysis (Willis et al. 2007). Nvivo software and OneNote were used to organise and code data. This section focuses on the three stages of coding, categorising, and theme identification. This four-stage analytical approach (including the previously mentioned immersion in the data by reading, listening and memoing) used in this study was enlightened by the works of Creswell (2013, pp. 179-213), Willis et al. (2007) and Green et al. (2007). The four-stage analysis was not a strictly linear approach. Instead, the researcher engaged in a back-and-forth process between the different stages when analysing the data.

The process of relational and meaningful coding

The next stage consisted of describing and classifying the data by tagging and labelling the data segments across the database. These segments could be words, sentences, or paragraphs and could be attributed to different codes and categories; the same code could also be repeatedly applied to different segments and across the database. For the investigator, the heart of this step lay in describing *the meaning of the point* made by participants and, more importantly, the *context* under which this statement was made. For example, participant 19, who is a doctor in the PPP hospital, talked about the "higher payroll" (including both "base pay" and "merit pay") obtained in the PPP hospital than that in the public hospital where he used to work. The investigator then associated "higher payroll" with the participant's identity, his occupation, and the context of the conversation. By this means, the investigator made notes at the margin of the associated sentences about "the discrepancy in salary between doctors in the PPP hospital versus public hospitals".

Another example was "millions of annual pays (for senior doctors)" raised by participant 3, who was an administrator in the PPP hospital. This participant thought of this handsome salary as one of the "advantages in talent introduction" of the PPP hospital compared to public hospitals, as local governments set payment limits for senior public doctors. The

investigator then added the context meaning to this code and labelled it as “millions of annual pays (for senior doctors) which was considered as advantages in talent introduction, in comparison with public hospitals” and “payment limit set by the state for senior public doctors” on the associated paragraph and marked this area in the same colour to display the associations between codes. This process of relational and meaningful coding not only allowed the investigator to know what participants were talking about but, more importantly, the context and meaning of what they were saying. This second step of data analysis was essential and laid the foundation for the next step of creating the categories.

The emergence of coherent categories

At the previous stage of coding, 108 codes were generated in total. This diverse range of codes was then revisited and entirely re-examined to find how these codes could be related to form several coherent categories. This step could be understood as a more substantial examination of the relations between codes. Participants usually had quite different and sometimes antagonistic perspectives and experiences towards specific aspects of hospital PPPs. The investigator then classified these diverse codes and sought to explain the differences and distinctiveness according to the context of this statement. By way of an example, among a cohort of healthcare professionals who had worked both in public and PPP hospitals, some talked about “higher payroll” in the PPP hospital; some mentioned “millions of annual pays (for senior doctors)”; some frontline doctors and administrators, however, felt that the financial return on their time and energy invested in the work of the PPP hospital was not enough, especially when compared to public hospitals. Such descriptive codes as “higher payroll”, “millions of annual pays (for senior doctors)”, and “not enough financial return for (some frontline doctors and administrators)” could be linked together and put under the category of “financial reward”. This category could be associated with another category of “over workload”, under which statements such as “work longer hours” and “an extensive range of clinical and administrative work” were being made. As was pointed out by Green et al. (2007, p. 548), there reached “saturation” of categories when participants’ experiences and perspectives could be explained in a coherent and logical manner by the data having been collected. Otherwise, the investigator would have to return to the data collection stage to recollect associated information and form a compelling chain of logic. The investigator interviewed one administrator who was involved in the building and operation stage of the

PPP hospital twice, and used passive snowball techniques to interview one expert who was a member of the very original team of the PPP hospital to clarify the reason why the PPP hospital adopted a not-for-profit nature (this will be discussed in chapter five). This categorisation stage assisted the researcher with coherently making sense of participants' ideas and experiences and explaining the context where exceptions occurred.

The arrival of theoretical themes

This step went beyond categories as it bridged categories of data and the concepts and theoretical framework relevant to the study. In other words, the identification of themes provided a structured and theoretical explanation or interpretation of the issues under examination (Green et al. 2007, p. 549; Willis et al. 2007, pp. 438-9; p. 442). It was at this stage that the researcher was able to generalise the findings to other contexts or social groups. In this study, for example, to bridge the categories of "financial reward" and the "irreplaceable position of senior doctors" and the reason why these categories were significant, the researcher turned to Bourdieu's concepts of "capital" and interpreted these benefits gained by doctors as symbolic capital. This study argued that the medical capital accessed and collected by doctors was realised by the use of the title such as "licensed medical practitioners" and "senior doctors": this not only brought them material profits but imposed a "system of meaning" on the healthcare field and brought them legitimation, recognition and symbolic profits. This step of theoretical themes enabled the researcher to gain a relational understanding of participant's experience under the categories of "financial rewards" and "irreplaceable positions of (senior) doctors" and locate these experiences in a border and meaningful context under which similar experiences were reported, thus providing more substantial evidence for understanding specific social phenomena. Another example is the category of "a set of business-like management techniques", under this category, a clock-in system and separated risk management focusing on data and indicators were analysed as strategies deployed by the new managerial profession to restructure medical habitus and the *Doxa* over the workplace according to market logic**.** The PPP hospital was subsequently understood as a space of struggle between the new managerial profession and the established medical profession over professional practice and over the conditions of the workplace. In this case, Bourdieu's conception of *Doxa* in relation to field and habitus helps us understand different rules contesting for legitimacy over the work and workplace.

Validity and reflexivity

For Bourdieu, any theoretical view of the social world, including that of the author and the researcher, is, first of all, a point of view**,** that is, a view taken from a specific point or position in the social space. This means points of view taken from various points of the social space tend to conceive the social world differently and even oppositely (Bourdieu 2004, p. 95). As is interpreted by Grenfell (in Grenfell & Lebaron 2014, p. 29), there involves a "*symbolic assertion of truth*" embedded in different and antagonistic points of view in their struggle over legitimation and recognition. In Bourdieu's words,

> "Individual A's perception is to B's perception as A's position is to B's position, with the habitus making the connection between the space of positions and the space of points of view" .
>
> (Bourdieu 2004, p. 95)

This is the reason Bourdieu considers any theory of knowledge both political and ontological and that without making sense of the point of view of the researcher as opposed to the researched and the space of the research, making sense of the practice of the researched would probably be an illusion and less trustworthy (Grenfell & Lebaron 2014, pp. 29-30). Bourdieu proposes a method of "*objectivating the subject of objectivation*", namely reflexivity, to make sense of this (Bourdieu 2004, p. 88-9). As is argued by Bourdieu (2004), reflexivity has everything to do with the social conditions of possibilities and constraints of these experiences imposed on the relations between the researcher and the researched.

The researcher of this study was born in a small county located in the southwest of China. The county was more than 400 kilometres away from Y city, which was the provincial capital city and the place where the fieldwork of this study took place. When the researcher was around 18 years old, she and her parents moved to Y City for her undergraduate study at a municipal medical university. The researcher chose Public Affairs administration (Health Economics and Management Direction) as her major (even though her first choice was clinical medicine, anesthesiology) and finished a seven-year undergraduate and postgraduate study at the public medical university and obtained a Mater's degree in health management.

During her studies, the researcher had opportunities to do internships in the administrative department of a tertiary public hospital and a district-level health bureau. All these living, educational and working experiences associated with public institutions, hospitals, health administrative departments and the local healthcare system enabled the researcher to deploy an "*insider*" position when interviewing participants in the local healthcare field. In this study, more than half of the participants had studied at the same university as the researcher or had worked in affiliated hospitals of the medical university (as this medical university is the largest non-military medical university in Y city). Having shared experiences facilitated the creation of a rapport with participants. The researcher was able to correctly understand the meaning participants tried to convey and understand their community culture. To further guarantee the accuracy and credibility of the findings, the researcher solicited participants' comments on her representation of participants' meaning during the interview for their timely feedback and when doing preliminary analysis. This strategy of taking participants back to the researcher's interpretation and written analysis helped reduce the likelihood of misinterpreting the participants' answers or their views on the PPPs and allowed participants to figure out what points of significance were missing. This "back and forth" process between the researcher and the interviewees also reflected a critical principle proposed by Stake (2005; also see Creswell 2013, p. 252): participants should play an essential part in directing and acting in a case study.

The researcher's position as an "insider" with participants also contributed to establishing *trust* between the researcher and participants. This made it possible for the researcher to dig deeply into interviewees' ideas and perceptions towards hospital PPPs and the underlying reasons for their feelings, thus enabling a detailed and thick description of interviewees' sentiments and responses when analysing data. For example, a thoracic surgeon who had worked in a public hospital for two years and the PPP hospital for four years told the investigator with a sort of guilt pleasure:

> "As you graduated from xx university [...], you know that there exists a phenomenon that promotion is also offered, to a great extent, according to one's seniority and working years in the public hospital (affiliated public hospitals of xx university). [...][in the PPP hospital] in general, there is room for improvement, but it requires the

> capability to match it, which means that there is no limit (on the improvement room)..."

As is described in the quote above, the participant was willing to share his feelings of working in public and PPP hospitals regarding the promotion prospect to an "insider".

However, this kind of "insider" position also displayed some weaknesses, for it may appear that the interviewer had already obviously understood what their meaning was without further explanation, or the researcher might assume the messages the participant tried to convey. To overcome this weakness, the researcher adopted the mindset of a learner, as suggested by Berger (in Berger 2015, p. 223), and regularly double-checked the meanings participants were expressing and solicited further explanation on the one hand. On the other hand, the fact that the researcher was studying at the University of Sydney as a PhD student in Sociology and Social Policy at the time of interviews also assisted her in employing an objective "*outsider*" position, thus keeping her a slight distance from participants. Moving from an "insider" position to an "outsider" position, or more specifically, from someone who had learned health management and worked in the local healthcare system to someone who studied overseas and was equipped with some sociological theories and perspectives brought the researcher some fresh points of view when approaching the hospital PPP phenomenon. For example, she posed questions about how doctors commented on their working relations with nurses and healthcare managers in public and PPP hospitals and vice versa. This insider-outsider transition also allowed the researcher to re-examine the potential bias produced by her position as a healthcare administrator – focusing more on the way hospitals operate and how healthcare professionals are managed. Armed with theoretical instruments, as is argued by Bourdieu (2004, p. 95), the researcher was able to objectify the space of all associated points of view from a new point of view, that is, all associated positions and position-takings in the field in question, regardless of whether they were doctors, nurses, managers or government officials, or in public or PPP hospitals.

Summary of the chapter

This chapter displays the research design of this study, which was guided by Bourdieu's three-level field analysis (in Grenfell & Lebaron 2014). Bourdieu's field analysis provides a

way to bridge objectivity and subjectivity, the social structure and individual agency, by working back and forth between the Chinese healthcare field and the habitus of field agents. By investigating in-depth the competition and struggle between field agents, the objective structure of the field and what is at stake in the competitions is revealed. Moreover, it is also necessary to analyse the relationship between the Chinese healthcare field and the field of power, or the Chinese state, because the state holds symbolic capital, which has the capacity to modify the exchange rate between types of capital both within and across social fields (Bourdieu 1994, also see Grenfell & Lebaron 2014). Following Bourdieu's logic, and in order to address the practice of the Chinese state in introducing Public-Private-Partnerships (PPPs) into the healthcare field, and the working experience of healthcare professionals and associated political and market agents with hospital PPPs, this study employs a qualitative, case-centred approach. Methods used to collect data were documentary analysis and informant interviews. Analysis of documents provided detailed descriptions of background data, policy changes, historical developments, and past events related to hospital PPPs. Informant interviews enabled a detailed understanding of how healthcare professionals and market agents experienced hospital PPPs and their understanding of what was happening. Data were analysed thematically through a process of meaningful coding, coherent categories and theoretical themes. Towards the end of this chapter, strategies used to enhance the validity and reflexivity of the study were explained. The following three chapters will present the findings of data analysis.

Chapter Four - The Practice of the State: Privatisation and PPPs in the Chinese healthcare field since the 1980s

Introduction

This chapter reports on the findings from the documentary analysis. Chapter three has provided the sampling framework and analytical approach for documentary analysis. Documents identified in this study mainly include health policies on privatisation or PPPs since 1978 (See Appendix H for a description of the flow of policies regarding the privatisation of the Chinese healthcare system)., official reports or statements on privatisation by the Health Ministry (especially by the Health Minister), news reports and official documents detailing changes caused by privatisation in the Chinese healthcare field, for example, the *China Health Yearbook* and the *China Statistic Yearbook*. Chinese health policies on privatisation since 1978 demonstrate that the Chinese healthcare system has displayed a pendulum-like movement between the state and the market since the 1980s. The first policy shift took place in the context of Chinese economic reform in 1978, with reductions in public health finance and insurance coverage while opening healthcare delivery to private capital. A second shift back to the state occurred in the early twenty-first century, restating the state's leading role in basic healthcare. The hospital sector, in contrast, has shown a trend of continuous privatisation, evidenced by the state's announcement of increasing the market share of private hospitals to 20 per cent of the total available by 2015 (Zhang 2016). Meanwhile, the state introduced Public-Private Partnerships (PPPs) to build and operate hospitals, which was a strategy to further expand health investment and financing channels (The General Office of the State Council Regarding Further Stimulation Opinions on the Vitality of Investment in the social sector Guobanfa No. 21, 2017).

This chapter focuses on how the state introduced PPPs into the Chinese healthcare field and how the practices of the state and the struggles within the bureaucratic field shaped ideas and practices, opportunities and constraints within the healthcare field. Section two maps out the varying positions and position-takings of key ministries engaged in health reforms in the Chinese bureaucratic field. The narratives in this section concentrate on the conflicting standpoints of the Ministry of Health and the Ministry of Finance over the way health

services should be financed and organised. Following this narrative, section three identifies the contested field of the Chinese state within which agents and agencies struggle over "a particular form of authority consisting of the power to rule" (Bourdieu & Wacquant 1992, p. 111). Section three subsequently explains how the privatisation practices of the state altered the power relations in the healthcare field, with a close examination of how this kind of reconfiguration creates the possibility for the rise of hospital PPPs. As health service providers, Chinese medical professionals are given attention in section four. This section discusses the historical development of medical professionals in the context of privatisation. The final section concludes that the Chinese state operates as a bureaucratic field embedded with contested interests, values and attitudes. The health policy shifts between the state and the market since the 1980s are associated with the struggles between key ministries involved in health reform, the Ministry of Health and the Ministry of Finance in particular. This chapter demonstrates that the privatisation and NPM practices of the state, and the struggles within the bureaucratic field, have significantly reshaped the relations of power within the healthcare field, especially the relative positions of the public and private sectors. The traditional principle of equity operating in the healthcare field has also come under threat from neoliberalism and managerialism. All these changes have provided for the possibility of the emergence of hospital PPPs in the Chinese context.

Connections between the Chinese healthcare field and the Chinese state: Contest between ministries

In China, after Deng gained power in the political field in 1978, documents such as the *Third Plenary Session of the 11th Central Committee of the Chinese Communist Party* proposed a transition from taking the class struggle as the central task of the state to concentrating on economic construction, thus moving from a highly centralised command economy to a socialist market economy. Deng and his supporters are credited with reducing the planned economy while pursuing a market economy, opening China to foreign trade and private capital, both domestic and international (So & Chu 2016).

Since the 1980s, in the Chinese healthcare field, state policies have displayed a pendulum-like movement between the state and the market in the way healthcare should be financed,

organised and delivered. The 1980s witnessed the first policy shift from state-oriented to market-oriented, as a result of which the government reduced subsidies in the health sector and the coverage of social health insurance, meanwhile encouraging user charges and drug mark-ups to finance public health institutions. It is noteworthy that private capital underwent a transition from being squeezed out to being welcomed as supplementary to the state-run healthcare finance and delivery system during this policy shift (WHO 2015, p. 159). An essential principle during this policy shift, as stated in the *Report on some Policy Issues related to Health Reform* (The Ministry of Health PRC 1985) and *Opinions on Several Issues Related to Expanding Health Services* (The State Council PRC 1989), both approved by the state council, was the use of private capital to supplement the state-oriented healthcare system, as well as Out-Of-Pocket (OOP) payments and drug mark-ups to compensate public health institutions, without necessarily increasing government subsidies in the health sector.

The Chinese healthcare system is, of course, a product of the Chinese state in the sense of policymaking. However, viewing the market-oriented changes in the Chinese healthcare system solely as a by-product of the state's economic reform tends to ignore the different or even antagonistic positions and position-takings of agents or agencies in the policy process. In the Chinese context of the 1980s, several ministries were involved in health policymaking and governance. These ministries often have conflicting interests, with each bearing its own responsibilities. For example, the Chinese Ministry of Finance is responsible for revenue generation, administrating the national annual budget and government expenditure and drafting fiscal policy and economic regulations (The State Council PRC 2014), and its focus is financial sustainability and cost efficiency (Lieberthal & Lampton 1992). Indeed it usually has more opportunities than other ministries for decision-making about where and how to use the financial budget. Following Bourdieu's logic, this influential power in financial decision-making and budget management defines the relative position of the Ministry of Finance in the bureaucratic field, and its position also defines the orientations of its practices (i.e., position-taking). An almost perfect correspondence exists between the space of positions and position-takings (stances) of ministries, according to Bourdieu (2005, p. 110). As two cadres, Xuyi and Chen Baosen (1984, p. 279) from the Chinese Ministry of Finance point out, and Lieberthal and Oksenberg (2020 [1988], p. 106) underline, one guiding principle behind the activities of the Chinese Ministry of Finance is to guarantee a balance between financial

revenues and expenditures, which is an indicator of the stability of the national economy. The Chinese Ministry of Finance has the responsibility to advise against government overspending, including that in healthcare delivery and health risk protection, while generally advocating free trade, deregulation of the economy, and privatisation in the healthcare field (Duckett, 2011).

In contrast, The Ministry of Health (now called the National Health Commission) is responsible for policymaking on health issues and coordinating healthcare reform (National Health and Family Planning Commission PRC 2014). It is charged with the responsibility of ensuring the management of the healthcare system. Like all other healthcare systems around the world, the Chinese healthcare system is under pressure and continually requests increases in the health budget to manage and enhance the healthcare system. Qian Xinzhong, who was minister of the Ministry of Health from 1965 to 1973 (and re-instated in 1979), expressed his wish for an increase in health investment in a speech at the *National Conference of Health Directors*:

> "To prevent and cure diseases, we must concentrate our resources on tackling major challenges. We must set a deadline to eliminate certain diseases and ensure an adequate supply of personnel, money and materials to achieve desired results."
>
> (Qian 1983b, p. 32)

Qian recommended increased funds for building infrastructure and purchasing high-technology medical equipment:

> "It's absolutely necessary to buy more when the need arises. Nevertheless, we must be fully aware that subjecting ourselves to high standards in complete disregard of the current context and financial resources is doomed to fail. We can do a comprehensive assessment of what we need and what we can achieve before seeking some funds to buy state-of-the-art devices and equipment that are made in China to facilitate diagnosis, treatment and testing."
>
> (Qian 1983b, p. 33)

Further calls for an increased health budget were made by the Ministry of Health in 1992:

> "Our public health programs are for the public interest. It's expected that central and local governments should increase annual investment in these programs in a phased manner and ensure the increase in investment is higher than that of fiscal revenue. Both state and local authorities can set foundations to better manage health initiatives and disease prevention."
>
> (The Ministry of Health 1992)

Chen Minzhang, who served as the Minister of Health from 1987 to 1998, said:

> "On the one hand, there is a growing need for healthcare services. On the other hand, there are very limited resources available for healthcare programs. In other words, there is an enormous gap between healthcare resources and people's needs."
>
> (please see Cao & Fu 2005)

The Health and Finance ministries deployed antagonistic perspectives, with the Health Ministry campaigning to increase the health budget and a leading role for the state in managing the sector, while the Finance Ministry sought to cut health finance and encourage private capital to enter this sector. This debate reflects a field of struggles between ministries and between the left and right hands of the state:

> "What I call the left hand of the state [represents] the set of agents of the so-called spending ministries which are the trace, within the state, of the social struggles of the past. They are opposed to the right hand of the state, the technocrats of the Ministry of Finance, the public and private banks and the ministerial cabinets. A number of social struggles that we are now seeing (and will see) express the revolt of the minor state nobility against the senior state nobility."
>
> (Bourdieu 1998, p. 2)

In the Chinese context, this left-right struggle is reflected in the different attitudes towards the role of the state and the market in health service delivery and health resource allocation:

> "The pro-market group, called the neoliberals, advocates market liberalism [...] They believe in the positive effects of the invisible hand with minimum government

> regulation and that China should rely on the market in both healthcare financing and provision. The pro-government group called the social democrats (New Left) advocates reducing social inequities and the need for a large government role in the production and distribution of health services."
>
> (Yip & Hsiao 2015)

Thus, struggles between ministries over the extent to which private financing should be sought are a defining feature of the contested field of healthcare, and the state is a central player in this field. Bourdieu rejects Marx's conception of the state as a mere instrument serving the interests of the materially dominant class, with no independence or autonomy, nor does he consider the state to be a closed system with absolute autonomy and a clear, well-defined boundary – as Weber does. This thesis accepts the Bourdieusian theory of the state, arguing that the Chinese state should be conceived as a Bourdieusian field. As a space of struggles itself, the centrality of the bureaucratic field to the healthcare field is manifested in the exchange of economic capital, such as that found with state subsidies, and the exchange of symbolic capital, as we find with juridical intervention, such as the imposition of legal permits for the private practices produced for the healthcare field.

Unlike a well-maintained football pitch, a level playing field does not exist in a social field or the field of power. According to Bourdieu, the field of power is "the system of positions occupied by the holders of the diverse forms of capital which circulate in the relatively autonomous fields which make up an advanced society" (Wacquant 1993, p. 20). Bourdieu has described the field of power as like a force field and composed of opposing forces, with economic capital and cultural capital operating as "two hierarchised poles" (Thomson 2014, pp. 69-70). Thus, the relative positions of the Chinese Ministry of Finance and the Ministry of Health in the field of power are determined by their relationship to the two poles: the economically dominant and culturally dominated pole, and the economically dominated and culturally dominant pole at each end (Bourdieu 1988, p. 270). It is noteworthy that, for Bourdieu (Thomson 2014, pp. 69-70), despite the fact that both forms of capital are advantageous within the field of power, economic capital can bring higher status and more power than cultural capital. In the Chinese context, the Ministry of Finance is located closer to the economic pole with the power to wield financial capital, while the Ministry of Health is closer to the cultural pole and has little opportunity or capacity to propose where and how financial capital should be used. Qian, in December 1979, added a pre-condition for his wish to increase healthcare investment in the quotes above, saying:

> "We can't afford to subject ourselves to high standards in complete disregard of the current context and financial resources."
>
> (Qian 1983b, p. 33)

A similar sentiment was expressed in another speech by Qian (1983a, p. 22) in March 1979:

> "The reason can't be simpler: Our country is not a highly developed one, which naturally means that we need to devote a greater part of financial resources and materials to industrial and agricultural development. It's simply not realistic to have many funds earmarked for importing foreign medical devices and cutting-edge technologies."
>
> (Qian 1983a, p. 22)

These notes reflect the Ministry of Health's weak bargaining power over the health budget, especially when compared to that of the industrial and agricultural bureaucracy of the time. This is determined by its subordinate position regarding economic relations both in the bureaucratic field and in the general field of power. Within this conceptual framework, different social fields and subfields constituting the field of power, such as the bureaucratic field and the healthcare field, the Ministry of Finance and the Ministry of Health , are by no means competing on a level playing field. Some fields are dominant, and such relatively subordinate fields as the healthcare field depend on the practices occurring in the field of the state; in the same vein, decision-making in the Ministry of Health is also highly dependent on the priority of investment set by the Ministry of Finance.

The introduction of hospital PPPs: the reconfiguration of the healthcare field

Arguments have been made that the second shift of health policy, that is, toward state control, was a rational response to the resultant high cost of healthcare services and health inequality and that these were caused by the absence of the state's regulation and supervision (government failure) and the market's failure in allocating goods and services efficiently

(market failure) (Li 2011; Duckett 2011). We cannot deny that state failure and market failure exist in the healthcare market, nor that these failures cause some problems. Taking the second shift as merely a rational response to the problem of marketisation, however, is an insufficient explanation for the contradictions of the healthcare reform in 2009, which is labelled as a left-hand turn (Yip & Hsiao, 2014; Meng et al. 2015). With the introduction of (1) *The Opinions of the PRC Central Committee and the State Council on Deepening the Reform of the Medical and Healthcare System* and (2) *The Plan on Recent Priorities in Carrying out the Reform of the Health Care System* in 2009, China entered a new round of healthcare reform, which was guided by the principle of equity (Yip & Hsiao 2014). The former document provided a blueprint for the new round of reforms to establish a basic healthcare system covering both urban and rural residents by 2020, with an increased financial budget of 850 billion Chinese Yuan in healthcare (The State Council PRC 2009). The latter focused on the priorities of the new reform, including establishing a fully covered medical insurance system, a national essential drug system, and a primary healthcare system, as well as equalising basic public health service for all and piloting the reforms of public hospitals (The State Council PRC 2009). The most striking statement was to encourage private capital investment in the hospital arena and, at the same time, moderately reduce the proportion of public health institutions, with a target of increasing the market share of private hospitals (including PPP hospitals) to 20 per cent by 2015 (The State Council PRC 2009, 2012). Subsequently, in *The Opinions of the State Council on Promoting Development of the Healthcare Industries (No. 40 [2013] of the General Office of the State Council)*, a policy goal was put forward, stating that a healthcare industry cluster should be established by 2020, with a total scale of 8 trillion Chinese yuan or above (The State Council PRC 2013).

During the second round of health reforms, the Chinese government also legitimised the use of PPPs in the Chinese healthcare field (The State Council PRC 2010). In the Chinese context, PPP is also known as a contractual partnership between public and private sector bodies in the broad sense, which is for the purpose of infrastructure construction and public service provision that are traditionally within the remit of the public sector (Yang et al. 2020, pp. 1-6; Yang et al. 2013; Savas 2000). As early as the beginning of the market economy reform in the 1980s, China started applying the BOT (Build-Operate-Transfer) mode in the infrastructure sector. Guangdong Shajiao B Power Plant was the first BOT project in China, with the joint participation of Shenzhen Special Zone Power Development Company and

Hopewell Power Co., Ltd. (a foreign party). The foreign party was responsible for the financing, construction, and operation (for ten years) of the project, and at the end of the contractual life, the ownership of the project was transferred to the public sector (Docin 2017). Since that time, PPP development in the Chinese infrastructure field went through a "scaled-up" period from 2003 to 2008 and then a "pushed back" period from 2009 to 2013 following the global financial crisis. Recent years have seen a resurgence of interest in the use of PPPs for public service delivery, with the State Council forwarding the *Guiding Opinions on Popularising the Public-Private-Partnership Mode in the Public Service Field* (No. 42 [2015], the State Council) in May 2015 (Tong 2020, p. 148). According to data provided by the National PPP Comprehensive Information Platform of the Ministry of Finance, as of 31 December 2019, there were 9,440 PPP projects in the project management database, with a total investment of 14.38 trillion yuan. Among them were 262 projects in the healthcare field, accounting for 2.78 per cent of the total; the total investment was about 21.3 billion yuan, accounting for about 1.4 per cent. In 2020, according to the database, there were 13 new PPP projects in healthcare (the figure for 2019 is 30), among which 11 were hospital PPPs project, with a total investment of around 10.5 billion yuan (the figure for 2019 is 16.2 billion yuan) (Wang & Han 2020; AFGC CUFE 2020). The most common delivery models were BOT (Build-Operate-Transfer), ROT (Renovate-Operate-Transfer), and TOT (Transfer-Operate-Transfer).

As "new solutions" to deliver public services, PPPs are believed to combine the resources and strengths of public and private sector bodies, such as authorities and the service of quality in public sectors and the expertise and experiences of private sectors in designing and building hospitals, operations, and management (Cheng 2013; Wu 2017). This thesis argues that the second health policy shift since the 2000s ostensibly swung back to the state, with increasing health finance and insurance coverage for all. In the Chinese healthcare field, however, the neoliberal framework emphasising the decisive role of the market force in health resource allocation remains. The reconfiguration of the Chinese healthcare field since the health reform of the 1980s has made it possible for the use of PPPs in hospital contexts. First of all, based on neoliberalism, a series of policies have enabled the growth of private sector services, allowing private capital to enter more areas of services, especially with regard to private hospitals and basic health services (The State Council PRC 2010, 2013). In 1982, the practice of private medicine became legal. Later in 1987, the multi-site practice also

became possible, although private hospitals remained restricted. In 2000, China issued its first regulation with regard to for-profit and not-for-profit health institutions, whereby private for-profit hospitals were also legally permitted (Liu et al. 2006). The government also encouraged an increase in the service scope of private hospitals, especially with regard to opening general hospitals and not-for-profit institutions and offering basic medical services (The State Council PRC 2013, 2017). In the past, most private investors focused their attention on for-profit specialty hospitals, such as stomatological hospitals, eye hospitals, and orthopaedic hospitals (Tang et al. 2014; Eggleston et al. 2010). These institutions rarely provided a full range of health services but were more likely to offer outpatient surgical services (Eggleston et al. 2010). In contrast, Chinese public hospitals were responsible for providing a full range of services, from preventive healthcare and regular medical services to emergency services and rehabilitation as well as conducting health education and medical research (The World Bank 2010).

The current system is distinct from its predecessor as differences between the areas of services engaged by public and private sectors gradually became less apparent. In 2010, for instance, there were 4239 non-public general hospitals (90 in mixed ownership, 3005 in private ownership) in China, constituting around 30 per cent of the total general hospitals. By 2019, private investors owned 12572 general hospitals (99 in mixed ownership, 9440 in private ownership), taking up 63 per cent of the total (The Ministry of Health PRC 2011; National Health Commission PRC 2020). In addition, private hospital sectors are now providing emergency services in response to pressures for diversification. For example, as the largest private integrated medical group in Singapore, Raffles Medical Group established its Beijing clinic in 1994 and started providing emergency services in 2020. In their cross-sectional study based on a national healthcare quality survey including 988 private and 3541 public emergency departments, Jin et al. found that private emergency departments became better staffed when considered as an average over the total number of beds, though private emergency rooms are often concentrated in densely populated urban areas (Jin et al. 2020). A spread of health services across private hospitals has further broken down the distinction between tasks performed by the public and private sectors. This blurred boundary has made it possible for collaboration between public and private sectors in specific areas of service, such as hospital PPPs.

The distinction between the two sectors has been further blurred, with the state removing resources from the public sector meanwhile strengthening its support for the private sector. A series of policy measures to support the development of private hospitals and to put public and non-public hospitals on an equal footing is an obvious example of this restructuring process. After cutting its financial support and allowing private capital into the healthcare field, the state stipulated that qualified private hospitals would be able to use medical insurance funds as public hospitals do. There are both public and private insurance plans in the Chinese health insurance system, and the public insurance plan consists of Urban Employee Basic Medical Insurance (URBMI), Urban Resident Basic Medical Insurance (URBMI), and New Rural Cooperative Medical Scheme (NCMS). Approximately 95 per cent of China's population is covered by these three insurance programs (Meng et al. 2015). Among the three programs, URBMI covers only urban employees and offers reimbursement for both outpatient and inpatient services, with a coverage of more than 2000 kinds of drugs; URBMI and NCMS target urban unemployed residents and the rural population, respectively, mainly reimbursing inpatient services and only covering 800-1200 drugs. The government introduced Private Health Insurance (PHI) during the first round of health reform in 1980. PHI was considered capable of filling the gap in the public insurance plan by offering substitute and supplementary forms of coverage for individuals, such as reimbursement for catastrophic disease and luxury health services (Wu & Ercia 2020; Wang et al. 2016). Over the past few years, PHI has grown rapidly with respect to total aggregate premium income. However, it only accounts for a minor part of total health expenditure. Social insurance expenditure is still the main source of the total expenditure on health (Meng et al. 2015). Involving selected non-public hospitals into the network of public medical insurance coverage has enhanced the position of non-public hospitals by distributing insurance funding (financial capital) to the private sector.

Other measures include enabling private medical professionals to be assessed in the official professional title appraisal system and offering tax benefits to private health institutions (The State Council PRC 2013, 2015, 2017, 2019). These measures have advantaged private hospitals in terms of attracting patients and medical professionals. The "resources" channelled to the private sector, and what Bourdieu would refer to as capital, function as

specific strengths in the field of struggles between public/ private hospitals in their competition for winning market shares. A seven-year period from 2010 to 2017 has seen a sharp climb in the number of private hospitals (including both fully private and mixed ownership hospitals) from 7068 to 18759, while the number of public hospitals during the same period reduced from 13850 to 12297 (National Health Commission PRC 2018, p. 10). The reduction in the number of public hospitals is also associated with the state strictly controlling the number and scale of public hospitals (The state council PRC 2015).

The status of public hospitals has become increasingly ambiguous since the 1980s, with the insertion of NPM practices in the Chinese hospital sector. Chapter two has described the doctrines of the NPM framework under which professional managers are empowered to manage the public sector with a greater emphasis on competition, performance-based measurement, output controls, cost control, and a separation of production and provision interests (Hood 1991; Verbeeten & Speklé, 2015). However, the way these doctrines are present in each case varies from country to country. In the context of Chinese hospitals, health reform since the 1980s has created a new system where publicly owned hospitals have had exposure to a set of business-like operational incentives, such as the need to sell diagnostic services, pharmaceuticals, and other services to ensure satisfactory financial performance. These practices were reinforced by the remuneration system for public doctors, under which the bonuses for doctors were entirely or partly associated with the financial performance of clinical departments.

During the second round of health reform in 2009, the government set as its reforming priority the separation between the functions of public ownership and government administration from hospital management. This means greater autonomy for public hospitals with regard to decision-making, financial management, and profit distribution. Pilot public hospitals were also officially allowed to distribute profits to staff after the reform (Allen et al. 2014, p. 152). More recently, the State Council proposed *Interim measures for the management of leadership of public hospitals* aiming to enhance the autonomy and capabilities of public hospital managers (Mei & Kirkpatrick 2019). These measures emphasised professional management training for potential hospital presidents and also allowed non-clinicians with managerial expertise to enter this role. Additionally, hospital leaders' compensation is increasingly tied to their performance rather than based on a fixed

pay scale (Mei & Kirkpatrick 2019). Implied is that public hospital presidents are urged to shift from government functionaries to leaders with a stronger sense of professionalism and professional identity (Mei & Kirkpatrick 2019). This kind of NPM practice highlighting "hands-on professional management" has strengthened the positions of managers and increased the value of managerial capital in the public hospital sector, as well as providing a base for future cooperation between the public and private sectors regarding operation management. For instance, as one of China's largest private hospital management companies, Phoenix has reached agreements (in the model of Invest-Operate-Transfer) with 16 public hospitals, under which it invests in upgrading hospital facilities and clinical services in exchange for the right to operate the hospitals. Under the agreements, Phoenix receives management fees and has the right to provide pharmaceuticals, medical consumables, and devices for a time span between 16 and 48 years. At the end of the agreement, the management right will be transferred to the public hospitals (Zhihu 2016).

The Chinese healthcare field and the values and principles operating in the field have transformed over time. In Mao's era, Chinese health policies embraced the principle of "serving the people", which aimed at improving health equality and social justice (Yang 2010). Almost all Chinese hospitals were state-funded, whereby the state subsidised the majority of their recurrent costs, paid the salary of their employees, and was responsible for the staff's welfare (Tu 2018). After the reform, the state cut its health funding, and private practice and private hospitals were allowed. The trajectory of the field has been towards a diversity of providers, with private capital entering the hospital field and increasing its market share within the sector. With the insertion of NPM practices in the field, particularly in public hospitals, the deep-seated equity principle has come under threat from the principle of efficiency improvement and cost control. This value orientation provides more spaces for cooperation between the public and private sectors, where the hospital PPP is one of the forms. The second round of health reform in 2009 is a continuation of the overall trajectory of the healthcare field towards further integration of private capital. Hospital PPPs in the Chinese context can be seen as a continuation of NPM practices, encouraging private sector bodies to take roles in public service delivery. NPM leads to an interest in unbundling units in the public sector into corporatised units around products, so there is a separation between *production* and *provision* interests. Efficiency advantages can thus be gained through contract or franchise arrangements with private or third-sector bodies, according to the NPM agenda

(Greve & Hodge 2007, pp. 180-82; Hood 1991). Recent years have seen practices of privatising and contracting out services in Chinese public hospitals, such as outsourcing clinical and clinical support services (like laboratory services, drugs, and consumables supply), management, and other services like cleaning and catering. The government justifies these practices in terms of their potential to control operating costs and improve the quality of services and business performance (State Council Office 2013; see also Xia 2017). Hospital PPPs enhance the way private sector entities are integrated into public service provision, building on previous New Public Management (NPM) practices. Baru and Nundy (2019, pp. 79-80) even argue that PPPs in the Chinese healthcare field can be seen as a "soft" expression of privatisation or leaving the responsibility for providing health services at the hands of the non-government sector. They attribute this "soft" expression to an impasse caused by the vigorous debate between the pro-government and the pro-market approach. Indeed, after the first round of health reform, patients have continuously expressed dissatisfaction with unaffordable access to the high cost of healthcare services and have participated in thousands of protests against the marketised healthcare system throughout the country (Yip & Hsiao 2008).

In the eyes of private investors interested in partnering with public sector bodies to deliver hospital services, there were some policy barriers regarding physician multi-site practices and reimbursement of social health insurance in non-public hospitals. As discussed earlier in this section, the Chinese government has lifted these barriers by relaxing the limit for doctors and nurses to practice at a single site and integrating selected non-public hospitals into the network of social healthcare insurance coverage. These policies have facilitated the growth of hospital PPPs in terms of attracting medical professionals and patients. Along with the entry of private capital into the healthcare market and the growth of private hospitals, there also emerged what is known as the Medical-Industrial Complex (MIC) in China. As described in Chapter Two, Relman (1980) defines MIC in the American context as "a large and growing network of private corporations engaged in the business of supplying healthcare services to patients for a profit – services heretofore provided by nonprofit institutions or individual practitioners". In the Chinese context, under the encouragement of a series of policies, private capital, both domestic and foreign, has entered a wide variety of subfields such as finance, pharmaceutical, medical technology, insurance, and consulting. These private capital participants partner with each other and formulate a network that is referred to as the MIC.

Among these groups of investors, several have diversified business interests, and there are partnerships both between private investors and between public and private investors. For example, China Resources Phoenix Healthcare Holdings Company Limited has partnered with public hospitals via joint ventures and specialises in hospital management and operations. All the hospitals and clinics it currently manages are covered by the Social Medical Insurance. Another example comes from Perennial Real Estate Holdings, an integrated real estate and healthcare company based in Singapore. Through joint ventures and partnerships with actors in the Chinese domestic market, Perennial has established hospitals, healthcare hubs, and eldercare homes across the country (for more details, please see Baru & Nunday 2019). It thus can be seen that under the encouragement of health policies since the 1980s, public hospital reform associated with the rapid growth of private sectors and the expansion of MIC jointly fuel the rise of PPPs in the hospital field. Hospital PPP can be read as a continuation of the practice of NPM and privatisation in China.

The Chinese medical profession in the changing context of privatisation and NPM

After the first round of health reform, the image of Chinese medical professionals has suffered following the reported immoral behaviours of doctors, such as receiving kickbacks and providing unnecessary treatment to patients. There has even been a growing dispute between doctors and patients in the Chinese healthcare field for the past several years. Statistics from the Chinese Hospital Association show that around 27 cases of medical violence happen in each hospital every year (People's Daily 2014). Some authors have partially attributed these phenomena to the marketisation and privatisation of the Chinese healthcare system (Mei & Kirkpatric 2019; Hou & Xiao 2012; Hesketh et al. 2012; Yang 2010, 2006). What is the changing power relationship between the Chinese state and medical professionals, between professionals and their medical institutions and patients under the context of health reform? How is the professional autonomy of Chinese doctors affected by the privatisation of health services? What characteristics of the medical profession in today's China distinguish it from that in Western societies under a global privatisation trend?

Before the health reform of 1978, "serving the people wholeheartedly" was the guiding principle of health policy. One of the efforts made by the state to achieve this end was the nationalisation of the medical profession (Yang 2010). The medical profession was nationalised in two ways, one of which was state monopolisation of all key health resources and control over the distribution of these resources and, accordingly, the absorption of private practitioners into state employment (Yang 2010). Medical professionals were organised through work units, such as public clinics and hospitals. Doctors were fully dependent on the state, and their work units determined monetary rewards and other social and economic benefits (housing, insurance, and education, for example), medical devices and even patients (Yao 2016). Moreover, as in other socialist countries, such as the former Soviet Union, state employment severely restricts the job mobility of professionals. In his empirical study among over 1000 Wuhan and Shanghai residents, Davis found strict bureaucratic control over the careers of managers and professionals in the early 1950s (Davis 2000). Additionally, the state reshaped professional ethics and codes of practice according to its own needs for socialist construction rather than handing this right over to professionals (Yang 2010). The other way state control occurred was through the reconstruction of medical education. The state produced more doctors in a short time by shortening the curriculum, which, to some degree, deprived doctors of their autonomy in setting the standards for, and the content of medical education. The combination of these elements reflects the absolute control over the medical profession by the state and work units, and these factors inevitably reduced professional autonomy. To borrow Yao's (2016) term, it is a process in which doctors are tamed by the state. However, at the same time, doctors gained some rights by being state employers and acting as guardians for state interests. In this sense, Chinese doctors in Mao's era became "state functionaries", generally prioritising the interests of the state over those of their patients.

Since the 1980s, the state has cut its financial support for public hospitals at the same time as increasing private capital in health service delivery. The permission given for private and multi-site practice, as described by Yang (2006), has enabled doctors the freedom to change careers and practice medicine in the private sector. However, in the public hospital sector, where both a public service orientation and a managerial ethos are emphasised, doctors have to submit to various economic and management requirements when enrolling patients,

prescribing medicines, undertaking examinations, and choosing treatment plans. Under the pressure of performance indicators set by hospitals, public doctors are not able to make medical decisions according to their professional knowledge and skills alone, which means their clinical autonomy has been eroded. An argument has been made that the reformed system has placed doctors in a disadvantageous position, as they are compelled to submit to the requirements of hospital management and are objectified by these requirements (Tu 2018). In Western countries, similar issues are raised by Light (1993, p. 285), Nigam and Ocasio (2010), who argue that under the changing context of privatisation, doctors are faced with increasing conflicts between the traditional ethos of professionals emphasising autonomy in health service provision and the managerial ethos stressing efficiency and cost control, potentially leading to a loss of professional autonomy.

Other studies (e.g., Yang 2006), suggest that some public doctors in China have even engaged in illegal activities, such as receiving drug kickbacks and 'red packets', which appear to be a response to their low basic salaries set by the state. Consequently, the public image of doctors has severely suffered, trust between doctors and patients has become fragile, and many cases of medical violence even occur. Therefore, Yao (2016) argues that the medical profession has become a buffer in a problematic system. These widely reported phenomena indicate that the state control of the medical profession has been undermined following the commercialisation and privatisation of health services. However, the medical profession remains in a powerless position in relation to the state and their work units as they have little say in their salaries and conditions of work (Yang 2010).

Summary of the chapter

This chapter explores the evolution of China's health policy, starting from its shift from a centrally planned system to a market-oriented one in the 1980s, the government's resurgence in 2009, and its subsequent return to a market-oriented approach with the introduction of Public-Private-Partnerships in the last decade.In this chapter, the Chinese state and the healthcare sector are analysed as fields that are intertwined rather than a mere reflection of external socio-economic forces or a closed system. Unlike the latter, where the healthcare system is functionally understood as a part of the whole social system and carries out

beneficial functions for the whole, the healthcare field, in a Bourdieusian sense, is relatively open to field-specific types of struggles, both within the field and in relation to other more or less powerful fields (Bourdieu 1993, pp. 40-5; also see Collyer 2018). An analysis of official documents, public speeches, reports, and academic literature finds that key ministries engaged in Chinese health reforms – namely the Ministry of Health and the Ministry of Finance – adopt antagonistic attitudes over whether to reduce the health budget and encourage a for-profit and privatised system. These contradicting viewpoints are found to adjust to Ministries' positions bearing different functions in the bureaucratic field – guaranteeing health service delivery as opposed to ensuring financial stability.

Since the 1980s, under the guidance of neoliberalism, the Chinese state cut its health budget, meanwhile allowing profit-seeking behaviours in public hospitals and removing restrictions for private capital from entering this field. The hospital PPP can be seen as a continuation of privatisation and NPM practices in the Chinese healthcare field as it also stresses the use of private capital and market logic to achieve higher efficiency and value for money, which is the hallmark of an NPM agenda. In other words, the "philosophy" of neoliberalism and NPM helps to justify the use of PPPs in the Chinese healthcare field. In addition, the practice of the state since the 1980s has facilitated the growth of private capital, the expansion of MIC, and thus reshaped the power relations within the field. In 2014, joint ventures between public hospitals and private capital became legitimate, accompanied by policies relaxing single-site practices of physicians and involving selected non-public hospitals in the network of social medical insurance reimbursement. These policies have further benefited the development of hospital PPP, and partnering with public sector bodies in building and operating hospitals became a strategy used by private capital to improve their position within the field. Therefore, this thesis argues that the reconfiguration of the Chinese healthcare field since the 1980s has provided the possibility for the historical emergence of hospital PPPs. In this policy process, the state's symbolic power is not only objectified in the forms of administrative measures and instances capable of *altering the power relationship of the healthcare field* but also appears as legitimated classifications that help justify neoliberalism. Under the context of privatisation and neoliberalism, Chinese medical professionals must be subject to increasing management requirements and suffer ongoing medical violence. Some arguments have been made that doctors have lost their professional autonomy, while others suggest the profit-seeking behaviours of doctors could be read as an

effort to adapt to the market environment. Chapters five and six thus will empirically analyse the contested experiences associated with hospital PPPs in the healthcare field. The next chapter will focus on public and private hospital managers.

Chapter Five - The experience of healthcare stakeholders with hospital PPPs: The state and spaces of positions and position-takings

Introduction

Chapter four emphasises that the Chinese state and healthcare sector are hierarchically structured fields open to contested interests, ideas and practices. As a contested field, the healthcare field has been reconfigured by the state over time, thus making the emergence of PPPs a possibility. Moreover, as discussed in the previous chapter, the Chinese healthcare field refracts the external forces exerted by the state in a "prism-like" manner according to its own configuration, which means the PPP arrangement by the state brings about varied effects on the positions occupied by different agents. Thus, this chapter takes as its focus the contested experiences of associated political and market actors concerning hospital PPPs, particularly in the context of a provincial healthcare field. These stakeholders have a good knowledge of the selected hospital PPP and the policy environment where the hospital PPP is placed so that the power relations of the provincial healthcare field could be explored. Understanding the experiences of healthcare stakeholders with hospital PPPs can help to reveal their attitudes and concerns, which can be useful for policymaking and implementation. Additionally, exploring the power relations in the provincial healthcare field can provide a better understanding of PPPs (especially hospital X), the local market and the policy environment.This chapter investigates interview data collected from hospital managers in the public and private sectors and local health officials.. Bourdieu's analytical tools (field, capital and habitus) in relation to his theory of practice and his concepts of positions, position-takings and dispositions are used to analyse the empirical data. This chapter begins with a brief background of the PPP hospital (in section two), and it maps out the relative positions of public/non-public hospitals within the local healthcare field to show the subordinate position of the PPP hospital in comparison to the more established public hospitals. Following this, section three examines the "not-for-profit" registration type of the PPP hospital and highlights the symbolic profits underpinning this practice. The conclusion of this section is that the "not-for-profit" practice of the PPP hospital should be understood as a strategy to maximise both material and symbolic profits within the local healthcare field.

To examine stakeholders' contested experiences with hospital PPPs, section four pays attention to the stakes and strategies used in the field of struggles between the well-established public hospitals and the new PPP hospital. The narrative of this section illustrates the struggles between public and PPP hospitals over licences, certificates, research funding, data sharing and medical professionals. Section five concerns the opposing viewpoints of participants towards hospital PPPs and the state's role in health service delivery, which are closely associated with the actors' field positions. It emphasises that rather than submitting to the neoliberal trend in the Chinese healthcare field, public sector participants show resistance or negative sentiments toward hospital PPPs and emphasise the state's leading role in health service delivery. This chapter concludes that the local healthcare field is best understood in terms of a field of struggles between dominant public hospitals and subordinate non-public hospitals, particularly with regard to the state's symbolic power. This symbolic power is not only objectified in the institutionalised forms of qualifications, licences, and titles, but also exists in subjective form as "principles of classification" imposed on agents as universal principles. Hospital PPPs represent neither a closed system detached from the external social and political environment nor a mere reflection of external forces. Instead, they constitute a sub-field of social action embedded in the local healthcare field in relation to other types of hospitals, patients as well as the state.

Location of the PPP hospital in the local healthcare field

Since the 1980s, with the increasing spread of neoliberalism in the Chinese bureaucratic field and the privatisation and NPM practices of the state in the healthcare field, the trajectory of the healthcare field has been towards increasing diversity of health service providers. The extent and the way neoliberalism is incorporated into the local healthcare field varies from province to province. In the second round of the health reform, it was first embraced by Y city, with the implementation of *Opinions on Deepening the Reform of the Medical and Health System* in 2009 (The State Council 2009). Following the directions of the central government, the local government of Y city sought to create a policy environment where both private and public medical institutions might benefit from the social health insurance system, scientific research grants, professional title evaluation and continuing education for medical

professionals (He 2019). In 2014, the local government took a further step by encouraging cooperation between municipal public hospitals and private capital to build hospitals, as outlined in the *Notice on Accelerating the Development of Social Medical Services* (The General Office of Y City's Government 2014). The effect of these policies has been mirrored in the substantial increase of private hospitals and a private workforce in Y city. The number of private hospitals increased by around 250 between 2015 and 2020, with the number of private general hospitals increasing by around 40. The 6-year period between 2015 and 2020 also witnessed a growth in the number of healthcare professionals working in private hospitals, with the number in 2020 twice that of 2015 (Y City Health Commission 2015; 2021). In contrast, the number of public hospitals and the public workforce both fell during the same period.

In 2014, X Medical Equipment Co., Ltd. signed a contract with XX Medical University to build a nonprofit PPP hospital jointly under the delivery mode of Building-Owning-Operation (BOO). It is the first and the only PPP hospital in operation in Y City. The PPP hospital opened in 2016 with around 1000 beds, and, as a general hospital, it performs most functions expected of a regional medical centre, including teaching, scientific research, emergency, mental health, infection branch, rehabilitation and other inpatient and outpatient services. Due to the comprehensive services provided by the hospital to residents in several regions, the teaching and research tasks it performs and its large size, which is mainly measured by the number of beds (at least 501 beds), the PPP hospital passed the assessment of the local health commission and was rated as a national tertiary first-class general hospital in 2020. It is also a designated medical institution for medical insurance in Y City.

The case hospital represents a common delivery model of PPPs in China, with the private sector body investing in building the hospital, co-owning and co-operating in the management of the hospital with the public sector body. X company was established in 2009, focusing on a range of businesses from medical equipment sales and medical services to medical project investment. It invested around 1.5 billion RMB in building the hospital and took up 75 per cent of the property rights over the PPP hospital. XX Medical University used intangible assets such as medical technology and management techniques as an investment, accounting for 25 per cent of the property rights. X company is involved in the operation of

the hospital in terms of marketing, supply chain support, financial management, equipment improvement, and brand management, and it will get paid by the PPP hospital (the hospital will pay 75 per cent of the annual balance of income and expenditure to the private sector as service fee). Moreover, the two parties agreed to guarantee that the private sector body supplies at least 75 per cent of the drugs, reagents, consumables and devices procured by the hospital.

The healthcare field is hierarchically structured in the sense that some agents or agencies are dominantly positioned while others are subordinate. This is defined by the volume and structure of species of capital at their disposal (Bourdieu 1992, p. 101), which functions as power relations in the field. A Bourdieusian approach situates the PPP hospital within a dynamic and hierarchically structured field, with differential access to specific forms of capital that can be accumulated and deployed in the field. Even though private hospitals and their workforce have increased and the field positions of private sector actors have become more favourable over recent years, their position remains subordinate to that of the more established and dominant public hospitals. Data from the health statistics yearbook 2021 of the local province demonstrate that, in 2020, the number of healthcare professionals working in public hospitals was twice that in private hospitals. Additionally, the numbers of outpatients and inpatients attending or in public hospitals in 2020 were respectively five times and three times greater than private hospitals (Y City Health Commission 2021). In the case of PPP hospitals, the data shows that the public hospital group located in the local area has approximately 800 healthcare professionals with the titles of either professor or associate professor, which is five times more than can be found in the PPP hospital. This suggests the public hospital places far greater importance on the cultural capital associated with academic status. These data indicate that the PPP hospital in this study is a newcomer and challenger in the local healthcare field and is subordinately positioned compared to the well-established public hospital group.

Symbolic interest: PPP hospitals as "not-for-profit" facilities

In the Chinese context, there is a significant difference in the way accounting profit and taxation are treated in for-profit and nonprofit hospitals. In contrast to for-profit hospitals, where profits must be distributed to their owners and shareholders, nonprofit hospitals do not distribute profits (Lin & Song 2016, p. 225). Thus, a general concern is that for-profit hospitals must set as their priority the maximisation of profits, with no incentive for the provision of public goods (Lin & Song 2016, p. 226). On the contrary, nonprofit hospitals are, by definition, established in order to deliver social and public services. Recent decades have seen an increasingly encouraging tone from the Chinese government regarding nonprofit health institutions. In 2010, the State Council issued *Opinions on Further Encouraging and Guiding the Establishment of Medical Institutions by Social Capital* and stipulated that private nonprofit health institutions were entitled to exemption from various taxes, including the business tax on income from medical services at a price-set by the state. In contrast, for-profit hospitals are required to pay corporate income tax according to associated tax policies (the State Council 2010). In 2013, the government released *the Opinions of the State Council on Promoting the Development of the Healthcare Industries* and took as its priority the development of private nonprofit health institutions, especially those able to provide essential medical services. The government took a further step by granting subsidies to private nonprofit hospitals and put public and private nonprofit hospitals on an equal footing regarding the construction of key disciplines and personnel training (the State Council 2013; 2015).

During the second round of health reform (in 2009), the Chinese government also began to relax constraints on the development of private hospitals by including selected private medical institutions within its network of insurance coverage. In other words, public health insurance now also covers some private providers and reimburses patients for health services in designated private health facilities. Currently, the percentage of private and for-profit health institutions covered by public health insurance is significantly lower than it is for the public and nonprofits (Wang et al. 2016). Take Y city as an example: among the 22 healthcare facilities covered by public health insurance at the municipal level, only two facilities are privately owned and registered as for-profits, 19 facilities are nonprofit public

institutions, and the remaining facility is the PPP hospital (which is registered as a nonprofit institution).

Participant 17 is an expert advisor for The Health Commission of the local area and a hospital manager involved in the building and early operational stages of several public hospitals and three PPP hospitals, including hospital X. He tells the investigator that:

> "Local public hospitals have a distinct edge over their private counterparts. Public hospitals are prestigious establishments widely known in the region and even across the country. They're the first choice when local people or residents from neighbouring provinces or cities get ill. Another attraction of public hospitals is that they're medical insurance-designated hospitals where patients receive partial reimbursement for expenses. Therefore, a couple of big public hospitals become a natural choice."
>
> (Participant 17, expert advisor for The Health Commission of the local area)

This quote reflects the recognition granted to public hospitals by patients and public health insurance departments. This form of symbolic capital significantly contributes to the dominant position of public hospitals in the local healthcare field. According to Bourdieu, symbolic capital is:

> "A transformed and thereby disguised form of physical 'economic' capital, [symbolic capital] produces its proper effect inasmuch, and only inasmuch, as it conceals the fact that it originates in 'material forms' of capital which are also, in the last analysis, the source of its effects."
>
> (Bourdieu, 1977, p. 183)

In this case, symbolic capital is reflected in being able to utilise public health insurance to attract patients, which enables greater revenue generation. In the Chinese context, patients are

inclined to choose health service providers with public health insurance reimbursement and low co-pay options (Wang et al. 2016; Cao et al. 2012). Another reason for patients' recognition of public hospitals arises from their distrust of private hospitals. In their empirical study of over 10,000 patients across the country, Pan et al. (2015) found a positive correlation between patient dissatisfaction and the market share of private hospitals and a higher level of competition in the healthcare providers' market. This finding is understandable in the sense that providers from the private sector usually practice in accordance with profit incentives and avoid providing unprofitable services, which has been widely documented in the literature (Liu et al. 2006; Lim et al. 2004). Therefore, gaining patients' trust and being involved in the network of public health insurance have become focal concerns of the newly established PPP hospital. Participant 17 explains:

> "[The PPP hospital of not-for-profit nature] brings several benefits. First, such a hospital absorbs resources in the medical care market, i.e. patients. [For-profit hospitals]would probably be identified as medical institutions whose primary goal is merely profit. Lack of trust among patients proved to be its downfall. […]
> The second benefit is policy support. Incorporating the PPP hospital into the medical insurance system means that former restrictions are lifted. Since the PPP hospital is not-for-profit, medical insurance is more likely to cover patients admitted by them. After they've developed some time, they can expand into new businesses which can be profit-driven."
>
> (Participant 17, an expert advisor for The Health Commission of the local area)

Unlike Weber's (1978, p. 339, 400; alse see Swartz 1996, p. 74-5) concept of economic action, which must satisfy a need established upon scarce resources and limited possible action, Bourdieu takes as a fundamental presupposition that every action is interest-oriented. He also sharply distinguishes his "science of the economy of practices" from rational theorists, where the action is based on conscious cost-benefit calculation. Instead, he abandons the dichotomy between material and non-material and assists in explaining the "seemingly disinterested" practice of the hospital PPP according to his science of interest orientation of practices. Bourdieu's idea of the "economy of practices" extends the narrow expression and calculation of self or hospital interests into the non-material dimension. The certification of "not-for-profit" institutions, able to attract public medical insurance, can be seen as a process where patients are acknowledged as a form of symbolic capital which can

be transformed into profit under specific conditions. To borrow Bourdieu's words, "the exhibition of symbolic capital is one of the mechanisms which make capital go to capital" (Bourdieu 1977, p. 181).

Participant 17 speaks to the investigator about the PPP hospital's additional strategies to expand the scale of business and improve profits:

> "After some development, they can provide high-end products or services offered by foreign medical teams. With their professional expertise, the PPP hospital can open a "medical care supermarket". Please allow me to explain it. It is a supermarket-style hospital staffed by medical teams both at home and abroad. These teams can be likened to items on the shelves of a supermarket. Every medical care module is like a product. Having stocked with a wide range of products, a hospital becomes a supermarket. Then why do we choose the supermarket model? An essential feature: We will provide more when a product sells well. Otherwise, its supply will be cut down."
>
> (Participant 17, expert advisor for The Health Commission of the local area)

These market strategies emphasising for-profit, high-end health services and demand-supply relations seem to oppose the "not-for-profit" orientation of the early development stage of the PPP hospital. Yet, from a longer-term perspective, the PPP can be seen to have been through various stages in its life cycle, and at each stage, it has sought to maximise both its material and symbolic resources within the healthcare field. In order to fully understand the "economic practice" of the PPP hospital, it is essential to reference its changing field position, from entering the field to "finding one place in the market" (participant 17, expert advisor for The Health Commission of the local area), its trajectory in the field and the alteration of the field itself. This Bourdieusian perspective stands in opposition to 'management theory', where the possibilities and constraints of the field, especially those "rules" imposed by the state, play little part (Bourdieu 2005, pp. 199-200, 204). As noted in earlier chapters, Rational theory similarly fails to explain the seemingly irrational and "not-for-profit" practice of the PPP hospital.

Contestation for state recognition: PPPs and public hospitals

The previous section draws attention to the logic of positions and position-takings underpinning the "not-for-profit" practice of the PPP hospital in pursuit of symbolic profits – the certification of the institution as a medical insurance designated institution as a strategy to attract both doctors and patients – and enhance its market position. This section concerns the stakes and the forms of capital used in the struggle between the well-established public hospitals and the newcomer – the PPP hospital. As detailed in chapter two, capital can be assets of different forms (economic, cultural, social and symbolic) that "are transformed and exchanged within complex networks or circuits within and across the different fields" (Moore 2008). According to Bourdieu (in Bourdieu & Wacquant 1992, p. 101), the distribution and exercise of capital constitute the fundamental structure of a given field; it confers power over the "rules of the game" in the field, thereby over "the profit engendered in it". Therefore, capital is a field-specific concept. Rather than a static object, capital should be understood as social relations in a specific field. For example, a specific form of capital yields more significant advantages in a particular field than others and becomes less valuable in other fields.

Particularly important in the field of struggles, from Bourdieu's perspective, is symbolic capital, which is capable of altering the rate of exchange between other forms of capital. Nearly all participants who are leading agents in various parts of the healthcare field – public and PPP hospital managers and CEOs – express opinions on the state policy or administrative measures. Participant 13 is currently a CEO of a newly-established for-profit private hospital owned by a Fortune Global 500 company. Before joining the private hospital, he had worked as a senior manager in the (case) PPP hospital for three years and as a professional manager in a private medical investment company for five years. Participant 13 expresses deep dissatisfaction with the red tape and time-consuming process involved in the application for various business licences and equipment certificates. He says this complicated application process is having a very detrimental effect on the development of private capital and wishes to transform the current situation:

> "A figure might give you a bit of shock. What I plan to do is open a check-up centre. To do this, I need 40-something licenses to be approved. A simple stamp requires a meeting for discussion and research and a third-party controlled assessment and testing. To establish a CT scan centre, I mean the regular CT, we must get a pre-assessment first, followed by an installation permit, a controlled assessment, a certificate showing you've joined training sessions on radiation safety, prevention and protection training sessions, and all kinds of licenses – you name it! Anyway, long story short, the whole process is very complicated and time-consuming. The government needs to launch a project to simplify the process."
>
> (Participant 13, CEO of a for-profit private hospital and previous PPP hospital manager)

The business licences and equipment certificates could be understood as an institutionalised form of symbolic capital, which is legally and socially known and recognised by all field agents. Following Bourdieu's logic and taking the Radiation Safety Permit, for example, it is important to ask questions about who examines, approves and issues the permit and who confirms the validity of this permit. And who certifies this? These questions reveal the end (as well as the start) of the logistical chain of all related official acts of authority where the state acts as "the central bank of symbolic capital" (Bourdieu 1998, p. 51-2). The state certifies the acts of the Ministry of Ecology and Environment of the People's Republic of China and the local Ecological Environment Bureaus in the approval and issuance of the Radiation Safety Permit. Related department officials are empowered to perform certain works on behalf of the state. This process of "official naming" or "taxonomies", to borrow Bourdieu's (Bourdieu 1985, p. 732-4) terms, is not only objectified in qualifications but also symbolically inscribed in the ideas and practices of individuals, thus shaping their relations. This system of meaning and significance and symbolic classification unavoidably produces social agents' dispositions to think and act following a certain symbolic order, and social agents regard this order as natural (Bourdieu 1998, p. 40; Loyal 2017, pp. 70-1; Loyal & Quilley 2017, pp. 433-4). In the Chinese healthcare field, field agents recognise and perceive these state regulations and administrative measures regarding business licence and equipment certificates as the natural order and unconsciously follow and obey these orders without the state necessarily employing physical force.

Understanding the state's symbolic power cannot be detached from analysis of the symbolic struggles over the state power – both in material and symbolic forms (such as the official rules, licences, names and funding) among competing agents. The management of licences, certificates and names is an approach to managing scarce material resources (Bourdieu 1985,

pp. 732-3). The business licence and equipment certificate conferred (or not conferred) on the PPP hospital within a given time period create advantages (or disadvantages) for the actors in various field positions. Also, the permits or research funds given or not given to an entity's competitors (such as a public hospital) have either a positive or negative influence on the relative position of the PPP hospital in the healthcare market. This symbolic capital achieved by hospitals could also be used as a "weapon" in further struggles among competing agents. In such struggles, analysis of the data reveals two opposing stances among participants: on the one hand, interviewees from the dominated private sector adopt a subversive stance (or strategies), aiming to transform the current state of hierarchisation within the field, thereby potentially altering the "rules of the game" to their advantage; on the other hand, interviewees from the dominant public sector take a conservative stance (or strategies), with the overriding aim of preserving the current, and favourable state of power relations, and defending or even strengthening their position in the hierarchical field.

Participant 12 was an administrator in the PPP hospital before entering a public medical university – the public partner of the PPP hospital. She bitterly complains about "Getting licenses for all kinds of testing equipment as a "big headache for us", and regards the whole process as fraught with all kinds of delays and obstacles. "Besides, another big headache raised is the application for research funding":

> "Research projects and key disciplines are of paramount importance for us to rank among leading hospitals across the country. We were one of the applicants. But the favourite child of xxx District Health Commission is the District xxx Hospital [a public hospital] which receives direct guidance from the Commission. After all, the xxx hospital is the biological son of the Commission."
>
> (participant 12, PPP hospital administrator)

The above "research project" and "key discipline" could also be comprehended as forms of symbolic capital expressed as official titles or names awarded by the state. These titles or names, according to Bourdieu (1985, pp. 733-4), receive relative values from a hierarchical system of titles formulated by the state, such as "key disciplines" and "scientific research projects" at all levels and various types (including at the national level, provincial level,

ministerial level, etc.). Hospitals receive material resources and, just as importantly, social recognition and credits (which are reflected in "the national rankings of hospitals" through a successful application, thereby helping to improve the relative positions of the hospitals. In sum, in understanding the indirect struggle between the PPP hospital and its competing public hospitals over state power, and in analysing the logistical practices of the agents, their strategies of action, their relative field positions and the possibilities and constraints of the field itself; we come to grasp Bourdieu's principles of "economic practices".

Besides complaining about the challenges of the application process for licenses, certificates, key disciplines, and research funding, participants from PPPs and the private sectors also note the direct threat from public hospitals in severely restricting private capital development. Interviewees from the non-public sectors strongly suggest that state policies should be effectively implemented to restrict the scale of public hospitals. Participant 31, a vice president of the PPP hospital and a core member of the board of directors, tells the investigator:

> "When implementing the policy of restricting the number and scale of public hospitals, health authorities create a very frustrating situation for private hospitals …The truth is that public hospitals are expanding endlessly. Take city Y, for example. Public hospitals like A and B (let's not identify their names) have branch facilities, while C is also building offshoots. It goes without saying that hospitals affiliated with the military are in much better shape. When public hospitals spare no effort to climb to the status of a tertiary hospital, they're using the resource that should have been allocated to private hospitals."
>
> (participant 31, vice president of the PPP hospital)

As discussed in section two, the field of healthcare is a hierarchically organised space where some hospitals are equipped with higher volume and an optimised structure of capital, thus dominantly positioned, while others are subordinate (Bourdieu 2005, p. 201). Well-established public hospitals usually have the capacity and incentive to introduce new talent

and technologies and to scale up, thus increasing their market share. The above-mentioned "public hospitals" in the dominant position are regarded as reference points for the PPP hospital in the sense that the PPP hospital is likely to be positioned in relation to the dominant hospitals in a manner proximate to, or distant from, them. Management in the dominant public hospitals confronting these newcomers from the PPPs or the private sectors are vigilant about what new technologies and health services are introduced and what talents are brought in by these challengers, especially the more powerful ones, according to a president of a public hospital (participant 15). Public hospitals under threat from challengers thus usually tend to promote their established field position, particularly with regards to the previously-mentioned scale-up strategies or struggles over the official title of a "tertiary hospital".

To closely investigate the direct conflict between the dominant public hospitals and the subordinate private hospitals, we need to examine the forms of capital they bring into this struggle. In the diagnosis and treatment of disease, for example, respiratory disease, X-ray CT (X-ray computed tomography) is of principal value in identifying chronic or acute changes in lung tissues. Besides CT equipment, the most critical constituent component in this clinical activity is the medical professional's capability to provide reliable imaging findings and diagnostic opinions. This is crucial for the following decision-making, such as whether patients are to be hospitalised or not and which treatment is optimal for patients. In the case of complex and rare respiratory diseases, the non-public hospital might lack such highly experienced and professional physicians to handle this high-demanding work competently. A private hospital manager tells the investigator:

> "But do you know what the ridiculous thing is? Since private hospitals have limited resources and a shortage of top-flight medical workers, testing reports like CT provided by these hospitals lack convincing diagnoses. So patients take these reports to public hospitals where they are told a new round of check-up is needed because equipment installed at private hospitals is questionable."
>
> (participant 32, private hospital manager)

In this case, the dominant public hospitals aim to maintain the hierarchical structure that benefits them the most, and to safeguard or to improve their position within this hierarchy, thus adopting a conservative stance. The strategy adopted by the public hospitals has a forceful effect in that patients are likely to visit public doctors at the beginning rather than risk doing repetitive examinations; the reliance of patients on quality public doctors further enhances the public hospitals' dominant position. To conclude, this direct struggle between dominant public hospitals and the dominated non-public hospitals implies that dominant hospitals have the capacity to reproduce the unequal distribution of resources in the local healthcare field for their benefit. Medical professionals are used as "weapons" in this struggle.

Moreover, medical professionals are also "what is at stake" in the direct struggle. After the second round of health reforms, the government issued a set of policies and regulations to promote the multi-site practice of physicians, aiming to redistribute high-quality medical resources between regions, such as between developed and less developed areas, and between the public and private sectors. The multi-site practice of physicians in China means individual practitioners are allowed to practice medicine in two or more sites during his or her practising period. In most cases, a physician from a tertiary public hospital may also work in a private hospital or a primary medical institution (Cai et al. 2022). This policy potentially increases the job mobility and autonomy of physicians to choose their sites of practice. However, the policy has not been well implemented, as data from the National Health Commission shows that by the end of 2019, only 210,000 licensed physicians were registered for multi-site practice, accounting for merely 6.5 per cent of the 3210515 licensed doctors in China. In their study, Xu and Zhang (2018) identify the contradictory interests between public hospitals (as physicians' original employers) and physicians as one of the major barriers to implementing this policy. From the side of public hospitals, these may confront difficulties in retaining talent, suffer patient loss and even a reduction of intellectual property if their high-quality physicians balance their time and resources between two or more hospitals (Xu & Zhang, 2018). Another study by Xie et al. (2014, p. 10) also reveals the conflicting interests between doctors and hospitals – the latter had been preparing the former for the medical profession,

thus having the final say in deciding the value of doctors' professional expertise. If multi-site practice is allowed, skills, patients, and even research achievements may be reduced. A similar concern is raised among our participants. Participant 13, who was a PPP hospital manager, points out an issue confronted by the PPP hospital in the battle for healthcare professionals with public hospitals:

> "Another important thing is the permission of doctors and nurses who can work at multiple sites. Actually, they're allowed to do so by law. But the reality is that tertiary hospitals and public hospitals show zero tolerance for multi-site practice. In that case, physicians have to stay away from private hospitals, causing de facto harm to the private sector. In other words, state authorities have given the green light to multi-site practice. But the policy is not implemented by local hospitals. There are many examples, such as the hospital affiliated with the military in XX city and the hospital affiliated with XX University."
>
> (participant 13, PPP hospital Manager)

When asked about the reason for public hospitals disallowing doctors to practice medicine in multi-sites, a president of a tertiary public hospital tells the investigator:

> "That's because doctors' income is based on all their working time spent at public hospitals. Multi-site practice reduces this time. Relevant deductions must be made […] If doctors leave public hospitals to work at private hospitals or PPP hospitals, be it an itinerant practice or an invitation tour, competition between hospitals will arise, the last thing that their original employer wants to see."
>
> (participant 15, public hospital president)

The opposing position-takings of the leading agents in the Public and PPP hospital regarding the multi-site practice of physicians are associated with their locations in the healthcare field. The president in the dominant public hospital seeks to retain medical professionals, thus adopting a conservation stance, while the relatively dominated PPP hospital manager aims to attract medical professionals, especially senior doctors, employing a subversive stance. If we stopped here by concluding that the dominant–dominated positions of public and PPP

hospitals command their opposing position-takings in terms of physician multi-site practice, we would not see the internal struggles between doctors and managers in the public hospitals. Most doctors interviewed take positive attitude towards multi-site practice. A public hospital dentist (participant 33) says, "We have no reason to refuse multi-site practice unless the hospital says no …But I don't want to be on the president's blacklist." Another surgeon (participant 7) from a public hospital expresses a similar positive sentiment towards multi-site practice, "Multi-site practice encourages doctors' initiative. Why not? The sad thing is that public hospitals have no supporting mechanisms […] That's why the well-meaning policy isn't well received."

At first glance, the doctors' hesitance to multi-site practice is associated with the potentially negative impact on their career development. However, the association between a doctor's location within the public hospital, how they perceive multi-site practice, and what action they take is a consequence of field effects. Most medical resources, such as patients, the database of medical cases, and research grants, are still attached to public tertiary hospitals, and public doctors are still heavily dependent on public hospitals to obtain good salaries, promotions and training. The majority of public doctors hold an established post in the work unit, which decreases the possibility of multi-site practice. In addition, working in a public hospital as a "state employee" is still a sign of high social status in China (see Xu & Zhang 2018; Yao 2016). Thus, the mismatch between the medical professions' positive sentiment towards multi-site practice and their actual opposing direction of action results from the characteristics and constraints of the healthcare field. Relating spaces of positions and position-takings within the hospital and between hospitals and other agencies (especially the state) in the field of healthcare enables us to overcome the shortcomings of the economic understanding of an institution as a singular actor where contestations between agents are absolutely ignored.

In the face of the conservative strategy used by public hospitals, PPPs and private hospitals have made demands that the state enforces a series of policies, including data sharing between public hospitals, PPPs and private hospitals, and multi-site practice for physicians. By this means, PPPs and private hospitals may have their CT images recognised by public

hospitals and gain credibility for their diagnostic opinions. On the other hand, medical specialists with high medical capital could enjoy more freedom to practice medicine in non-public hospitals and gain additional material and symbolic profits. Bourdieu defines "codification" in "*In other words"* (1990, pp. 78, 80, 82) as "an operation of symbolic ordering, or the maintenance of the symbolic order"; to codify means to normalise and formalise practices and eliminate vagueness, ambiguity and indeterminacy, especially in the case of interactions. In this study, the state policies enforcing "data sharing" between public and non-public hospitals and multi-site practice – as demanded by PPPs and private hospitals – could be understood as a strategy to codify the practices. Codifying these activities, from a Bourdieusian perspective, is to impose a symbolic order on these activities, including legitimate principles of classification, vision and division. It clearly distinguishes what is allowed from what is not, and what is to be shared from what is entirely confidential. Thus, codification guarantees a "basic minimum level of communication" (Bourdieu 1990, p. 80), especially where struggles or conflicts occur.

Positions and dispositions: the role of the state and debates over public versus private facilities

A long-standing debate in the Chinese healthcare field concerns the appropriate role of the state and the market in health reform and health service delivery. During the years leading up to the second round of health reforms in 2009, officials and intellectuals bitterly debated whether the state or the market was better at financing, organising, and delivering health services. Professor Ge Yanfeng from the Development Research Centre of the State Council, and Professor Li Ling, from the School of National Development, Beijing University, represented the "government approach" camp, arguing that government should undertake the major responsibility for funding and providing health services because only government can ensure fairness (Li 2006). In contrast, Song Xiaowu, former director of the leading group office for the reform of the medical insurance system for employees, the State Council, and Gu Xin, from the School of Government, Beijing University, offered a "market approach". They firmly insisted that Chinese health reform in the past 30 years had not been fully marketised, and because it was incomplete, was likely to be inefficient and would not meet

demand, and hence there should be an unwavering adherence to a marketisation and privatisation strategy in the upcoming reform (Song 2006; Gu 2005).

Participants from public and non-public sectors hold quite antagonistic points of view towards questions about the role of PPPs in healthcare and the relationship between the state and market actors in health service delivery. Almost all PPPs and private sector participants speak highly of the strengths of private sector bodies in the hospital PPPs, the power of private capital, and how these might ease the state's financial burden, advance managerial and operational techniques, and lead to more sustainable designs in the building of hospitals. They stress the decisive role of market logic (especially the advantages of competition) in health resource allocation, which, for Bourdieu, is associated with a 'right-hand' political framework of the state. Through the lens of Bourdieu, a right-hand political framework emphasises individual responsibility in healthcare provision and the integration of market principles (such as de-regulation and re-regulation management) into public service delivery (Bourdieu 1998, pp. 1-4; also see: Richard 2018, p. 2484; Loyal & Quilley 2017, p. 455). Participant 13, who is currently a CEO of a for-profit private hospital owned by an insurance company, mentions that:

> "I'll take xx Insurance company as an example. How can it engage in the healthcare industry? It has three inbuilt competitive advantages: money, clients and an oversight system for all processes. This system is highly relevant to the healthcare industry. The same principle applies to real estate companies. They have intimate knowledge about how to design architecture, create the right atmosphere, and provide sound and human-centred solutions for hospitals. My advice about the strengthened partnership is based on a well-known fact: Developing medical facilities is a long-term investment that requires good financial support to buy state-of-the-art equipment, attract high-calibre professionals, perfect diagnostic and treatment processes, and provide patient-centred services […] Our country also badly needs such support to harness the power of private capital."
>
> (participant 13, for-profit private hospital CEO and previous PPP hospital manager)

Another participant, who is the vice president of the PPP hospital, points out the functions of private capital in relieving the state's financial burden, creating jobs and enhancing the healthcare delivery system:

> "Fiscal support is demanded by many sectors. Moreover, our country has channelled a lot of resources into the medical care industry. If private investment like the PPP hospital not only costs the government no money but also creates many jobs or increases accessibility to medical care, it will be a real blessing to the country."
>
> (Participant 31, vice president of the PPP hospital)

In *Social Space and Symbolic Power*, Bourdieu (1989) argues that what matters in a social space is the relations between positions that are proximate to or distant from each other. Agents in similar positions, for example, tend to acquire similar dispositions (or habitus), thus producing similar practices. Participants from PPPs and the private sector acquire "a sense of their non-public place" through their relative positions in the healthcare field. Accordingly, they display a positive sentiment towards hospital PPPs and even the full privatisation of health services. For PPP and private sector participants, market principles (such as the law of value, supply and demand, and efficiency improvement) are central to healthcare delivery, while the equity principle comes secondary. Participant 32, a senior manager of a for-profit private hospital, regards healthcare as:

> "not a question of fairness, but a question of whether each side can have its needs satisfied. Our needs for service and price are bound to differ. Even the government has its need for the diversification of medical institutions […] I think healthcare needs should be satisfied by the market."
>
> (participant 32, private hospital manager)

In *Social Space and Symbolic Power* (1989), Bourdieu illustrates the relationship between agents' positions and dispositions:

> "The social space is so constructed that agents who occupy similar or close positions are placed in similar conditions and submitted to similar dispositions and interests, thus producing practices that are themselves similar. The dispositions acquired in the position occupied imply an adjustment to this position, which Foffman called the 'sense of one's place."

Participants from the public sector, on the contrary, are concerned about the "for-profit" nature of private capital and its "financial independence from the state". Seen through a Bourdiesian lens (1990, p. 130), the different and even antagonistic perspectives of public sector participants reflect the "public sector" location from which they are taken. Their concerns about hospital PPPs tend to adjust to their "public" locations. As mentioned by public sector participants, "medical expenses" in PPP hospitals might be higher than in public hospitals. On the other hand, in PPP hospitals, the salary paid to medical professionals, especially senior doctors, is higher than in public hospitals, potentially resulting in higher costs for the PPP hospital. The president of a tertiary public hospital compares public hospitals and PPP hospitals in terms of the "for-profit" nature of private capital and says:

> "As things stand, PPP hospitals are making smooth progress and solving some problems that are related to people's access to medical care. PPP hospitals are supported by what public sector bodies are good at – brands, professionals and technologies. The downside is the expense which is slightly higher because of the mixed ownership […] Capital needs an independent operation […]In contrast, public hospitals do demand not so much autonomy [as PPP hospitals do]. As long as their needs in building professional expertise, expanding services, and complying with state regulations are met, public hospitals will do well. However, whe ther it is the case, in the long run, it's hard to tell or conduct an assessment."
>
> (Participant 15, public hospital president)

Additionally, Participant 15 points out the potentially higher salary of medical professionals working for hospital PPPs:

> "And you can't expect doctors to work at PPP hospitals because the work is the same, and incomes don't increase. The only change is an added site, demanding them to travel more. Naturally, they won't welcome such change. But if that is the case, then mixed ownership is meaningless."
>
> (Participant 15, public hospital president)

Several public sector participants bring the issue of health inequality and state responsibility in healthcare delivery into the interview. Participant 7, a public hospital doctor, expresses his hope for a wholly state-oriented healthcare system covering all basic medical needs and the salaries of public doctors. Participant 20, a senior manager from a tertiary public hospital, shows concern about the health inequalities that result from mixed ownership and the involvement of private capital in healthcare:

> "If the government encourages the partnership between public hospitals and private capital to form mixed ownership, will there be big impacts on common people? Mixed ownership means that doctors earn more, which is likely to result in some inequalities or imbalances. Moreover, the general public has reduced access to basic medical care. That explains why mixed ownership is still in its infancy."
>
> (participant 20, public hospital manager)

The negative or vague attitudes of public sector participants toward hospital PPPs, and the perception of an association between mixed ownership and health inequalities, are aligned with Bourdieu's left-hand political framework. Unlike the right hand of the state, which is characterised by a neoliberal ideology, the left-hand political framework stresses state responsibility in healthcare provision, asserts healthcare as a public good of both non-excludability and non-rivalry and stresses the leading role of the state in regulating the market (Loyal & Quilley 2017; Samuelson 1954). Within neoliberalism, social action is understood in economic terms, and human nature is assumed to be based on self-interest, rationality and individuality (Peters 2001, vii, pp. 14-5). Moreover, it assumes, as Bourdieu (1998, p. 31) states, that market forces are irresistible. From the perspective of public sector participants, the for-profit nature of hospital PPPs perfectly fits into the right-hand or neoliberal framework and tends to undermine the state's responsibility for human wellbeing and for

alleviating any consequences such as health inequalities. Therefore, these quite antagonistic points of view towards hospital PPPs reflect a plurality of views towards civil society and create a base for symbolic struggles between public, PPP, and private sector agents over the "legitimate principle of vision and division" of the social world (Bourdieu 1990, p. 134). Struggles thus not only take place between agents or agencies over the symbolic capital of the state, where the aim is to conserve or transform the current state of power relations in the healthcare field, but agents or agencies also act over the dominant political belief of the state which monopolises the production of legitimate categories of perception and the imposition of the symbolic order. Both left-hand and right-hand political beliefs, as mentioned above, tend to be imposed as a dominant and even universal vision of the social world, which, as a matter of fact, arise instead from a specific position in social space.

Summary of the chapter

This chapter focuses attention on the experience of social and political agents with hospital PPPs revealing a picture of the social and policy environment faced by hospital PPPs. This chapter explains the opposing strategies deployed by management in public and PPP hospitals using Bourdieu's conceptual framework (field, capital, habitus, the state, positions and position-takings). The local healthcare field is analysed as a field of struggles between well-established public hospitals and a newly built PPP hospital. By registering as a not-for-profit hospital, managers in the PPP hospital aim to gain patient trust, on the one hand, and utilise medical insurance funds, on the other, thus maximising the hospital's field position relative to that occupied by public hospitals. Public and PPP hospital managers express requests for state support in terms of business licences and equipment certificates, research funding, data sharing and multi-site medical practice, and these requests are often contrary, either seeking to preserve or transform the current state of play. In addition, antagonistic perspectives towards hospital PPPs can be found between public and non-public sector participants. These opposing strategies and attitudes reflect the actors' dominant or dominated, public or private locations in the local healthcare field, respectively. It can also be seen that public hospital managers, rather than submitting to the neoliberal trend, show resistance to hospital PPPs and associate this phenomenon with health inequality and the withdrawal of state responsibility for health service delivery. What appears to be at stake in

this field of struggle is the state's symbolic power, which is not only institutionalised through qualifications, licenses, and titles but also exists subjectively through the principles of classification imposed on agents in universal ways. The next chapter, chapter six, will investigate the contested experience of healthcare professionals (primarily doctors and nurses) with hospital PPPs.

Chapter Six - The experience of healthcare professionals with hospital PPPs: Contest, Struggle, Capital and Habitus

Introduction

Chapter Five investigates the experiences of political and market actors associated with hospital PPPs, particularly in the context of a provincial healthcare field. This chapter examines the experience of healthcare professionals in a PPP hospital, comparing these with experiences in public hospitals and employing concepts elaborated in chapter two, such as professions, professional autonomy, field, capital and habitus. Sections two and three of this chapter are focused on the medical and managerial professions in both public and PPP hospitals. This part of the chapter concurs with the view that the medical and managerial professions are not best understood within the functionalist tradition but rather from an approach that theorises the professions as agents in a Bourdieusian field. The fourth section concerns the response of doctors and nurses to the pressures for revenue generation, the evidence-based evaluation system and a clinically unfriendly purchasing system. The findings reveal that some participants comply with the managerial ethos within the PPP hospital, while others display a critical sentiment towards it even though little effort is spent in open confrontation. The chapter concludes with the proposition that the experience of healthcare professionals with hospital PPPs is best understood as a contestation between the traditional medical profession and the newly emerged managerial profession over control and domination of professional practices and work conditions.

On medical professionals in various types of hospitals in the healthcare field

Chapter two offers a critical review of the theorisation of the medical profession, examining the conventional functionalist approach and the subsequent Marxist and Weberian explanations. The early functionalist approach under which the medical profession is defined by a set of traits, such as a specific body of abstract knowledge and skills and an altruist set of values, came under criticism from scholars using either Marxist or Weberian perspectives for failing to link professional authority with the class structure, on the one hand, and with other social actors, the state for instance, on the other. Bourdieu, however, argues there is a need to

go beyond Marxist and Weberian explanations and recommends replacing the concept of the profession with that of the field. He criticised the concept of the profession as:

> "a folk concept which has been uncritically smuggled into scientific language and which imports into it a whole social unconscious. It is the *social product* of a historical work of construction of a group and of a *representation* of groups that has surreptitiously slipped into the science of this very group."
>
> (Bourdieu & Wacquant 1992, pp. 242-3)

The reason for Bourdieu's criticism is that it has the "appearance of neutrality" but veils the struggles over who deserves the title of the profession, who should be placed highly within the occupational hierarchy, and which profession is worthy of greater autonomy and higher social status (Bourdieu & Wacquant 1992, pp. 235-47). Using the analogy – "as a chef is to a restaurant, so is a famous doctor to a hospital", one participant (participant 17, expert advisor for the Health Commission of the local area) stresses the irreplaceable position of senior doctors in the hospital system. This analogy illustrates the value of prestigious doctors and explains the practice in PPP hospitals of seeking to poach public doctors by offering higher salaries. This finding reveals the fact that some doctors are dominant, and others are subordinate within the professional hierarchy. Important questions raised here are: what constitutes the medical profession in the Chinese context? What social factors are essential to maintain a dominant position in the professional hierarchy?

During the Republican period, the term "*ziyou zhiye zhe*" (free professionals) was first used in official documents of the nationalist government to identify professional groups such as medical doctors, lawyers, journalists and academics. As of 1922, both traditional Chinese and Western-style doctors were required to be examined and registered by the state authority, as was stipulated in a regulation enacted by the Ministry of Interior (Xu 2001, pp. 1-3, 137-9). During the same period, medical professionals constantly sought support from the state to protect their professional privilege, for example, their autonomy in setting education standards and service fees, forming medical associations, and publishing medical journals (Yao 2016). These events and efforts indicate the importance of state recognition and legitimacy granted to Chinese doctors in their claim to be a profession. With the

establishment of the People's Republic in 1949 (and as discussed in chapter four), Chinese doctors became state employees and served the interests of the state. For the next two decades, doctors had little say in their work and work conditions. Arguments have been made that Chinese doctors during this period underwent a process of de-professionalisation (Sidel & Sidel 1973). After the health reform of 1978, however, the state cut its financial support for public hospitals while introducing NPM, privatisation and PPP practices into the system. Under these circumstances, Chinese doctors had to take into consideration their own interests, those of their patients, and the economic interests of their organisations when practising medicine. In other words, their position in the healthcare field and within the occupational hierarchy after the reform has not been solely determined by cultural capital (medical knowledge and skills): their capacity to satisfy economic and management requirements also matters.

A new trend emerged in 1998 when the *Medical Practitioners' Law* was introduced. The law specifies requirements for licencing examinations and procedures and also clarifies doctors' rights and obligations. In 2002, the Ministry of Health proposed that public medical professionals should be transformed from a "work unit person" to a "social person". This was read as a significant step by the state in turning Chinese doctors into free professionals (*ziyou zhiye zhe*) (Yao 2016, p. 12; Yang 2006). After the second round of health reform in 2009, the state placed more emphasis on medical education and academic research by developing universities, reforming curriculums, and standardising the qualities of medical education (please see Hou et al., 2014; Xu et al., 2010 for details). All these policy measures have increased the professional autonomy of Chinese doctors.

Seen through a Bourdieusian lens, the historical development of the Chinese medical profession suggests that medical professionalism is continuously at stake both within the professional field and in the general field of power. The definition of medical professionalism is constantly debated. The medical profession thus can be seen as a group of agents located in the contested field of healthcare, which rests upon a set of institutionalised medical practices (e.g. Noordegraaf & Schinkel 2011; Bourdieu & Wacquant 1992). As described above, Chinese medical professionals, over time, increasingly invested in education and research (cultural capital), which is institutionalised in the form of qualifications, in associations

(which can be seen as social capital in the institutionalised form of memberships and credentials), as well as in marketable knowledge. These efforts were made by Chinese medical professionals to gain recognition in the field of power, especially recognition from the state. Therefore, to become a medical professional, one has to acquire legitimate professional capital, thus a form of symbolic capital. The distribution of symbolic capital determines who is a professional and who is not, who is dominant and who is dominated. In other words, those medical professionals who can wield more power (capital) are dominant, more prestigious, and thus obtain higher salaries. Thus, a Bourdieusian understanding of the medical profession in relation to the field assists with explaining why senior doctors get an annual salary of millions of RMBs within the PPP hospital. A hospital administrator with 3-year public and 4-year PPP hospital working experience points out that:

> "[...] we [the PPP hospital] have advantages in talent introduction because public hospitals won't spend a lot of money on hiring experts like directors and professors of the XXX Medical University. However, we [PPP hospital] invest a lot in this... For example, we have experts entitled to the State Council's allowance and experts who participate in the consultation of the Central Military Commission [...] In terms of the annual pay, we provide millions of RMBs of annual pay (for experts), which is impossible for public hospitals, and [the PPP hospital] has advantages over public hospitals in this aspect."
>
> (Participant 3, an administrator)

It is perhaps not surprising that the higher income of doctors, including their basic wage, job subsidies and performance pay, are found in the PPP hospitals rather than in the public sector:

> "The payroll [in the PPP hospital] is much higher [than that in the public hospital] [laughter]. Both merit pay and base pay are twice as much as the original [in the public hospital]. "
>
> (Participant 19, a doctor)

While in contrast with their private counterparts, public hospitals are not able to put so much economic capital into physician retention as a result of the *salary system of public hospitals*, which was jointly issued by the Ministry of Human Resources and Social Security, the

Ministry of Finance of the People's Republic of China, National Health Commission and The State Administration of Traditional Chinese Medicine (The Ministry of Human Resources and Social Security PRC, 2017). The salary system stipulates the upper limit of the annual salary of public doctors at all levels; the maximum annual pay for senior doctors is around RMB 300,000, although the limit varies from province to province. As stated by the government, this salary system is to curb the endless pursuit of profit and maintain the nature of public welfare in public hospitals (Medical Administration and Hospital Authority PRC 2013; Qin 2016). Public hospitals and PPP hospitals in the healthcare field have their own "rules of the game" and their internal "logic of practice" (Moore 2014, p. 53, 56-7; Thomson 2014, p. 68). In this case, the state, as a dominant player in the field of power, through policies concerning salary setting for public doctors, exerts symbolic power towards the public hospitals and shapes what they can do regarding doctors' pay, while privately owned hospitals enjoy more autonomy in terms of this issue.

Bourdieu bridges objectivity and subjectivity by revealing the relations between field and habitus, thus between the objective "social reality" and the subjectivity of doctors. The relations between the structure of the medical field and the medical habitus of doctors and nurses hold the key to understanding the logic of their practice (Bourdieu & Wacquant 1992, p. 127). Medical habitus, of course, can be transformed across different cultures and contexts. It is, according to Bourdieu's conceptual framework, structured by one's family upbringing and educational background in medical schools, past career experience in medical institutions, and present work circumstances (Bourdieu 1975, pp. 29-30; Maton 2014, pp. 50-3). Doctors gradually develop a feel for the game within the healthcare field and become conversant with the yardsticks of being a doctor and what constitutes a good doctor (Luke 2003, pp. 23). These include but are not limited to the importance of knowing the medical discipline and practical skills such as making clinical diagnoses, giving prescriptions and performing operations, and communicating with patients and colleagues. Doctors then think and act in correspondence with the inherent rules of the game within the medical field, which become embodied in the minds and bodies of doctors. Within the traditional public hospital, the practice of doctors conforms to the underlying principle of "being a good doctor both in clinical work and scientific research" (participant 28, a doctor), a principle which was historically established within that field. When these public doctors leave for the PPP

hospital, where there is strict financial performance evaluation, they nevertheless maintain traditional modes of thinking and acting. This results in *Hysteresis,* Bourdieu's term for this problem. In *The Logic of Practice,* Bourdieu emphasises the indeterminate nature of *Hysteresis* effect:

> "The presence of the past in this kind of false anticipation of the future performed by habitus is, paradoxically, most clearly seen when the sense of a probable future is belied and, when dispositions ill-adjusted to the objective chances because of a hysteresis effect,... are negatively sanctioned because the environment they encounter is too different from the one to which they are objectively adjusted. "
>
> (Bourdieu 1990, p. 62)

In this case, doctors and nurses' trajectory from public to PPP hospital, results in a mismatch between their attitudes, dispositions and practices which are historically structured through experience (especially previous experiences in the public hospital) and the market atmosphere in the PPP. . Such a mismatch explains participants' feelings of being "overwhelmed" and "squeezed" (participant 2, an administrator; participant 9, a doctor) and thus being a "fish out of water" (Maton 2014, pp. 58-9, 61). Although the doctors who participated in the study reported the existence of financial incentives in the PPP hospital, almost all feel that their workload in the PPP hospital is much higher than it was when working in the public hospital. Doctors, particularly frontline doctors, mention that they work overtime almost daily without extra pay. It is also reported that the doctors have an extensive amount of both clinical and administrative work, some of which they claim to be unnecessary. According to the physicians interviewed, they seldom have free time outside of work:

> "I […] arrive at the hospital at 7:50 [am] every day for handover, and after the handover, at about 8:00 [am], then start receiving patients [...] Since we are surgeons, sometimes the operation takes a long time, and after that, I will also do some paperwork, such as a therapeutic schedule for patients, and try to get to know the patient's condition and explain. So usually, we can't be off until eight o'clock in the evening […] We used to be not so tired when we worked in public hospitals […] Since we came here [the PPP hospital], we have always felt tired every day. We usually go to sleep when we get home and go to work when we wake up, and so on. Today is the weekend; that's why I have time for your interview."

(Participant 25, a doctor)

When asked why they feel so overworked, doctors complain that the job in the PPP hospital, compared with that in the public sector, is more demanding in terms of financial (including business and operation) performance indicators. Performance Indicators, or Key Performance Indicators (KPI), are used as a management tool to measure accountability and performance and track progress towards a predetermined target (Noodegraaf 2015, pp. 1-3). The demanding requirements concerning financial performance reflect an emphasis on outcome control, an emphasis commonly found in the private sector and adopted in the management of the public and not-for-profit sectors (NPM agendas). In the hospital context, the financial outcome of individual workers and departments is tightly linked to relative rewards and resource allocation (Noodegraaf 2015, pp. 33-8; Hood 1991, p. 4). Performance evaluation was introduced into the Chinese hospital system in the 1980s, and the major tools used to evaluate individuals include KPIs and Balanced Score Cards (BSCs) (Mei & Kirkpatrick 2019). In the PPP context, the administrative work assigned to clinical doctors and demands for the financial and performance management of their clinical work, in Bourdieu's terms, can be seen as strategies used by hospital managers and administrators to regulate doctors' clinical practice.

The problem of *Hysteresis* is illustrated by participant 27 (a doctor), who resigned from his job as a public doctor three years previously and joined the newly established PPP hospital, which he thought would bring about better financial rewards and promotion prospects. Nevertheless, he indicated the strict business performance indicators to be a primary cause of distress. When participant 27 was interviewed, he had had an exhausting workday:

> "The hospital of public-private partnership or private nature usually has higher business indicator requirements for its departments. It will rank the business indicators in the middle or at the end of each year. It is more obvious than in public hospitals [...] It ranks not only among the departments but also within departments [...] The amount of surgery, the amount of patient income and expenditure, and the number of prescriptions, basically that's all [which will be considered for ranking]. The public hospital will provide you with a ranking by overall income, which, however, won't be so obvious [...] If you rank lower [than other doctors], you will

> definitely receive some [blame] from the leader, and if you rank higher, you will surely be rewarded... which will bring a lot of pressure..."
>
> (Participant 27, a doctor)

This quote from participant 27 reflects his sense of resistance to the market-oriented changes in the work environment - from a public sector with lower revenue-generation pressures to an intensely competitive private arena. This oppressive atmosphere also produces a sense of guilt about advising patients to be hospitalised when unnecessary or retaining patients when knowing that alternative private hospitals do better in dealing with this kind of disease.

These different but negative responses to the market-like atmosphere, with revenue-generating pressures and performance rankings, are results of *hysteresis* (mismatch) between the traditional medical habitus of doctors and the field of the PPP hospital before a new habitus adapted to the market context is established. In Bourdieu's words, there always incurs "negative sanctions" when the mismatch occurs (Bourdieu & Passeron 1977, p. 78). Therefore, participants' sense of overload and resistance mainly arises from financial pressures, and it is repeatedly cited that the PPP hospital focuses more on business outcomes than individual patients or academic research. Their habitus, which is shaped by their social past and the evolving field and field positions in which they are situated, is the source of their logic of practice. Therefore, moving back and forth between field and habitus and understanding professionals as active and creative agents in contextual fields holds the key to understanding their meaningful practice. Before we turn to a more detailed discussion of the responses of doctors and nurses to the managerial ethos within the PPP hospital, we elaborate on a Bourdieusian meaning of the managerial profession in the hospital field.

On managerial professionals and management in the healthcare field

With the introduction of New Public Management and managerialism into the Chinese healthcare field, healthcare managers have become powerful in setting standards and altering the organisation of healthcare delivery. This latter has primarily been achieved through the adoption of a corporate management model in health service organisations, which claims to

improve efficiency, the quality of care and control of costs, in other words, to achieve "Value for Money" (Liang et al. 2020a; Mei & Kirkpatrick 2019). This new class of managers has been educated through credentialised courses such as a Master of Public Service Administration, Master of Health Service Management and Master of Business Administration, which all include core units from economics, financial management, human resource management, and organisational management. Managers build associations where they can exchange resources and share sets of work codes to standardise and professionalise their managerial activities (Liang et al. 2020b; Noordegraaf & Schinkel 2011, pp. 108-9). In China, for example, there are managerial associations such as the China Hospital Professional Managers Alliance, which is closely linked with China Hospital President Magazine, The Hospital Management Research Institute of Tsinghua University and some private Medical Groups. This alliance portrays itself as "focusing on the operation, management and operation of Chinese hospitals, with professional management and baseline requirements as the guide, and professional hospital directors as the main body, to build production, academia and research capital... " (Chinese Hospital President Magazine 2017). In Y City, there is a major association of hospital managers, Y City Hospital Association, which was formerly known as Y City Hospital Management Association. It holds annual academic conferences focusing on topics such as performance appraisal of public hospitals, Diagnostic-related Group (DRG) payment and hospital operation management. It develops continuing education programs for its members. Following Bourdieu's logic of "distinction", these efforts are invested not only in making themselves competent managers but, more importantly, in distancing themselves from the already-established professions, such as medical professionals. In the healthcare field, managerial capital is a form of capital that is disguised and doesn't appear as a form of economic exchange. It is presented as reflecting the intrinsic value of managerial knowledge and skills and the capability of disinterested managers to improve efficiency. It veils the space of struggles over whether managerial capital is more valuable and worthy than other forms of capital within the field. Thus, Managerial capital is a form of symbolic capital.

In the PPP hospital, the performance management system, including performance-based pay and regular rankings of the financial performances of departments and individual doctors, as mentioned in the previous section, could be viewed as efforts made by hospital managers to

redesign the work standards of doctors. Hospital managers and administrators deploy managerial capital and speak about doctors' work in a managerial way, for example, by using terms like "KPIs" and "competitions". As has been argued by Noordegrassf and Schinkel (2011), "Managerial professionalisation, in other words, is not so much about managers and their capital, but about managers in relation to others, most especially other professionals." Even though there have been complaints about the overwork produced by revenue-generation pressures and insufficient healthcare workers; doctors and nurses also express positive sentiments towards the increased administrative efficiency in the PPP hospital where managerialism is more evident.

> "It seems that many administration arrangements are serving clinical services, for example, in the grant application. Whenever you have a problem, the staff of the Research Section will actively assist you in solving it. The staff of the Research Section is very enthusiastic about providing application guidance to you, and they will update you on the progress made. After the grant is successfully received or awarded, they will tell you the procedure to reimburse some costs[...] [as for] public hospital... [the thing is] after you communicate with the clerk, the clerk will communicate with his leader, and the leader will communicate with his leader, which will take a long time. There is no such face-to-face communication [with the leader of the administrative department]. However, the administrators in the PPP hospital are all very responsible. As long as you ask, they will be enthusiastic about helping you. This is a huge difference. "
>
> (participant 5, a nurse)

A former administrator who left the PPP hospital also discusses its higher administrative efficiency than public hospitals.

> "The difference is that the work efficiency and working capacity requirements (of PPP hospital administrators) are higher than those of public hospitals. This gives me the feeling of working for a Fortune 500 foreign company. The work intensity is very high, and the working capacity is demanding. [...] Our department is called the Department of Personnel Science and Education. In the past, the Department of Personnel Science and Education (in a public hospital) had more than 50 people (administrative staff). [...] The Scientific Research Office of XXX Hospital (a public hospital), its office has several people, the ethics committee has several people, and the library has several people. Then, the Scientific Research Office is a division-level unit. There are various departments (section-level departments) below, and the staff in

> the scientific research department adds up to nearly 20 people. However, the scientific research management work I am responsible for (in the PPP hospital) alone is equivalent to (the workload of) 20 people, and surely our (work) is not as large as theirs. Still, we are responsible for as many affairs (items) as they do."
>
> (participant 2, an administrator in the PPP hospital)

Nurses interviewed for the study are also complimentary about the work of PPP hospital managers, saying that they show care for employees and invest in some resources (fitness rooms and club activities, for example), which makes the nurses feel important and valued:

> "I've been in [the PPP hospital] for several years, and on the occasion of every 12th of May [International Nurses Day], we usually organise some meaningful and interesting activities. [In the public hospitals], you will be given only a bunch of flowers or a small gift, that's all [seems very perfunctory] [...] In fact,12th May is kind of important for nurses, and [the PPP hospital] pays great attention to the care for the employees and the training of employees".
>
> (participant 4, a nurse)

These sentiments in favour of the efficiency of the hospital administration, in a Bourdieusian sense, reflect the managerial capital deployed by healthcare managers. In this case, healthcare managers introduce practices with names such as "communication skills", "grant application tools", and "care for employees". These strategies are used to express support for doctors' and nurses' work and emphasise the importance of their professional work. However, seen through a Bourdieusian lens, these efforts are made to secure managers' and administrators' field positions and legitimise their power and control over their professional practice and work conditions. To conclude, understanding medical and managerial professions as agents in contextual fields display a shift from the functionalist explanation of the profession to a structuralist account that links healthcare professionals as agents and other actors in an ever-changing field in which they were, and are, situated.

Medical and managerial capital and habitus contest for domination

For Bourdieu:

> "a field consists of a set of objective, historical relations between positions anchored in certain forms of power (or capital), [...] A field is simultaneously a *space of conflict and competition*, the analogy here being with a battlefield, in which participants vie to establish a monopoly over the species of capital effective in it [...] and the power to decree the hierarchy and 'conversion rates' between all forms of authority in the field of power."
>
> (Bourdieu & Wacquant 1992, pp. 16-8)

The PPP hospital involves doctors, medical technicians, nurses, administrators, managers and some other actors, such as patients. Positions occupied by these actors are objectively and historically connected as well as contested. The most strategic distinction of medical professionals, as proposed by Freidson (1970, pp. 82-3) and Willis (1983), is their legitimate autonomy and control over their work and their medical domination over other healthcare workers: something which is achieved by the subordination, limitation and exclusion of other healthcare workers (Willis 1983). However, within the PPP hospital, it has been increasingly difficult for doctors and nurses to maintain their autonomy over professional practice. For example, according to the doctors and nurses interviewed, the supervision and management of clinical work and the medical workforce are integrated and flexible in public hospitals. The quality control system is exercised through a patient-centred team and focuses on the clinical work itself. However, the clinical work in the PPP hospital is organised separately, and the evaluation focuses on the data. Participant 5 is a clinical nurse who joined the PPP hospital three years ago. She expresses a difference of opinion towards the evaluation system between the public and the PPP context. She notes that the evaluation activities in the public clinical nursing department follow the logic of tracing the source of risk identification and finding out the systematic strategy for risk mitigation:

> "For example, if you are chosen for the spot check, and you are the nurse in charge, then you will be checked whether you are familiar with the therapy condition of the patient if the patient falls, which is of high risk, how you will deal with it [to avoid such a high-risk event]? And whether the patient will agree with you. They (the administration) will also check whether the department provides training on the

> solution to high-risk patients, whether the department has set up such a system, and whether the nurses implement it. That's how it is [traced] back."
>
> (Participant 5, a nurse)

In the PPP context, however, the clinical nursing work is evaluated separately. As participant 5 points out, the evaluation system looks pretty rigid and is not clinically driven:

> "For example, I got a patient today. The nursing department will check if the patient is at high risk and whether there are high-risk indicators. But they do it in a very brief and rough way. They will read the note about the patient and see what kinds of indicators the condition should deliver, then check the patient to find out if his or her indicators will match. That's how they do it."
>
> (participant 5, a nurse)

The view of participant 5 is corroborated by another nurse — participant 22. This nurse worked in a public hospital for fifteen years and then began her career in the PPP hospital three years previously. She explained that the supervision of clinical activities in the PPP hospital is "formal" compared with the "flexible" system of the public hospital. The Personal Digital Assistant (PDA), she mentions, is a small electronic device that has come in recent decades to be used in healthcare to assist doctors and nurses with daily activities. The public hospital she used to work at, and the PPP hospital use the PDA to supervise clinical activities such as registering one's arrival at a specific work location, performing transfusions, and overseeing the ward. The public hospital chooses to merge the "punch in/out" for transfusion and ward overseeing to adapt to the clinical activities during rush hours, whereas the PPP hospital strictly adheres to the clock-in system, which may sometimes distract nurses from busy clinical schedules. These different approaches to management produce a variation in participant 22's feelings from "flexible" to "stiff" and "formalised". Participant 22 also discusses the way the public hospital uses an 'integrated' form of holistic care for patients, while the PPP hospital uses a 'separated' form of patient care:

> "[In] the hospital where I used to work, the patient would be totally in my charge from his admission to discharge, and I would tell him about everything, including pre-operative education, prompts during operation and [precautions] related to nursing, and teach him how to cough up [mucus] and the nursing he would receive after the

> operation, which is all completed by me... It's not like [in the PPP hospital] I am temporarily in charge of some patients arranged by the team leader today, and tomorrow after I change shift, they are not in my care."
>
> (participant 22, a nurse)

The "integrated" - "separated" differentiation of management style is also reflected in the interview of participant 23, a matron with 14 years of work experience in one public hospital and four years in the PPP hospital. As participant 23 points out, public doctors directly communicate their orders with ward nurses, who are in charge of the same patients, so that nurses can execute their orders as correctly as possible. There is a "middleman" - an office nurse in the PPP hospital - between doctors and ward nurses, and ward nurses are usually informed of the doctor's instructions via this middle person. Participant 23 states that in most cases, doctors responsible for the same patient do not even know who she is. This is a problem that rarely occurs in the public hospital.

The management of medical activities in traditional public hospitals, as noted by both doctors and nurses in this study, focuses on the "patients" and the "clinical work" itself, which means medical professionals enjoy significant autonomy over their day-to-day professional practice and appear to possess absolute authority over professional decision making. Seen through a Bourdieusian lens, the positive sentiment of doctors and nurses towards the clinical management in public hospitals is associated with their past experiences in the public hospitals as these individuals carry with them pre-dispositions from the habitus arising from the public hospital, where doctors and nurses enjoy a high level of autonomy over their everyday professional practice. Thus, several participants have the view that they "fit in better with" the ethos of a medical professional rather than the managerial ethos of the PPP hospital.

When doctors and nurses migrate to the PPP hospital, where their performance is continuously evaluated and their professional autonomy is eroded, they confront a clash between the pre-disposition of their habitus and the *doxa* of the PPP hospital. In the PPP hospital, the business-oriented management practices seek to restructure the medical habitus

and introduce a new *doxa* (or unquestioned rules of the game) based on market logic. Managerial principles assume that, like the tasks in standard production organisations, medical activities can also be assessed by performance standards and measures, preferably in the form of quantitative data (Hood 1991, p. 4). Indeed, an even more fundamental principle introduced by the NPM agenda is the disaggregation of organisational logic and a greater emphasis on competition. Individual healthcare workers are regarded as profit-making entities, and the rivalry between them is believed to hold the key to higher efficiency and lower costs. Moreover, managers are accountable for the performance of individual workers and the overall use of resources and balance sheets (Hood 1991, p. 5; Meagher et al. 2009, p. 334). This philosophy potentially re-orients medical practice towards profit-driven activities, and the medical habitus of professionals is likely to alter with the new practices and regulations set by administrators.

Where the new managerial ethos is confronted by workers in the PPP hospital, some participants seek to comply with the performance and data-based evaluation system, while others resist this. Some doctors regard themselves as part of the "business department personnel" and focus their attention on revenue generation in the PPP context, which means treating more patients, improving the economic performance of the unit or the hospital as a whole, and devoting less effort to integrating clinical work with the needs of the workforce (participant 9, participant 27, doctor). In this way, these doctors comply with managerial beliefs and principles, focusing on competition, efficiency, and outcomes, thus undermining the *doxa* of the traditional public hospital. Bourdieu's conceptual framework could be applied to explain this phenomenon as a practical process of adjusting one's dispositions to his or her current position in the PPP hospital. The "business department" in the PPP hospital bears responsibility for generating revenue and making profits. Participants' practices of conformity to such market-oriented processes suggest the transformation of dispositions as they adapt to their field positions.

Not all participants comply with the managerial ethos in the PPP hospital, as described above. Some doctors interviewed convey a sense of resistance to this market process:

> "I used to work in a public hospital, and after I entered our hospital, the biggest difference, I think, to put it frankly, is that this kind of hospital of public-private partnership puts economic benefits first, while I feel that public hospitals put their duty to serve the society first. Although our hospital is a public-private partnership, the profit-seeking nature of social capital cannot be changed [...] For example, public hospitals will arrange training in other provinces (or even foreign countries) on a regular basis for doctors, with the aim of fostering a talent pool and establishing a perfect talent team. But in our hospital, this kind of training opportunity is relatively less, and it seems that sending personnel out for training is a waste of human resources."
>
> (Participant 28, a doctor)

It can be seen from the quote above that the PPP hospital involves economic and management requirements that may not sit easily with the public sector habitus of many staff. This mismatch is also reflected in a surgeon's description after experiencing a managerial ethos in the PPP hospital:

> "Because the clinical department is the core one in the hospital. Frankly speaking, the hospital can only survive, only if the patients can be diagnosed and cured. One cannot run a hospital with just some administrative staff. Therefore, theoretically, the administrative staff shall serve the clinical staff. But the case is the opposite in our hospital (the PPP hospital). I feel that the administrative departments have a lot of power. For instance, in a clinical department, such as our surgical department, we have to admit many patients every day, and there are many surgeries every day. But sometimes the administrative department often arranges some meetings for us in the hospital. There are many meetings in this hospital, and almost every week, we have to attend a meeting. Doctors are required to participate in meetings in the hospital [...] whether they have operations or not. If there is an operation, a special explanation must be provided, and after asking for leave from the director of the department, the doctor should report it to the administrative department for approval. This gives us the feeling that it is more important to have a meeting than to treat a patient and conduct an operation. If you don't sign in at the meeting, you will be punished according to all kinds of punishment systems in the following forms: informed criticism, deduction of the employee points in the department, and direct fines."
>
> (Participant 9, a doctor)

This criticism of the managerial process in the PPP hospital represents a contest between forces to conserve the established medical habitus and the managerial ethos and demonstrates

the possibilities and constraints of working conditions under which medical capital is exercised.

In the field of struggle over control of professional work and working conditions, even though some doctors and nurses display a deep sense of resistance to the managerial ethos in the PPP hospital, little effort is invested in *open confrontation* to maintain the medical habitus associated with public hospitals. Bourdieu's conceptual framework would explain this phenomenon as a strategy used by these participants to maintain their positions in the healthcare field. As discussed in Chapter four, the state permission given for privatisation and PPP practice in the Chinese healthcare field has increased the autonomy of medical professionals to practice in the non-public sector. However, medical professionals still exercise little power over their salaries and work conditions, which means they remain powerless in relation to the state and their work units. Despite the fact that China does have peak professional associations such as the Chinese Medical Doctor Association (CMDA) and Chinese Nursing Association (CNA), unlike its Western counterparts where the professional bodies represent the professional interests of doctors and nurses independent of the state, the Chinese national professional associations mainly perform regulatory and training functions on behalf of the state (Mei & Kirkpatrick 2019; Yao 2016; Yang 2010, 2006). In addition, medical professionals are still largely dependent on their employing hospitals to access various resources such as patients, medical equipment and research grants and to get promotions in the medical professional ranking system (Degling et al. 2006). In the PPP hospital, senior hospital managers, as indicated by some participants, exercise control over the criteria used to evaluate the performance of doctors and nurses, the appointment process (e.g., the appointment of chief physicians), and finally, the distribution of medical resources between departments and individual doctors. Therefore, to maintain their position in the healthcare field and secure resources attached to that position, doctors and nurses display a tendency to avoid open confrontation. The relatively powerless position of medical professionals in relation to the state and their work units further contributes to this tendency. This finding resonates with Degeling et al.'s (2006) cross-cultural study on the relations between the medical profession and management in China and several Commonwealth countries (Australia, England and New Zealand). Dengeling and his colleagues find that compared to their Commonwealth counterparts, Chinese medical professionals are more

receptive to a managerial ethos in hospital settings and adopt a much less defensive stance towards issues that their Commonwealth counterparts consider to be threats to their clinical autonomy. However, our interviewees display a sense of agency to the managerial ethos in the PPP context. They draw upon their past experiences in public hospitals, their professional ethos, and their understanding of their work and the needs of the patients to judge the new structural conditions in the PPP hospital: rather than being passively transformed by the new conditions, as suggested by Degeling and his colleagues. It can be seen that some doctors interviewed express dissatisfaction over the threats to their professional autonomy, and consider themselves as members of a medical profession with medical knowledge and expertise. According to Freidson (1970a, p. 82), professional autonomy – "a position of legitimate control over work" – is seen as the most important distinction between professions and other occupations. In other words, a medical profession is immune from external intervention, enabling its members to make independent decisions in practice. However, when confronting the managerial ethos in the PPP hospital, participants do not have a formal professional body representing them in the struggles with the new hospital managers or the state. This implies that even though the training and socialisation of Chinese doctors provides them with an identity of professionalism and professional practice, the Chinese medical profession is less established as a formal institution than in some other countries such as America, Australia, and Britain. Chinese doctors occupy a less powerful position than in some other developed countries.

With regard to the purchase of drugs and medical devices in the PPP hospital, there are contrasting viewpoints among the interviewees. On the one hand, interviewees speak favourably of the faster purchasing process and greater investment in drugs and medical devices in the PPP hospital relative to the public hospital, particularly for sophisticated and costly equipment:

> "As you know, our hospital [PPP hospital] has had MRI equipment, a Gamma Knife, and nuclear medicine since it opened, and an investment in all hardware... it is not the case for the XXX Hospital [a public hospital of almost the same scale], which invests in a very slow manner [...] When I joined the XXX Hospital [the public hospital], it had been open for six or seven years, and for the first time, it was equipped with MRI [equipment]."

(participant 3, an administrator)

The availability of very advanced devices also appeals to some senior doctors:

> "[For a Surgery Department director,] the biggest temptation for joining the hospital is to use a very good scalpel, which is very expensive. The former hospital [can't buy it] according to the relevant government procurement regulations or hospital procurement regulations, [so] it can't be used there."

(participant 8, a doctor)

The examination and approval of new drugs and medical devices are also sped up in the PPP hospital, according to a matron (participant 4):

> "Our department adds a new program, which requires some consumables and medicine... in our hospital [the PPP hospital], such an application will be approved soon... But in a public hospital, it would be difficult. For example, if you want to apply for a piece of equipment or an instrument for the department, it will take forever to approve."

(participant 4, a matron)

The private investor of the PPP hospital, X Capital, contributes significantly to the more timely and greater investment in drugs and medical devices. The hospital PPP case is an operational arrangement between the public medical university and for-profit X Capital. The roles X Capital takes in this contractual relationship include building and operating the hospital, and at the end of the contract period, X Capital and the public partner share ownership of the hospital. The two parties agreed to guarantee that X Capital supplies at least 75 per cent of the drugs, reagents, consumables, and devices procured by the PPP hospital, as described in Chapter five. However, fundamental distinctions exist between the procurement of drugs and medical devices in public and non-public hospitals. First, public procurement requires a significant amount of government funding, while private and PPP hospitals generally draw on their private capital to satisfy purchasing needs. In Y City, it is typical for a public hospital to have a periodic purchasing plan, for example, an annual or a monthly plan. They are required to inform the

municipal health commission of their anticipated purchasing needs. The municipal health commission, jointly with the finance department and the market regulation administration, examine and authorise their overall budget under a procedure approved by the local People's Congress. The budget for a public hospital's purchase is finally authorised again by the municipal finance department (Wang & Li 2014; China Tendering and Bidding Association 2013). As Xu et al. (2019) point out, budget allocation to public hospitals is based on fiscal capacity and capital investment rather than the needs of each facility or local community. Second, tendering methods are divided into open tendering and invitation to tender. Open tendering, also known as unlimited competitive tendering, is where the tenderee invites unspecified legal persons or other organisations to tender after the issuance of a tender notice. Invitation to tender, also called limited competitive tendering, means that the tenderee invites specific legal persons or other organisations to tender after the invitation. *The Y City Bidding Regulations* stipulate that open tendering is required for construction projects in which state-owned funds are controlling or dominant (e.g. public hospitals) and which must be tendered in accordance with the law. Invitation to tender can be adopted when non-state-owned funds (including private and foreign investment) are controlling or dominant in the projects related to public social interests and public safety. In this sense, the PPP hospital enjoys more autonomy on the purchasing issue because of its financial independence from the state, and this explains the faster purchasing process and, at least partially, the more significant investment in drugs and devices. This phenomenon also implies the importance of inter-field relations when examing what happens in a specific social field. In this purchasing case, what happens in the public hospital depends on what happens in the state, while the purchasing activities in the PPP hospital depend on X Capital, which is also an actor in the field of power and is close in position to the economic field. It is relevant at this point to emphasise that X Capital is the largest supplier of drugs, medical devices, and other equipment for the PPP hospital because of the agreement made on procurement. The implication is that X Capital occupies a monopolistic position in the supply of drugs and medical devices (i.e., there are no competitors). This point, in turn, constitutes the primary reason for the negative perception of interviewees towards the purchasing process in the PPP hospital:

> "Public hospitals can invite tenders, right? Our functional department will lead the tender, and we have the leading power. No manufacturer can skip the functional department. However, quote what was said about X Capital before, "I can only use X

> Capital, and I can do nothing about it". They [X Capital] have signed an agreement with the university [the public partner], stipulating that only X Capital can be used (in 75 per cent of the procurement) [...] in that case, for example, if they buy a piece of equipment, its price is possibly higher than the market price."
>
> (participant 3, an administrator)

X Capital's monopoly of drugs and device supply not only places hospital buyers in a situation of disadvantage regarding price negotiation but also narrows the hospital's purchasing choice down to the investor's option.

> "The medicine [and consumables] are purchased by the funding company, so they will decide what medicine and medical equipment can be used by the hospital... [in fact, for the purchase of medicine consumables] there shall be a comprehensive evaluation mechanism, including price, consumable medicine quality, and manufacturer strength [...] [Thus doctors can use] the real user-friendly [equipment]."
>
> (participant 8, a doctor)

Thus, it is because the private investor holds a monopoly in the supply of drugs and devices that interviewees generate opposed perceptions towards the purchasing process. The disadvantageous situation hospital buyers confront due to X Capital's monopolistic status may cause cost overruns, which may then translate into revenue-generation pressures on the medical professionals. Medical professionals in the medical field are more closely positioned to the cultural pole (culturally dominant and economically dominated) in the field of power, while X Capital, the managerial field, and therefore the hospital managers, have a greater affinity with the economic pole (economically dominant and culturally dominated). Following Bourdieu's logic, the economic field dominates all subfields of the cultural field, and economic capital can bring higher status and greater power than cultural capital, even though both are advantageous in the field of power (Bourdieu 1994, p. 144). The different and even opposed positions that agents/agencies (for instance, medical professionals, managers, private investors, and public institutions) take in the field of power shape the specific social fields (the PPP hospital) in which agents/agencies are involved, their relations in the social field, their relative habitus, dispositions, and pre-dispositions. In a period of neoliberalism, the market that is closer in proximity to the economic field is in a dominant

position in the field of power. The private investor, managers, and administrators who are close to the economic field and have an affinity with the managerial habitus, can intervene in professional work and the workplace and alter the medical habitus that traditional public hospitals initially structured. The forceful intervention in purchasing issues by the private investor thus potentially alters medical professionals' habitus in using the "real user-friendly [equipment]", as participant 8 (a doctor) indicates. It thus can be seen that struggles in the PPP hospital occur through either conservation or transformation of the traditional medical habitus and through the deployment of either medical, managerial or economic capital possessed by field agents in different and opposed positions both within the PPP hospital and within the general field of power. The day-to-day practice within the PPP hospital is consistently oriented and re-oriented according to different and sometimes splintered logic: professional or managerial logic, clinician-centred or data-based and profit-driven principles.

Summary of the chapter

The purpose of this chapter is to investigate the healthcare professionals' experience with hospital PPPs. The PPP hospital is situated within a healthcare field of struggles between the established medical profession and the new managerial profession over control of both professional practices and the conditions of work. The chapter reveals that healthcare professionals experience a set of market processes in the PPP hospital that is characterised by better financial rewards, heavier workloads, higher revenue-generation pressures, separate rather than integrated patient-management systems, data-based evaluation systems, and a purchasing procedure based on a market monopoly; each of which stands in contrast to practices in public hospitals. It is noteworthy that participants respond differently to this market process in the PPP hospital, showing either compliance with, or resistance to, the managerial ethos. Their practices of compliance and resistance are not merely a reflection of their past experiences and socialisation, nor of the current conditions of the PPP hospital, but a result of an encounter between their historically structured habitus, their field positions and the state of play of the PPP hospital in which they are located. The next chapter, chapter seven, will discuss the finding of this study to address the research questions.

Chapter Seven - Conclusion

Introduction

This thesis addresses the introduction of PPPs into the healthcare field by the Chinese state, the impacts of the state introducing privatisation and NPM practices into the healthcare field, and the experiences and responses of healthcare professionals and associated political and market agents in the midst of these changes.

The relevant theoretical literature in the healthcare sector is first analysed in Chapter two. A critical analysis of orthodox economic perspectives, pluralism, and Marxism in the existing literature reveals a problematic locus with the way the state and the healthcare sector are theorised. In the orthodox economics explanation, the state is theorised as a rational actor, and privatisation and PPPs in the healthcare sector are presented as rational choices to address social problems such as fiscal constraints, low efficiency and high costs in the healthcare sector. Under the economic argument, the market is promoted as an ideal choice for delivering public services, and the state should assist the private sector in delivering health services by not interfering in the market (Meagher et al. 2009, p. 334; Hood 1991). Where reasons for the pendulum-like movement of the Chinese healthcare system are discussed, an orthodox economics perspective assumes the privatisation of healthcare since the 1980s results from fiscal constraints and the early twenty-first century, left-handed movement of the state, arguing this was a rational response to the problems faced by the Chinese health care system, such as unequal access and a dramatic health expenditure escalation (see for example Yip et al. 2019; Yip & Hsiao 2014; Wang 2003; Hesketh & Wei 1997; Hesketh & Zhu 1997; Hillier & Shená 1996). However, as suggested in earlier sections of this study, this kind of explanation fails to explain the surging national administrative spending in a time of fiscal constraint. It also fails to explain why the Chinese state continues to privatise the healthcare sector in the face of damaging impacts caused by the first round of health reform. In Marxism (see, for example, Navarro et al. 2006; Samson 1994), however, the state is conceived as an agent of capital, where state policies such as privatisation and PPPs are structurally determined by capitalist market demands. Moreover, the package of

ideas surrounding neoliberalism and managerialism is understood as an ideology used to justify privatisation and PPPs. This explanation falls into a functionalist thinking pattern, the healthcare sector is seen as a constituent part of the social system, and what happens in the state and the healthcare sector merely reflects the ideology of capitalism. Seen through a Marxist perspective, both state and other societal actors in the policy process are congruent. Even though Pluralism remedies these shortcomings by pulling the focus of analysis back to individuals and groups, it is still criticised by Marxism for ignoring the effects of structured, social arrangements. Nevertheless, the main weakness of the Marxist explanation lies in reducing the Chinese healthcare sector and the state engaged in health issues to a mere reflection of the external political-economic forces. In the Marxist approach, there is little sense made of how actors think and act in the process of privatisation and PPPs, and how these ideas and practices reshape the healthcare system, which, in turn, provides opportunities and constraints to social actions. In other words, the interactions between the system and social agents or agencies are ignored in the functionalist explanation. Bourdieu's theory of the state and his thinking tools of field, capital, habitus, and practice are introduced to address these issues and gain insight into the Chinese healthcare field and the social actions of both state and societal actors in the policy process. Also, Bourdieu's theoretical framework is used to transcend the dichotomy between objectivity and subjectivity, between social structure and individual agency. This thesis proposes a Bourdieusian understanding of the phenomena of privatisation and PPPs in the *Chinese* healthcare field and argues for the importance of empirically investigating privatisation and the hospital PPP phenomenon as a process of both state and other societal agents in practice.

In section two, the research findings are discussed, addressing the research questions of the thesis. This is followed by section three - an outline of the theoretical implications of the research. Finally, the chapter summarises some of the study's limitations and potential areas for future research.

Discussion of findings

The significant contribution of the state to the re-shaping of the healthcare field

In order to address the research questions, the researcher applies Bourdieu's three-level field analysis (Bourdieu & Wacquant 1992, pp. 104-7), mapping out the power relations both within the healthcare field and between the healthcare field and the field of the state, as well as analysing the habitus of agents associated with hospital PPPs (healthcare professionals mainly) in relation to the changing field. The first step of analysis lies in identifying the position of the Chinese healthcare field vis-à-vis the field of power, in particular, the field of the state. Narratives of Chinese health policy shifts since the 1980s suggest there has been a continual display of a pendulum-like movement of health policies between the state and the market in the way health services have been organised, financed, and delivered. The empirical study demonstrates the operation of the Chinese state as a bureaucratic field embedded with contested values and attitudes. The pendulum-like movement is associated with tensions between the conflicting interests, values, and preferences of government ministries, especially the Ministry of Health and the Ministry of Finance. The two ministries display quite different perspectives on the role of the state and its relations with the market in healthcare financing and provision, with the Ministry of Health seeking to increase the health budget and advocating an increased role of the state in this area, while the Finance Ministry inclines toward the market to provide health services and cut public health finance. In the Chinese context, the antagonistic value orientations of government ministries towards financial input in the healthcare system reflect their different positions and relative functions and power in the bureaucratic field. The Chinese Ministry of Health possesses influential power in health policymaking and health reform implementation and is primarily concerned with increasing the health budget and improving the health system. In contrast, the Ministry of Finance is mainly responsible for financial decision-making and budget management, thus focusing more on maintaining a balance between financial revenue and expenditure and acting to ensure against overspending on healthcare delivery and maintaining a high level of risk protection. They orient their practice in one way rather than another to maintain their control and promote their positions in the bureaucratic field.

The empirical study makes evident the weak bargaining power of the Ministry of Health over the health budget when compared with that of the agricultural and industrial bureaucracies of

the 1980s and suggests its subordinate position is based on unequal economic relations both within the state and the field of power. This thesis argues that as constituent parts of the field of power, different social fields, such as the Chinese healthcare field and the Chinese state, and its agencies, such as different government ministries of the state, are not located on a level playing field. Agents (e.g. agencies) are located in distant positions in relation to the economic and cultural poles of the field of power. Some social fields and subfields are relatively dominant as they are located proximate to the economic pole, while others are closer to the cultural pole, thus subordinate. In this case, the Chinese Ministry of Health is relatively subordinate as health policymaking is dependent on the investment priority set by the Ministry of Finance; what happens in the Chinese healthcare field is also significantly affected by the activities and policy agendas in the field of the state. However, The Ministry of Finance occupied a weaker position during the periods of centrally planned economy and ultraleftism than it did after the economic reform of the 1980s. Under the Soviet model and centrally planned economy, a set of investments and priorities made by the state is challenging to dislodge when no significant problems exist. In a period of ultraleftism, notably the Cultural Revolution (1966-76), leftists opposed the focus of the Ministry of Finance on financial and credit balance and control over budgetary expenditure. Mao advocated for an "active balance" approach that relied on meticulous planning, as opposed to a "passive balance" strategy of the Ministry of Finance (Bachman 1989). Therefore, the capacity of the Finance Ministry to direct economic activities has been diminished during this period. However, the position of the Finance Ministry has been strengthened since the economic reform in the sense that its preferences towards economic balance and an increased role of the market in production activities have received recognition in the bureaucratic field. Thus, the enhanced position of the Ministry of Finance also partly results in the dependence of the Health Ministry on the investment priority set by the Finance Ministry.

In the 1980s, Chinese health departments sought some non-budgetary sources of healthcare, such as "permitting private medical practitioners to practice medicine" (The State Council 1980). In addition, the government carved out significant autonomy for the health institutions and allowed them to function largely independently as long as they met their contractual obligations (such as budgets, staffing levels, and service quantities and quality) to the health departments, which were called "economic management". In a similar fashion, fee and pricing systems were reformed to increase revenue from non-state resources. These policy

measures are compatible with both neoliberal ideology and the NPM agenda, which emphasise the use of a "market logic" in the healthcare field. The private sector is promoted as more flexible and efficient, able to offer consumers a greater variety of goods and services in contrast to the alleged inefficiency, red tape, and corruption of the public sector (Meagher et al. 2009; Jessop 2013; Klikauer 2015, p. 1107; Noordegraaf 2015, p. 1). Much of the literature of the period pay attention to the performance and problems caused by the first round of health reform, with a focus on unequal access and dramatic health expenditure escalation, and takes the second policy shift (the 2009s) as merely a rational response to these problems (see, for example, Yip et al. 2019; Yip & Hsiao 2014; Wang 2003; Hesketh & Wei 1997; Hesketh & Zhu 1997; Hillier & Shen 1996). This thesis, in contrast, argues against the economic perspective by revealing an inherent contradiction in the reform of 2009 – under the goal of improving access to care, the Chinese state continued to encourage an increase of private hospitals and introduced the use of PPP in the hospital sector, at the same time continuing to apply the NPM agenda focusing on improving competition and cost control in the management of public sectors. This thesis has shown how a contestation has played out between key ministries - between the left and right hands of the state - in the healthcare field. It resonates in Western countries, where there has been a shift from Keynesian economics and the building of strong public sectors to neoliberal, market-oriented policies. The thesis demonstrates that the global shift has also occurred in China, albeit with some variations in form and timing.

By applying Bourdieu's thinking tools of field, capital and habitus, this study argues that the Chinese bureaucratic field, through administrative measures, has significantly contributed to shaping the state of the healthcare field and that this reconfiguration of the field has provided the possibility for the introduction of hospital PPPs. Bourdieu describes a field as in a continual state of flux, with internal dynamics that cause changes (Bourdieu 1984, pp. 128-9). The movement of positions and positional practices within a field could be described as upward, stable or downward. The analysis of this study reveals that after the Chinese state cut financial support and allowed private capital into the health sector in the 1980s, the positions of private capital could be described as upward. The practice of the state has enabled private capital to enter the hospital sector, expand the scope of services and increase its market share within the sector. The position of private capital has been further enhanced with the

government permitting joint ventures between the public and private sectors and channelling financial capital and human resources to the private sector via accreditation, deregulation and the like. These policies have facilitated hospital PPPs in terms of recruiting healthcare professionals, using medical insurance funds, and thus attracting patients. What is happening in China is the emergence of the Medical-Industrial Complex (MIC) under which private corporations, from a wide range of subfields from finance and insurance to pharmaceutical and technology, partner with each other and formulate a network engaged in the business of providing health services for profit. Some investors, for instance, finance companies, real estate companies and investors from hospital chains, are interested in the potential profits attached to hospital PPP projects and formulated partnerships with public hospitals via joint ventures. In this sense, hospital PPPs can be seen as a strategy adopted by financially powerful groups to maximise their position within the healthcare field. On the other hand, this study points out that the hospital PPP model is also a continuation of privatisation and NPM practices in the Chinese healthcare field. Since the first round of health reform, there has been a continuous emphasis on a separation between policymaking and implementation, the introduction of business-like management practices and measures of performance, and greater competition within the public hospital sector. This philosophy justifies hospital PPPs under which market logic and private sector involvement are stressed in public service delivery. In summary, hospital PPPs, in association with privatisation and NPM reform, continue the trend, bringing change to the Chinese healthcare field: under the encouragement of the government, there has been a significant growth of private capital and an expansion of the medical-industrial complex.

Public and PPP hospitals contest for state recognition and a dominant vision of the social world

Bourdieu theorises the field as “a field of struggles”; some field agents or agencies are dominant while some are dominated; this hierarchised relation between positions is defined by the volume and structure of the species of power at their disposal (Bourdieu & Wacquant 1992, p. 101). An analysis of the field-specific capital (e.g. medical professionals, patient resources), respectively, possessed by the PPP hospital and in comparison to a public hospital group in the same area, suggests that the well-established public hospital group occupies a

dominant position in the local hospital field. In contrast, the PPP hospital is a newcomer and a challenger in the field, thus positioned as subordinate. Contestations between the new health institutions (the PPP hospital) and well-established health institutions (public hospitals) are analysed in chapter five. In the struggles over the *dominant principle of hierarchisation* (Bourdieu 1993, pp. 40-2; Thomson 2014, pp. 75-6), the public and PPP hospitals utilise two opposing action strategies – conservation or subversion strategies. On the one hand, the dominant and well-established public hospitals usually adopt conservation strategies to maintain the existing order where they hold a secure and dominant position in the healthcare field; the dominated PPP hospital, in contrast, seeks to transform the current state of power relations and the "rules of the game" to improve their position in the field in question. The orientation of practice adopted by the PPP hospital is to seek to transform state policy and current administrative measures, for example, by simplifying the application process for business licences and equipment certificates, increasing research funds for private capital, restricting the scale of public hospitals, supporting multi-site practices for of medical professions and data sharing between public and PPP hospitals. Public hospitals firmly resist each of these measures.

The thesis demonstrates these contrasting practices and strategies, but also the contrasting perspectives between the public and non-public sector participants on how to view hospital PPPs and comprehend the relationship between state and market actors in this partnership. Private and PPP sector participants claim that private capital brings new strengths into hospital PPPs, such as the introduction of new and effective managerial techniques and better designs for hospital buildings; others claim private capital creates jobs in the healthcare market and eases the financial burden for the state. Private sector participants arrive at the conclusion that market logic should play a decisive role in health resource allocation, for it brings more choices and allows for more diversified demands to be met. On the contrary, public-sector participants explicitly point out the "for-profit" nature of private capital and its financial independence from the state. They show concern for the health inequalities caused by private capital involvement and the higher healthcare costs for patients, which are associated with the higher salaries of medical professionals in the PPPs and private sector hospitals. This group of participants stress that the equity principle should come first in health service delivery, and the state's primary responsibility for healthcare provision. These

antagonistic dispositions and position-takings of participants reflect the "public/ non-public sector" locations from which they are taken.

The resources deployed by the actors in this field of struggle are various species of capital (medical, managerial, and economic, for example). These various resources are at stake, the most significant of which is the *state's capacity* to confer official titles, codify activities and alter the *exchange rate* between species of capital, such as the *relative value* of economic capital as opposed to medical capital, thereby exercising influence over the relations of power between the occupants of different positions (for a more detailed discussion of the state's symbolic power, see Bourdieu 2018, pp. 93-4; Bourdieu 1994, pp. 4-5; Emirbayer & Johnson 2008, p. 13). In this study, state power is shown not only to be objectified in the form of official titles, licenses, qualifications, and administrative measures but also in the "principles of classification" imposed on field agents. The previously mentioned struggle between rival views from public/ non-public sector participants clearly illustrates the classification struggle over the dominant principle of visions and divisions, which protects and improves the value of their properties and the reproduction of their respective values.

Medical and managerial professionals contest for domination

In this study, the differing experiences of healthcare professionals (doctors, nurses, managers, and administrators) working in the public and PPP hospitals are analysed. It has revealed the relations between the different types of hospitals and the habitus of medical professionals, the "social reality" of the changing field for medical professionals. A Bourdieusian portrayal of medical professionals as agents in a contextual field has presented a shift from a functionalist interpretation of the 'medical profession' to an account that links the medical profession as an *agent* in an ever-changing contextual field. Compared to working in public hospitals, a "feeling of being overwhelmed" is noted among doctors in the PPP hospital, and this "sense of being squeezed", as is complained about by doctors, results from the more demanding performance indicators in the PPP hospital**.** These financial and business performance indicators reflect the managerial ethos in the PPP hospital, which is in conflict with established professional practice and the habitus of the public sector. In Bourdieu's terms, doctors' resistance to the changing context associated with the relatively lower pressures for revenue generation in the public hospitals in comparison with the competitive

PPP arena, can be understood as a situation where the medical profession's habitus fails to match the market habitus of the PPP hospital. This scene is vividly described in Bourdieu's words as a "fish out of water" (Maton 2014, p. 56).

The experiences and practices within a PPP hospital have been analysed in this thesis in terms of contestations between the traditional medical profession and the new managerial profession over control and domination of professional practices and conditions of work. These intra-organisational struggles are characterised by both the professions' deployment of forms of capital and their orientation of practice, directed by their respective habitus**.** The medical and managerial capital brought into the competition by the professions within the field defines their relative positions and *strategies* in the struggle (see Thomson 2014, pp. 74-5). Both medical and managerial capital are analysed as symbolic forms of capital in this study as they are disguised and don't appear as a form of economic exchange. Meanwhile, they veil the struggles over whether medical or managerial capital is more valuable in comparison with other forms of capital within the field.

As described in chapter six, there presents a structural homology between spaces of positions and dispositions. The traditional medical and new managerial professions unconsciously produce their habitus through their social origins, educational backgrounds, career trajectories and the fields they are engaged in. The medical profession gradually develops a "feel for the game" as doctors learn what constitutes a "good" doctor, how to maximise their professional autonomy and control and what makes up distinctive medical capital, which includes but is not limited to having adequate knowledge of the medical discipline and practical skills, as well as an advanced capability for undertaking scientific research (Luke 2003). Nevertheless, managerial capital deployed by healthcare administrators and managers in the PPP hospital is developed in a field reshaped by neoliberalism and managerialism**,** and this new group of professions tend to emphasise efficiency improvement and cost control. These healthcare administrators and managers have gained power and control over some medical resources (such as financial, equipment and human resources) and are also deeply involved in the promotion process for the medical professions.

These two differently structured habitus give rise to varying possible position-takings by the professions, thus expanding the field of possibilities. The analysis suggests that clinical supervision and management in public hospitals is integrated and flexible, with a quality control system that revolves around clinical work itself and demands a patient-centred team of specialists and other health workers. The medical profession, in this context, enjoys considerable authority within the framework of its daily professional practice and has the autonomy to make independent decisions. In the PPP hospital, however, clinical work is organised separately, evaluations focus on management-generated data and evidence, and there is an emphasis on competition between workers – all of which is in line with the managerial ethos of the neoliberal context. In this regard, the new business-oriented management approach may be viewed as an attempt to restructure the medical habitus and alter the basics of medical capital in line with market logic.

The data from the empirical study shows various kinds of responses to managerialism within the PPP hospital, which are associated with their positions in the field and their dispositions (associated with past experiences). Some participants tend to comply with a market logic, thus giving priority to competition and economic performance. Participants revealed the pressures for doctors to have a primary focus on revenue generation and to respond to various quantitative indicators such as the number of patients, prescriptions, surgeries, etc., which means abandoning the flexible and integrated management of clinical work. However, other participants take the role of a "challenger", offering resistance to management and conveying a sense of agency in the market atmosphere of the PPP context, something that rapidly becomes evident when compared with their experiences in public hospitals. The challengers described this resistance in various ways, for instance, "[this business-like management pattern] will bring a lot of pressure" (participant 27, doctor), "is unreasonable [...]and will distract (us) from busy clinical works, and [I feel] not in a stable team with colleagues" (participant 22, nurse); and their words reflect their sense of agency and a mismatch between their dispositions structured by past experiences (with public hospitals in particular) and the current state of the PPP hospital. It is worth mentioning that participants with a sense of resistance to the hospital PPP and its managerialism display a tendency to avoid *open confrontations* with management. This phenomenon is explained by their relatively powerless position in relation to the state and the work units in the Chinese healthcare field. Even though participants show concern for the market atmosphere that will erode their autonomy

and consider themselves as professionals with knowledge and expertise, they lack a formal body to fight for them in the struggle with the hospital managers. This implies that the medical profession in China is less developed as a formal institution and is less powerful than in some other developed countries. These findings concerning the participants' compliance and resistance practices with regard to the managerial ethos of the PPP hospital echo Sawyer et al.'s (2009) report on how healthcare professionals engage in their everyday practice when confronted with increasingly complex risk management processes defined by NPM. By negotiating the risk management policies of the work environment, the study participants display a "high sense of agency". This finding is also comparable to Waring and Bishop's (2011) study, revealing clinicians' perceptions of the transition from the public sector to an independent organisation with a market ethos. There are some clinicians who embrace the change and those who cling to the traditional ethos of the public sector. This pattern contrasts with the findings of McDonald et al. (2007), who found that therapists and social workers acted on managerial ethos, and their actions and thinking patterns were altered by the market-oriented context. Taking healthcare professionals as Bourdieusian agents in a changing field rather than mere reflections of the structural context helps reveal the relations between positions and dispositions of professionals and the past and current state of play in the field they were or are engaged in. This study has revealed the importance of actors in the transformation of the healthcare field. These struggles between managers and clinicians are a reflection of the broader shift toward neoliberalism, but not just a reflection of this shift - they are the very means through which neoliberalism and the new dominance of the right hand of the state, are brought about.

Implications and contributions to knowledge

Various scholars revisiting Chinese health reforms explore the role of the state in the policy process. Yip and Hsiao (2015), for example, propose that the ideologies and social values of the government and the market mainly drive the Chinese healthcare reforms. They define ideology as "a systematic body of theory for social-economic programs" and regard the government and the market as mere vehicles used to meet specific social ends. Yip and Hsiao rely for their analysis on the concept of "ideology" – the ideology of whether the state or the market is more efficient in resource allocation and how much priority should be assigned to equity – which acts as a set of ideas that freely travels across different social areas. However,

their approach does not answer the question of why antagonistic ideologies might exist at different historical stages. Whose interests do these ideologies represent? How have these ideologies and social values arisen? Little sense can be made of the way ideas, actions and practices in the healthcare sector reshape the healthcare field itself and the effects of the healthcare field in this process. In this argument, even the Chinese state and the market have no autonomy and act according to the overall ideological functioning of the whole social system, and are thus explained as a reflection of external political and ideological pressures. In this study, in contrast, the analysis of the struggles between key ministries over health policymaking adds a different perspective on the role of the state in the policy process. As a bureaucratic field constituted by contested interests, values and perspectives, the Chinese state, through health reforms and policy measures, has significantly reshaped the healthcare field. The position of private capital has been enhanced with private companies being allowed and indeed encouraged to enter more areas of service provision, hospital PPPs have become possible, and the boundary between the public and private sectors has been blurred.

Some scholars have paid attention to the effects of the Chinese state's reforms on the healthcare sector, with a focus on access, quality of care, the efficiency of service delivery, and health expenditure (e.g. Yip et al. 2019; Yip & Hsiao 2014; Tam 2010; Ma et al. 2008). The findings of these studies indicate that what is happening in the Chinese healthcare field is considerably impacted by the ideas and practices of the state. However, the main weakness of these studies is their silence on the activities of agents and agencies in the policy process. These studies pay little attention to how privatisation and PPPs policies, neoliberalism and managerialism are received, experienced, and practised by social agents in their day-to-day working lives. There is some literature focusing attention on the impact of privatisation and NPM on healthcare professionals, arguing that various economic and management strategies have decreased the clinical autonomy of medical professionals (Yao 2016; Yang 2006), a process described as “de-professionalisation” (Wang 2010). As suggested by Degeling et al. (2006), the practice of Chinese medical professionals is compliant with the managerial ethos in the hospital setting and has been objectified by these managerial requirements. However, very few studies have systematically investigated the situation in Chinese PPP hospitals. This study fills the gap by focusing on the experiences of healthcare professionals and stakeholders with hospital PPPs in China, and demonstrating how this struggle is ongoing and central to the processes of neoliberalism and NPM.

In contrast to the findings reported in Degeling et al.'s research (2006), the empirical findings of this study demonstrate the diversity of participants' responses to hospital PPPs, managerialism, the role of the state and its relations with the market in health service delivery. Indeed, some participants emphasise various benefits inherent in hospital PPPs and acknowledge the benefits of managerial techniques and the essential role of the market in health resource allocation. Nevertheless, other participants show concern about the for-profit nature of private medicine and the resultant health inequality, and criticise the managerial ethos in the PPP hospital, regarding this as undermining their clinical autonomy. The implication of these findings is that it is too simplistic to take the Chinese healthcare field as a mere reflection of what occurs in the political and economic fields – instead, we can see that the struggles and tensions in this field are what constitute the political and economic fields. Incorporating Bourdieu's theoretical framework and conceptualising hospitals and professionals as existing in the Chinese healthcare field enables the researcher to reveal the interaction between external socioeconomic forces and the internal dynamic and structure of the healthcare field. This kind of understanding also helps to illustrate how a specific field refracts, restructures and even repels external forces according to its internal logic and structure. Participants' criticisms and reflections on hospital PPPs, neoliberalism and managerialism manifest their resistance to external forces. This all stems from Bourdieu's theoretical framework with his conceptualisation of the specific field as a field of relations, competitions and struggles. Rather than the representations of hospitals, stakeholders, and professionals as existing independently of each other, a Bourdieusian understanding takes these agents or agencies as embedded in mutually interdependent relations with other institutions and individuals. It shows how hierarchically structured positions and the unequal distribution of power shape the different or even antagonistic strategies and orientations adopted by agents or agencies. The empirical analysis of this study suggests that public/non-public (including PPP) hospitals and medical/managerial professionals contest to conserve or transform the division and shape of the healthcare field by deploying their forms of capital (economic, cultural, medical, managerial capital etc.). They offer their vision of hospital PPPs, the state's role in health service delivery and professional practice as a dominant or even a universal vision of the field, thus modifying the rules of the game to their advantage. The application of Bourdieu's thinking tools leaves room for analysing how agents, endowed with historically structured dispositions, respond to the opportunities and constraints in an ever-changing healthcare field. In summary, the Chinese healthcare field is an arena open to

political and social struggles both within the field and in relation to other fields, especially the Chinese bureaucratic field.

Conclusion

In this thesis, particular emphasis is placed on investigating the hospital PPP phenomenon as a process of state and other societal agents in action**.** The healthcare sector in China is conceived as a Bourdieusian field of struggles with permeable boundaries and placed in relation to other fields, especially the field of the Chinese state. The study makes evident the Chinese state is a contested field, fuelled by symbolic power both in objectified forms and legitimated classifications. Under the guidance of neoliberalism, the state has considerably reconfigured the power relationship within the field of healthcare. Over time, the reconfiguration of the healthcare field itself has made it possible for the state to introduce PPPs into the hospital system. In the local healthcare field where the PPP hospital is situated, the experiences of associated social agents working with hospital PPPs are analysed in terms of contestations between the dominant public hospitals and the newcomer PPP hospital for state recognition, especially over the state's symbolic power to provide legitimate classifications and to impose recognised visions and divisions on the social world**.** Within the PPP hospital, healthcare professionals' experiences are analysed as struggles between the traditional medical professions and the newly emerging managerial professions in a neoliberal context over the control and domination of professional practices and work conditions. This thesis has demonstrated that Bourdieu's conceptual framework of field, capital, habitus, and the state carries considerable implications for analysing the relations of power both within the healthcare sector and in relation to the general field of power and the bureaucratic field. The joint use of Bourdieu's framework and the concepts of the profession, medical profession, and medical dominance allows the researcher to map out positions and dispositions assumed by the medical and managerial professions on the one hand; on the other hand, it helps to link the past experiences and the current circumstances healthcare professionals were and are engaged in.

This thesis has paid attention to how the neoliberal trend is embraced or resisted by healthcare professionals and stakeholders in the Chinese healthcare field. However, the

empirical study of this thesis is confined to the Chinese healthcare field. In a global context of neoliberalism and privatisation, it is imperative to undertake a systematic comparison of different countries' healthcare systems if we are to understand the similarities and differences of the historically specific forms of struggles, the complex and ever-changing relations of power between key agents or agencies, and the values and forms of capital in action within different social spaces.

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Appendices

Appendix A - Ethics Approval

THE UNIVERSITY OF SYDNEY

Research Integrity & Ethics Administration
HUMAN RESEARCH ETHICS COMMITTEE

Wednesday, 29 January 2020

Assoc Prof Fran Collyer
Sociology & Social Policy; Faculty of Arts and Social Sciences
Email: fran.collyer@sydney.edu.au

Dear Fran,

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.

I am pleased to inform you that after consideration of your response, your project has been approved.

Details of the approval are as follows:

Project No.:	**2019/1013**
Project Title:	**Public-private-partnerships (PPPs) in the Healthcare Systems of Australia and China**
Authorised Personnel:	**Collyer Fran; Cheng Qiuxian;**
Approval Period:	**29 January 2020 to 29 January 2024**
First Annual Report Due:	**29 January 2021**

Documents Approved:

Date Uploaded	Version Number	Document Name
29/11/2019	Version 2	Group (1) in China_Participant information statement_English
29/11/2019	Version 2	Group (2) in China_Participant information statement_English
29/11/2019	Version 1	message content
29/11/2019	Version 1	recruitment information
11/11/2019	Version 1	Safety Protocol (Fieldwork Overseas)
10/11/2019	Version 1	Group (1) in China_Participant info statement
10/11/2019	Version 1	Group (2) in China_Participant info statement
10/11/2019	Version 1	Participant Consent Form_English version
10/11/2019	Version 1	Participant Consent Form_Chinese version
10/11/2019	Version 1	Interview topics

Condition/s of Approval

- Research must be conducted according to the approved proposal.
- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.
- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
  - Serious or unexpected adverse events (which should be reported within 72 hours).
  - U foreseen events that might affect continued ethical acceptability of the project.
- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).

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- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.
- Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.
- Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.
- Ethics approval is dependent upon ongoing compliance of the research with the *National Statement on Ethical Conduct in Human Research*, the *Australian Code for the Responsible Conduct of Research*, applicable legal requirements, and with University policies, procedures and governance requirements.
- The Ethics Office may conduct audits on approved projects.
- The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely,

[redacted]

Associate Professor Rita Shackel
Chair
Human Research Ethics Committee (HREC 3)

The University of Sydney of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2007) and the NHMRC's Australian Code for the Responsible Conduct of Research (2007)

Appendix B - Participant Information Statement [Participant Group (1)] in English

THE UNIVERSITY OF SYDNEY

Department of Sociology and Social Policy
School of Social and Political Science
Faculty of Arts and Social Sciences

ABN 15 211 513 464

Fran Collyer
Associate Professor of Sociology

Room 352
Social Sciences Building (A02)
The University of Sydney
NSW 2006 AUSTRALIA
Telephone: +61 2 9351 2653
Facsimile: +61 2 9351 2653
Email: fran.collyer@sydney.edu.au
Web: http://www.sydney.edu.au/

Public-private-partnerships (PPPs) in the Chinese Healthcare Field

PARTICIPANT INFORMATION STATEMENT [Participant Group (1)]

(1) What is this study about?

You are invited to take part in a research study about *Public-private-partnerships (PPPs) in the Chinese Healthcare Field.*

This research aims to compare the Public-private-partnerships in the healthcare systems of Australia and China. The results of this research will be used by the researcher, Qiuxian Cheng, as a significant component of her postgraduate research project, being undertaken in the Department of Sociology and Social Policy at The University of Sydney.

You have been invited to participate in this study because you may be involved in the PPPs in healthcare (from the broad sense). This *Participant Information Statement* tells you about the research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary.

By giving your consent to take part in this study you are telling us that you:
- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.

You will be given a copy of this Participant Information Statement to keep.

(2) Who is running the study?

Qiuxian Cheng is conducting this study as the basis for the degree of Doctor of Philosophy at The University of Sydney. This will take place under the supervision of Associate Professor Fran Collyer.

(3) What will the study involve for me?

If you decide to take part in the research study, you will be asked to take an *Interview*. A *Participant Consent Form* will be provided before commencing the interview. The interview will take approximately one hour. With your consent, the interview will be recorded by an audio recorder or by an interview transcript.

This is a semi-structured interview, so there will be some open-ended discussion concerning specific questions. The interview mainly includes questions about:

- What role do you have in your organization? Is there a connection between your role and the healthcare system? If yes, what is this?
- What is a Public-private-partnership (PPP) in healthcare in your opinion?
- What experience have you had with PPPs?
- How do you evaluate the performance of a PPP in the hospital system?
- What conflicts or challenges do you think PPP present in the hospital system?
- What suggestions do you have to address the problems you mentioned above?

(4) How much of my time will the study take?

The interview will take approximately one hour.

(5) Who can take part in the study?

Agents who may be involved in the PPPs in healthcare (from the broad sense) can take part in the study.

(6) Do I have to be in the study? Can I withdraw from the study once I've started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of Sydney.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time. You can do this by refusing in oral or writing.

You are free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview.

(7) Are there any risks or costs associated with being in the study?

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study.

(8) Are there any benefits associated with being in the study?

We cannot guarantee that you will receive any direct benefits from being in the study.

(9) What will happen to information about me that is collected during the study?

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. There will be an audio recorder or an interview transcript with your consent. Your information will only be used for the purposes of analysis and publications, as outlined in this *Participant Information Statement*, unless you consent otherwise.

Your information will be stored securely and your identity/information will be kept strictly confidential, except as required by law. Study findings may be published in forms of student theses, journal publications, conference presentations, but you will not be individually identifiable in these publications. Data will be handled in a fair and appropriate manner. The researcher will analyse the data according to University of Sydney protocols regarding academic integrity.

(10) Can I tell other people about the study?

Yes, you are welcome to tell other people about the study.

(11) What if I would like further information about the study?

When you have read this information, *Qiuxian Cheng* will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact any of the following people:

Research Contact Person

Name	Qiuxian Cheng
Position	Co-investigator
Telephone	+61 0472567770/ +86 18716445077
Email	Qiuxian.cheng@sydney.edu.au

Name	A/Prof. Fran Collyer
Position	Chief Investigator
Telephone	+61 2 9351 2653
Email	fran.collyer@sydney.edu.au

(12) Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback by ticking the relevant box on the consent form. This feedback will be in the form of one-page lay summary. You will receive this feedback after the study is finished.

(13) What if I have a complaint or any concerns about the study?

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of the University of Sydney *[INSERT protocol number once approval is obtained].* As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007).* This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university or the independent local complaints contact using the details outlined below. Please quote the study title and protocol number. The Manager, Ethics Administration, University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** human.ethics@sydney.edu.au
- **Fax:** +61 2 8627 8177 (Facsimile)

The Local Contact:

Name	Wei Li
Position	Associate Professor Wei Li, Chongqing Medical University
Telephone	+86 13018365757
Email	liwei@cqmu.edu.cn

This information sheet is for you to keep

Appendix C - Participant Information Statement [Participant Group (2)] in English

THE UNIVERSITY OF SYDNEY

Department of Sociology and Social Policy
School of Social and Political Science
Faculty of Arts and Social Sciences

ABN 15 211 513 464

Fran Collyer
Associate Professor of Sociology

Room 352
Social Sciences Building (A02)
The University of Sydney
NSW 2006 AUSTRALIA
Telephone: +61 2 9351 2653
Facsimile: +61 2 9351 2653
Email: fran.collyer@sydney.edu.au
Web: http://www.sydney.edu.au/

Public-private-partnerships (PPPs) in the Chinese Healthcare Field

PARTICIPANT INFORMATION STATEMENT [Participant Group (2)]

(1) What is this study about?

You are invited to take part in a research study about *Public-private-partnerships (PPPs) in the Chinese Healthcare Field.*

This research aims to compare the Public-private-partnerships in the healthcare systems of Australia and China. The results of this research will be used by the researcher, Qiuxian Cheng, as a significant component of her postgraduate research project, being undertaken in the Department of Sociology and Social Policy at The University of Sydney.

You have been invited to participate in this study because you may be involved in the PPPs in healthcare (from the broad sense). This *Participant Information Statement* tells you about the research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary.

By giving your consent to take part in this study you are telling us that you:
- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.

You will be given a copy of this Participant Information Statement to keep.

(2) Who is running the study?

Qiuxian Cheng is conducting this study as the basis for the degree of Doctor of Philosophy at The University of Sydney. This will take place under the supervision of Associate Professor Fran Collyer.

(3) What will the study involve for me?

If you decide to take part in the research study, you will be asked to take an *Interview*. A *Participant Consent Form* will be provided before commencing the interview. The interview will take approximately one hour. With your consent, the interview will be recorded by an audio recorder or by an interview transcript.

This is a semi-structured interview, so there will be some open-ended discussion concerning specific questions. The interview mainly includes questions about:

- What role do you have in the healthcare system (if any)?
- What experience have you had working in, or associated with a PPP hospital?
- What conflicts or challenges do you think PPP present in the hospital system, according to your working experience?
- What suggestions do you have to address the problems you mentioned above?

(4) How much of my time will the study take?

The interview will take approximately one hour.

(5) Who can take part in the study?

Agents who may be involved in the PPPs in healthcare (from the broad sense) can take part in the study.

(6) Do I have to be in the study? Can I withdraw from the study once I've started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of Sydney.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time. You can do this by refusing in oral or writing.

You are free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview.

(7) Are there any risks or costs associated with being in the study?

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study.

(8) Are there any benefits associated with being in the study?

We cannot guarantee that you will receive any direct benefits from being in the study.

(9) What will happen to information about me that is collected during the study?

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. There will be an audio recorder or an interview transcript with your

consent. Your information will only be used for the purposes of analysis and publications, as outlined in this *Participant Information Statement*, unless you consent otherwise.

Your information will be stored securely and your identity/information will be kept strictly confidential, except as required by law. Study findings may be published in forms of student theses, journal publications, conference presentations, but you will not be individually identifiable in these publications. Data will be handled in a fair and appropriate manner. The researcher will analyse the data according to University of Sydney protocols regarding academic integrity.

(10) Can I tell other people about the study?

Yes, you are welcome to tell other people about the study.

(11) What if I would like further information about the study?

When you have read this information, *Qiuxian Cheng* will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact any of the following people:

Research Contact Person

Name	Qiuxian Cheng
Position	Co-investigator
Telephone	+61 0472567770/ +86 18716445077
Email	Qiuxian.cheng@sydney.edu.au

Name	A/Prof. Fran Collyer
Position	Chief Investigator
Telephone	+61 2 9351 2653
Email	fran.collyer@sydney.edu.au

(12) Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback by ticking the relevant box on the consent form. This feedback will be in the form of one-page lay summary. You will receive this feedback after the study is finished.

(13) What if I have a complaint or any concerns about the study?

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of the University of Sydney *[INSERT protocol number once approval is obtained]*. As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university or the independent local complaints contact using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** human.ethics@sydney.edu.au

- **Fax:** +61 2 8627 8177 (Facsimile)

The Local Contact:

Name	Wei Li
Position	Associate Professor Wei Li, Chongqing Medical University
Telephone	+86 13018365757
Email	liwei@cqmu.edu.cn

This information sheet is for you to keep

Appendix D - Participant Information Statement [Participant Group (1)] in Chinese

THE UNIVERSITY OF SYDNEY

人文与社会科学学院
社会学与政治学学院
社会学与社会政策系

ABN 15 211 513 464

Fran Collyer
社会学系副教授

澳大利亚 新南威尔士州
悉尼大学 社会学大楼（A02） 352办公室
邮编：2006
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传真：+61 2 9351 2653
电子邮箱：fran.collyer@sydney.edu.au
网址：http://www.sydney.edu.au/

关于中国医疗领域公私合营的研究

致参与者的信息声明书（第一组参与者）

(1) 该研究的主要内容是什么？

诚邀您参与到题为“**关于中国医疗领域公私合营的研究**”的研究当中。

本研究旨在比较中国与澳大利亚医疗领域内的公私合营。该研究的结果将作为研究者之一成秋娴于悉尼大学社会学与社会政策系博士毕业论文的重要组成部分之一。

之所以邀请您参与到本研究是因为广义而言，您可能作为医疗领域公私合营的相关主体之一。本《**致参与者的信息声明书**》将告知您关于本研究的主要内容以及您将会为本研究提供哪些信息，以便于您决定是否参与到本研究。请仔细阅读本声明书，并就您有所困惑并希望进一步了解的内容提出问题。

本研究秉持自愿参与原则。

如果您同意参与到此次研究，意味着您：
- ✓ 理解本声明书上的相关内容；
- ✓ 同意参与到本研究；
- ✓ 同意研究者采用您所提供并授权的信息。

本研究将为您提供一份《**致参与者的信息声明书**》的复印件以供保存。

(2) 谁将会进行此项研究？

调查员成秋娴将会进行本项研究，以为其悉尼大学博士学位论文提供实证支撑。本研究将在副教授 Fran Collyer的指导下进行。

(3) 我需要为该研究提供哪些方面的信息？

如果您决定参与到此次研究，您将会被邀请进行一次访谈。在访谈之前，您将会签署一份《参与者同意书》。本次访谈将持续约一小时，在征得您同意的情况下，本次访谈将会被录音或者笔记记录。

由于本访谈采取半结构式访谈的方式，所以可能会针对一些具体问题与您展开讨论。访谈的问题主要包括：

- 请简单描述您在您的单位所扮演的角色，您所扮演的角色与医疗卫生系统有任何联系吗？如果有，能否对其进行简单描述？
- 您所理解的医疗领域的公私合营是什么？
- 您有关于公私合营的相关经验或经历吗？如果有，请问是什么？
- 您如何评价中国公私合营医院的表现？
- 您认为公私合营医院面临着怎样的挑战或者冲突？
- 针对您上述提及的挑战或者冲突，您有何建议？

(4) 此研究（访谈）将会花费我多长时间？

该访谈将会花费您大约一小时。

(5) 该研究参与者的纳入标准是什么？

本研究的参与者需要在广义上被包含在医疗系统公私合营的领域之内。

(6) 我必须参与此次研究吗？我可以在中途退出吗？

该研究秉持完全自愿的原则，所以您不是必须参与此次研究。并且，您的决定将不会对您与研究者以及悉尼大学的其他任何人员的关系造成任何影响。

如果您决定参加本研究但是中途改变主意，您可以在本研究的任何阶段选择退出，请以书面或者口头形式告知研究者。

您也可以在访谈的任何阶段选择中止。您关于此次研究的所有相关信息、访谈记录（包括录音和笔记记录）都将被研究者删除，除非您希望研究者继续保存。在访谈途中，您可以拒绝任何您不愿意回答的问题。

(7) 参与该研究存在任何风险或者成本吗？

除开您需要花费的时间成本，参与本研究目前预计不会有任何其他风险或者成本。

(8) 参与本研究会有任何收益吗？

我们无法向您保证此次研究会为您带来任何直接收益。

(9) 关于我在本次研究中提供的信息将如何处理？

如果您同意接受此次访谈，意味着您将为本研究提供相关的信息。在您同意的情况下，本次访谈将进行录音记录或者笔记记录。

您所提供的信息将仅用于本研究，以及相关研究成果的发表。结果将以完全匿名方式发表发表，且不会出现任何对您的身份有指向性的信息，发表方式包括学位论文、期刊文章，以及会议报告。在未取得您同意的情况下，您所提供的信息将不会用于其他任何途径。

(10) 我能将此研究告知其他人吗？

可以，欢迎您将本研究告知其他人。

(11) 如果我希望获得关于该研究的进一步信息应该怎么办？

如果您希望了解关于本研究的进一步信息，请联系调查员成秋娴，她将尽可能解答您的疑问。如果您在本研究过程中有任何疑问，欢迎联系下列人员：

研究人员列表

姓名	成秋娴
职位	联合调查员
联系电话	+61 0472567770/ +86 18716445077
电子邮箱	Qiuxian.cheng@sydney.edu.au

姓名	Fran Collyer 副教授
职位	调查负责人
联系电话	+61 2 9351 2653
电子邮箱	fran.collyer@sydney.edu.au

(12) 我会被告知该研究的研究结果吗？

您有权获得关于本研究研究结果的反馈。如果您希望获得研究结果反馈，请在同意表的相关栏目上划勾（或口头告知我们）。该研究结果将会在本研究结束之后以总结的形式反馈给您。

(13) 如果我要针对本研究进行投诉或者有其他诉求应该怎么办？

在澳大利亚进行的涉及人类的研究均由名为人类研究伦理委员会的独立小组成员进行审核。该研究涉及伦理层面的内容已由悉尼大学人类研究伦理委员会审核通过（协议编号为：XXX）。作为本审核过程的一部分，我们已经同意研究者根据《澳大利亚国家关于人类研究伦理行为的声明（2007）》相关规定实施调查。该声明目的在于保护被调查者。

如果您对于该研究的实施有任何疑问，或者您希望进行投诉，请通过以下方式联系悉尼大学，并附上研究题目以及协议编号。

悉尼大学伦理办公室管理员

- **联系电话：** +61 2 8627 8176
- **电子邮箱：** human.ethics@sydney.edu.au
- **传真：** +61 2 8627 8177 (Facsimile)

此声明书由您保存

Appendix E - Participant Information Statement [Participant Group (2)] in Chinese

THE UNIVERSITY OF SYDNEY

人文与社会科学学院
社会学与政治学学院
社会学与社会政策系

ABN 15 211 513 464

Fran Collyer
社会学系副教授

澳大利亚 新南威尔士州
悉尼大学 社会学大楼（A02） 352办公室
邮编：2006
联系电话：+61 2 9351 2653
传真：+61 2 9351 2653
电子邮箱：fran.collyer@sydney.edu.au
网址：http://www.sydney.edu.au/

关于中国医疗领域公私合营的研究

致参与者的信息声明书（第二组参与者）

(1) 该研究的主要内容是什么？

诚邀您参与到题为“**关于中国医疗领域公私合营的研究**”的研究当中。

本研究旨在比较中国与澳大利亚医疗领域内的公私合营。该研究的结果将作为研究者之一成秋娴于悉尼大学社会学与社会政策系博士毕业论文的重要组成部分之一。

之所以邀请您参与到本研究是因为广义而言，您可能作为医疗领域公私合营的相关主体之一。本《**致参与者的信息声明书**》将告知您关于本研究的主要内容以及您将会为本研究提供哪些信息，以便于您决定是否参与到本研究。请仔细阅读本声明书，并就您有所困惑并希望进一步了解的内容提出问题。

本研究秉持自愿参与原则。

如果您同意参与到此次研究，意味着您：
- ✓ 理解本声明书上的相关内容；
- ✓ 同意参与到本研究；
- ✓ 同意研究者采用您所提供并授权的信息。

本研究将为您提供一份《**致参与者的信息声明书**》的复印件以供保存。

(2) 谁将会进行此项研究？

调查员成秋娴将会进行本项研究，以为其悉尼大学博士学位论文提供实证支撑。本研究将在副教授 Fran Collyer的指导下进行。

(3) 我需要为该研究提供哪些方面的信息？

如果您决定参与到此次研究，您将会被邀请进行一次访谈。在访谈之前，您将会签署一份《**参与者同意书**》。本次访谈将持续约一小时，在征得您同意的情况下，本次访谈将会被录音或者笔记记录。

由于本访谈采取半结构式访谈的方式，所以可能会针对一些具体问题与您展开讨论。访谈的问题主要包括：

- 请问您在医疗系统扮演什么样的角色？
- 您有关于公私合营的相关经验或经历吗？如果有，请问是什么？
- 根据您的工作经验，您认为公私合营医院面临着怎样的挑战或者冲突？
- 针对您上述提及的挑战或者冲突，您有何建议？

(4) 此研究（访谈）将会花费我多长时间？

该访谈将会花费您大约一小时。

(5) 该研究参与者的纳入标准是什么？

本研究的参与者需要在广义上被包含在医疗系统公私合营的领域之内。

(6) 我必须参与此次研究吗？我可以在中途退出吗？

该研究秉持完全自愿的原则，所以您不是必须参与此次研究。并且，您的决定将不会对您与研究者以及悉尼大学的其他任何人员的关系造成任何影响。

如果您决定参加本研究但是中途改变主意，您可以在本研究的任何阶段选择退出，请以书面或者口头形式告知研究者。

您也可以在访谈的任何阶段选择中止。您关于此次研究的所有相关信息、访谈记录（包括录音和笔记记录）都将被研究者删除，除非您希望研究者继续保存。在访谈途中，您可以拒绝任何您不愿意回答的问题。

(7) 参与该研究存在任何风险或者成本吗？

除开您需要花费的时间成本，参与本研究目前预计不会有任何其他风险或者成本。

(8) 参与本研究会有任何收益吗？

我们无法向您保证此次研究会为您带来任何直接收益。

(9) 关于我在本次研究中提供的信息将如何处理？

如果您同意接受此次访谈，意味着您将为本研究提供相关的信息。在您同意的情况下，本次访谈将进行录音记录或者笔记记录。

您所提供的信息将仅用于本研究，以及相关研究成果的发表。结果将以完全匿名方式发表发表，且不会出现任何对您的身份有指向性的信息，发表方式包括学位论文、期刊文章，以及会议报告。在未取得您同意的情况下，您所提供的信息将不会用于其他任何途径。

(10) 我能将此研究告知其他人吗？

可以，欢迎您将本研究告知其他人。

(11) 如果我希望获得关于该研究的进一步信息应该怎么办？

如果您希望了解关于本研究的进一步信息，请联系调查员成秋娴，她将尽可能解答您的疑问。如果您在本研究过程中有任何疑问，欢迎联系下列人员：

研究人员列表

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(12) 我会被告知该研究的研究结果吗？

您有权获得关于本研究研究结果的反馈。如果您希望获得研究结果反馈，请在同意表的相关栏目上划勾（或口头告知我们）。该研究结果将会在本研究结束之后以总结的形式反馈给您。

(13) 如果我要针对本研究进行投诉或者有其他诉求应该怎么办？

在澳大利亚进行的涉及人类的研究均由名为人类研究伦理委员会的独立小组成员进行审核。该研究涉及伦理层面的内容已由悉尼大学人类研究伦理委员会审核通过（协议编号为：XXX）。作为本审核过程的一部分，我们已经同意研究者根据《澳大利亚国家关于人类研究伦理行为的声明（2007）》相关规定实施调查。该声明目的在于保护被调查者。

如果您对于该研究的实施有任何疑问，或者您希望进行投诉，请通过以下方式联系悉尼大学，并附上研究题目以及协议编号。

悉尼大学伦理办公室管理员

- **联系电话：** +61 2 8627 8176
- **电子邮箱：** human.ethics@sydney.edu.au
- **传真：** +61 2 8627 8177 (Facsimile)

此声明书由您保存

Appendix F - Participant Consent Form in English

THE UNIVERSITY OF SYDNEY

ABN 15 211 513 464

Department of Sociology and Social Policy
School of Social and Political Science
Faculty of Arts and Social Sciences

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Public-private-partnerships (PPPs) in the Chinese Healthcare Field

PARTICIPANT CONSENT FORM

I, ... [PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- The researchers have answered any questions that I had about the study and I am happy with the answers.
- I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of Sydney now or in the future.
- I understand that I can withdraw from the study at any time.
- I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study. I also understand that I may refuse to answer any questions I don't wish to answer.
- I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.
- I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

I consent to:

- **Audio-recording** YES ☐ NO ☐
- **Interview transcript** YES ☐ NO ☐
- **Photographs** YES ☐ NO ☐
- **Being contacted about future studies** YES ☐ NO ☐

I would like to review my interview transcripts YES ☐ NO ☐

I would like to receive feedback about my personal results YES ☐ NO ☐

I would like to receive feedback about the overall results of this study YES ☐ NO ☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal: _____

_____

☐ Email: _____

.....
Signature

.....
PRINT name

.....
Date

Appendix G - Participant Consent Form in Chinese

THE UNIVERSITY OF SYDNEY

人文与社会科学学院
社会学与政治学学院
社会学与社会政策系

ABN 15 211 513 464

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关于中国医疗领域公私合营的研究

参与者知情同意书

本人，_____（正楷姓名），同意参与此次研究，并作出如下陈述：

- 本人理解该研究的目的，本人将被问到的问题，以及相关的风险及收益。
- 本人已阅读《致参与者的信息声明》，并已与调查员讨论清楚在本人同意的前提下对于该研究的参与详情。
- 调查员已就本人提出的该研究相关的所有问题进行了解答，本人对于回答满意。
- 本人理解参与此研究属于完全自愿。本人关于是否参与此研究的决定不会对本人与研究者以及悉尼大学的其他任何人员的关系造成任何影响。
- 本人了解可以在研究的任何阶段退出该研究。
- 本人了解可以根据自己的意愿在访谈的任何阶段选择退出，一旦选择退出该研究，本人关于此次研究的所有相关信息、访谈记录（包括录音和笔记记录）都将被研究者删除，除非本人希望研究者继续保存。在访谈途中，本人可以拒绝任何不愿意回答的问题。
- 本人明白在该研究中涉及到的本人个人信息将会被安全、秘密地保存，并且本人所提供的信息仅用于本人同意的目的。本人明白在未取得本人同意的情况下，本人提供的信息将不会用于其他任何途径，除非被法律强制要求。
- 本人明白该研究的成果可能会被发表，且发表内容不会涉及任何关于本人姓名等身份指向性信息。

本人同意：

- 录音　　是 ☐　否 ☐
- 访谈记录　　是 ☐　否 ☐
- 照相　　是 ☐　否 ☐
- 就未来的研究与本人联系　　是 ☐　否 ☐

我希望检查我的访谈记录　　是 ☐　否 ☐

我希望收到关于我个人访谈结果的反馈　　是 ☐　否 ☐

我希望收到该研究总体结果的反馈　　是 ☐　否 ☐

如果您的回答为“是”，请告知您希望收到反馈的方式及地址：

☐ 邮政地址：_____

_____

☐ 电子邮箱：_____

.....

签名

.....

正楷姓名

.....

日期

Appendix H - Key policies with specific regard to Chinese Health Reform

Table 1			
Title: Key policies with specific regard to Chinese Health Reform (privatisation)			
Year	**Promulgator**	**Name of the Law or Regulation**	**Main Tasks**
1978-the 1990s			
1980	Ministry of Health (forwarded by The State Council, PRC)	The Request on Permitting Private Staff to Practice Medicine (关于允许个体行医问题的请示报告)	▪ Permitted individual doctors to practice medicine.
1985	Ministry of Health (forwarded by The State Council, PRC)	The Report Concerning Some Questions on the Reform of Health Work (关于卫生工作改革若干问题的报告)	▪ Raised health funds from multi-channels, namely the state, the collective and individuals; permitted doctors qualified to practise medicine in multi-site.
1989	The State Council, PRC	Advice on Relevant Issues in the Expansion of Health Services (关于扩大医疗服务有关问题的意见)	▪ Promoted the contracted responsibility system for medical institutions, allowing them to finance and operate independently upon ensuring the completion of tasks under the contracts. ▪ Encourage health institutions and individuals qualified to provide paid health service in unemployed time.
1992	The National Health Conference, PRC	The Outline of China's Health Development and Reform (中国卫生发展与改革纲要)	▪ emphasised the public welfare nature of health service and encouraged joint health funds by the state, the collectives and individuals at the same time.
The 1990s-2009			
1997	The State Council, PRC	Decisions of the CCP Central Committee and the State Council on the Health Reform and Development (中共中央、国务院关于卫生改革与发展的决定)	▪ Chinese health service had the nature of public welfare: (1) health institutions were not for profit and would enjoy preferential tax policies and reductions in fees; (2) Chinese health service were jointly funded by national budget, social fund raising and charges for healthcare services, among which national budget was the main source; (3) Relationship between social and economic benefits in healthcare should be appropriately managed, take into consideration both social and economic benefits, put social benefits in the first place when conflicts emerge, and try to achieve the unification of them.

2001	The State Council, PRC	Guiding Opinions for the Rural Health Reform and Development (关于农村卫生改革与发展的指导意见)	▪ Established a rural healthcare system served with basic medical services and public health service. ▪ Ensure access to primary healthcare for all rural residents.
2000	The State Council, PRC	Guiding Opinions for the Urban Medical and Healthcare System Reform (关于城镇医药卫生体制改革的指导意见)	▪ Established an urban healthcare system served with affordable and high-quality medical services; regulated the process of drug production and circulation, curbed the unreasonable growth of medical expenses; streamlined the medical institution by using temporary staff instead of permanent workers.
1998	The State Council, PRC	Decisions on Establishing Urban Employee Basic Medical Insurance System (关于建立城镇职工基本医疗保险制度的决定)	▪ Established a basic medical insurance system for urban employees, which covered basic medical services and a wide range of populations; the insurance was paid by both employees and their work units and adopted a payment method of social pooling combined with individual accounts.
2003	The State Council, PRC	Opinions on Establishing New Rural Cooperative Medical Scheme (关于建立新型农村合作医疗制度的意见)	▪ Established a rural cooperative medical scheme for peasants, which was featured by voluntary participation and revenue-based spending strategy; the insurance mainly covered serious disease, with the state, collectives and individuals jointly providing funds.
2009-			
2009a	The State Council, PRC	Opinions of the CCP Central Committee and the State Council on deepening the Reform of the Medical and Healthcare System (中共中央国务院关于深化医药卫生体制改革的意见)	▪ drew a blueprint for the new round of reforms to establish a basic healthcare system covering both urban and rural residents by 2020.
2009b	The State Council, PRC	the Plan on Recent Priorities in Carrying out the Reform of Health Care System (医药卫生体制改革近期重点实施方案)	▪ Achieve a fully covered medical insurance: enrol urban and rural residents not covered by the UEBMI in the URBMI and NCMS, respectively, with a subsidy (120 Chinese Yuan per capita per year in 2010) by the government. ▪ Pilot the reform of public hospitals: increase financial input in the public hospitals and improve corporate management of public hospitals; separate ownership from regulation, separate government administration from hospital management, separate

			drug sales from hospital revenues, and separate for-profit from not-for-profit; increase the market share of private hospitals to 20 per cent. ▪ Equalise basic public health for all: the funding standard is no less than 15 Chinese Yuan per capita in 2010 and no less than 20 Chinese Yuan in 2011. ▪ Improve primary health care for all: strengthen the infrastructure (including primary medical staff) for primary healthcare, especially in the rural areas. ▪ Establish a national essential medicine system: include all essential medicines into the medical insurance drug reimbursement list.

Source:

The State Council, 1980, The Request on Permitting Private Staff to Practice Medicine (关于允许个体行医问题的请示报告), viewed 28 June 23, http://www.elinklaw.com/zsglmobile/lawView.aspx?id=783.

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The State Council, 2009b, the Plan on Recent Priorities in Carrying out the Reform of Health Care System (医药卫生体制改革近期重点实施方案), viewed 28 June 23, 国务院关于印发医药卫生体制改革近期重点实施方案（2009—2011 年）的通知　医药卫生体制改革近期重点实施方案（2009—2011 年）　2009 年第 11 号国务院公报　中国政府网 (www.gov.cn).

The National Health Conference, 1992, the Plan on Recent Priorities in Carrying out the Reform of Health Care System (医药卫生体制改革近期重点实施方案, *Chinese Journal of Health Education,* no. 2, p. 41.