Social policy reform driven by crises: Promoting and reshaping social policy during the SARS and COVID-19 pandemics in China

Tao Liu

School of Public Affairs and Academy of Social Governance, Zhejiang University, Hangzhou, China

Correspondence
Tao Liu, School of Public Affairs and Academy of Social Governance, Zhejiang University, Yuhangtang Road 866, 310058, Hangzhou, China.
Email: taoliu1975@zju.edu.cn

Abstract
This article focuses on one particular and under-investigated dimension in the study of social policy – crisis events and their special function in promoting and shaping social protection programs. Crises are usually regarded as negative social events that tempestuously challenge the pre-existing socio-economic order, triggering social conflicts and disruption, either temporarily or in a more enduring fashion. However, social crises may also foster new opportunities for social investment, public finance expansion and welfare state building after the outbreak of a crisis and even during the post-crisis period. This article first examines the SARS pandemic and analyzes its developmental trajectory, reconstructing the national debates and discourses on the negative consequences and lessons learned in the SARS and post-SARS period. I argue that this crisis event revealed many loopholes in the Chinese public health system, constituting a powerful driving force for rebuilding the medical insurance system and health governance in China, and strengthening public discourse on welfare state responsibility. Second, I explore how, during the COVID-19 pandemic, scholars and experts have constructed the ‘short board’ of Chinese social policy, calling for further social policy reforms to narrow the gaps in health protection resources among social classes and to eliminate the fragmentation of health resource distribution.

KEYWORDS
crises, driven forces, loopholes, pandemics, short board
1 INTRODUCTION

Sociological modernization theory assumes that the welfare state is one of the cornerstones in modern society, along with other core institutional mechanisms such as the market economy, competitive democracy, and mass consumption (Zapf, 1994). Within the framework of modernization theory, state-organised social policy is closely linked to the grand transformation incurred by socio-economic changes, including economic growth, the monetarization of society, industrialization, urbanisation, etc. (Wilensky, 1974, 2002). In this vein, social policy has been considered as a form of institutional arrangement to offset risks in industrialised society and to provide the functional equivalent of family security, which substantially eroded during modernization. Although it is reasonable to link the emergence and extension of welfare states to socioeconomic modernization and related social change, this article reveals another side of social policy formulation and evolution in modern society, which remains marginal in the study of social policy: crises as driving forces for reforming and reshaping social policy. In particular, this article focuses upon pandemic events and elaborates their impact on discourses and narratives of social policy, which favour resource mobilisation and new reforms.

Concretely, this article identifies two pandemic-related social crises in the post-millennial era in China – the SARS and the COVID-19 pandemics – and explores how social and political mobilisation at these critical junctures has been transformed into national debates and discourses on reforming and reshaping social policy in China which surprisingly stimulated new reform initiatives in Chinese social policy, especially within the public health system. The COVID-19 pandemic has additionally accelerated digital governance in the arena of social policy administration; public health services are more digitally organised and provided via the Internet than in the pre-pandemic period. This article has mainly used the research methods of qualitative content analysis, discourse and document analysis through the systematic scan and scrutiny of a multifaceted dataset, which includes government reports, published and unpublished documents from research institutes and universities, and reports from influential news media and emerging social media. The primary emphasis has been placed upon controversial reports and discourses produced by high-level think tanks, like the Development Research Centre (DRC) of the State Council during the SARS-pandemic, which has attracted intensive nationwide attention to the loopholes in health insurance systems, inducing a critical rethinking on the failing state and the failing public health sector.

This research project concludes that the two selected pandemics have caused a ‘crisis chain’, including different types of critical events, such as epidemic, economic, political, social, and health-related crisis events, bringing Chinese society into a state of emergency that required an effective and quick response by governments. As soon as society crossed the critical threshold during the pandemics, implicit problems have suddenly become explicit, the largely neglected loopholes and ‘short boards’ in public sectors have become perceivable and tangible in everyday life; at the same time, public discontent has rapidly increased, and governments feel the acute pressure and need to re-legitimize their governance and regain the public’s trust. During these critical events, the constraints for public discussions and discourses have been relaxed, intellectuals and netizens are more daring in expressing their critical opinions, and social criticism on current public systems has been more tolerated than in the pre-crisis period. All these factors coalesce into driving forces for reform, readjustment, and recalibration of social policy. The pandemics unintentionally played a key role in social policy development and expansion in China, and these critical events should be taken into consideration in the study of Chinese social policy.

2 THEORETICAL FRAMEWORK: EPIDEMICS, CRISES, AND SOCIAL POLICY

Crises consist of critical events that have brought a society or country into an exceptional state deviating from the norm (Holton, 1987). During crises, social conflicts may escalate, and social contradictions may intensify since different areas such as economy, finance or public sectors cannot operate as usual. The dysfunctionality of different social
systems creates a power vacuum and a failing state, which stimulate social discontent, protest, or even highly intensified conflicts, causing social disruption and social turmoil. Crises call for quick and proficient crisis management by the state (Boin et al., 2016; Pearson & Clair, 1998), and the state must mobilise social and political resources to recreate social order; otherwise, society would be exposed to social disintegration. Crises can be divided into different types: economic crisis, financial crisis, social crisis, political crisis, and war-related crisis. Different types of crises require different kinds of response mechanisms and action strategies. Epidemics, and their intensified forms – pandemics – belong to a special kind of crisis, usually associated with infectious diseases that can quickly spread from people to people or from biological organism to people. They generate a highly dangerous and unpredictable fluid state, which produces anxiety, panic, suspicion and stigma, and society can be involved in a variable and emotional maestrom that goes beyond anyone’s immediate control (Strong, 1990; Pearson & Clair, 1998). Although social crises caused by epidemics and their extreme form of pandemics share some commonalities with other kinds of crises, they have also some unique features. Epidemics and their risks of contagion and permeability breed a psychology of fear, which causes a collective feeling of discontent, agitation, restlessness, and dysphoria; thus, the state must adopt emergency measures and create an almost war-like emergency state, or risk losing the battle against viruses and diseases (Kapiriri & Ross, 2020; Strong, 1990).

Since epidemics and pandemics pose an acute and urgent threat to society and state, the initiatives of organised collective action have increased accordingly, and public discourses and opinions on reform and change have also dynamically thrived. During crisis, the voices of critics continue to rise, and ‘metaphysic questions’ (Strong, 1990) are raised and hotly debated: what or which unpredictable forces have caused the pandemic? Who is blame for such a horrible scenario? What does the pandemic reveal about society? Epidemics and pandemics have not only intensified state-organised emergency actions such as lockdowns, curfews, and quarantines; they have also resulted in a politics of disease epidemics (Dingwall et al., 2013; Kapiriri & Ross, 2020), with diversified (and mostly critical) views from civil society, public spaces, and cyberspaces, unseating the authority of rulers and the monopoly of information sources in the authoritative context. As a result, a broad reflection on the causality and suffering of pandemics may emerge and cause a rethinking of public systems and public administration in a society; the key question is related to the attribution of responsibility for infectious diseases (Kapiriri & Ross, 2020). In this vein, epidemic-related crises breed new opportunities for the enlightenment of the public, creating strong pressure for policymakers to fundamentally change. Thus, pandemic management is related to new forms of governance and even the emergence of a new management culture (Carney & Bennett, 2014). With pandemic management in an emergency state, and new reform initiatives, rulers may change their passive states and seek to regain public trust in order to restore legitimacy to their rule. Epidemic-related crises may unintentionally create a chain reaction of positive social change.

There are two different views on the relationship between crisis and social policy. One view holds that the economic and financial crisis will lead to the withdrawal of the welfare state which can be labelled as ‘retrrenchment approach’, and the other view holds that the crisis will lead to the expansion of the field of state management and regulation, which is conducive to the establishment of the welfare state. Conventionally, crises have been considered negative events that cause malfunction of different social systems and deviation from the normal state (Holton, 1987). At the same time, the financial resources of the welfare state have dried up, its fiscal capacity has eroded, and the logical sequential development is a reduction in the public sector and welfare retrrenchment. For instance, the oil crisis and the following stagflation in Western economies in the 1970s have been broadly considered the origin of a long-term transformation and readjustment of the welfare state, mitigating the enduring expansion process of the welfare state in the post-war epoch, and marking the caesura of the golden age of capitalism (Dukelow, 2011; Pierson, 2001). During the 2007–2008 global financial crisis, Ireland, the so-called Celtic Tiger, also partially cut benefits for family welfare and jobseekers, while a sudden increase in public sector debt and deficits threatened to shrink investment in the welfare state (Dukelow & Considine, 2014; Hick, 2014). However, other studies have proved through empirical data that the ‘black swan’ of the economic crisis does not always impede the development of social policy. On the contrary, the consequences of the economic crisis have forced the government to increase fiscal expenditures to expand the social insurance and social assistance schemes, resulting in a special
situation in which the economic crisis drives the development of the welfare state (Hort & Kuhnle, 2000). The ‘late-comers’ and the ‘early birds’ also show different development paths: the established Western welfare states often choose the path of welfare retrenchment when faced with crises, while the new welfare states like the East and Southeast Asian countries are inclined to increase social expenditures in the crisis. This article also moves beyond the retrenchment approach and underpins the ‘expansion and establishment approach’, assuming that crisis not only causes social disruption but also breeds novel opportunities for metaphysical reflection on the nexus between state and society and indirectly stimulates public investment and the building of the welfare state. Usually, the negative outcomes of social crises, whether economic, financial, or war-related, have rigorously challenged the current social order, making implicit social problems in ‘normal’ times explicit. Social deficiencies and contradictions have been exposed and become topics with social explosiveness. The disorder and the danger of anarchical disintegration as well as the emotional maelstrom at a critical juncture have created a pressure structure which motivates bold action and allows more leeway for unorthodox policy design; thus, massive social problems like currency devaluation, anarchy, strikes, unemployment, famines, and malnutrition may force rulers and policy makers to launch social reform initiatives. Historically, different critical events have demonstrated that crises have been unintentionally transformed into new opportunities for social protection programs. For instance, the origin of the American welfare state was related to the outcomes of the Great Depression in the 1930s (Amenta & Carruthers, 1988). The second wave of welfare programs in different social insurance branches of Northeast and Southeast Asian nations started during the Asian economic crisis in 1997 and this trend of welfare extension has persisted in the post-crisis period (Hort & Kuhnle, 2000). The establishment of social assistance programs in urban China is also closely linked to crises after the radical reforms of the SOEs (state-owned enterprises) in the 1990s (Liu & Sun, 2016b). In general, compared with various forms of crises, the pandemic-related crisis displays the ‘war-like’ characteristics. The resource control and personnel flow control (such as curfew and lockdown) during the pandemic are closer to a special state of emergency during a war. The social policy arrangements of the welfare states need to respond urgently to the negative effects of the pandemic, including the rapid spread of disease and the sharp rise in unemployment and relative poverty.

In this article, I argue that epidemics and pandemics such as SARS and COVID-19, as a special form of crisis, have severely affected the current socioeconomic order in China. They have also broken through the monopoly of official narratives on infectious diseases and public services systems, resulting in a plurality of discourses and debates on the failing state and the failing public sector. Pandemics and their shocking consequences have created a strong impulse for Chinese society to express critical concern over social policy in China and its loopholes and ‘short boards’. The systemic deficiencies of social protection programs have been revealed and the public health sector has been constructed as a puzzle of reforms that requires concrete policy action to change. Further, the shock waves of the pandemic-related crises have endured even in the post-crisis period, unexpectedly acting as powerful driving forces for reforming the Chinese public health system. The epidemic-related crises should thus be included in the study of Chinese social policy and social governance reforms.

3 | PANDEMICS AS AN IMPULSE FOR SOCIAL POLICY REFORM IN CHINA

3.1 | The SARS pandemic

The SARS pandemic, literally ‘severe acute respiratory syndrome’, is a type of atypical pneumonia first diagnosed and identified in Shunde, Guangdong Province, in 2002. It then spread to Hong Kong, Taiwan, and Southeast Asian nations, and afterwards to many Western countries, turning into an international pandemic. In 2003, the World Health Organisation (WHO) announced a travel ban on several regions in Mainland China, Taiwan, Hong Kong, and Singapore, among others. Since 15 June 2003, no new cases of SARS have been diagnosed; the spread of the SARS pandemic has been globally contained. On 24 June 2004, WHO announced the lifting of the travel ban on Beijing, and the pandemic basically came to an end. According to WHO statistics, worldwide, a total of 8096 SARS-patients
had been diagnosed, and a total of 774 deaths was reported, with a mortality rate of 9.56% (WHO, 2004). In the following sections, this article will address how the SARS pandemic and a general mood of crisis motivated Chinese society and the Chinese state to change and reform the public health system during crisis and post-crisis periods.

3.1.1 | SARS, crisis management and a comprehensive reflection on social protection and public health

Emotional maelstrom
Like the trajectory of any epidemic, Chinese society was swept into an emotional maelstrom as the SARS pandemic escalated. During the early spread of the SARS pandemic, people who had lived in an era of peace and prosperity for a long time witnessed frightening scenes for the first time: the quarantine of suspected and diagnosed SARS patients, the lockdown of districts and cities, the travel ban announced by the WHO to certain regions in China, the isolation of people, regions and even countries. Chinese society experienced fear, panic, uncertainty and discontent, and distrust toward government as well as criticism about the inaction and opaqueness of local governments mounted, especially among the netizens that had become an emerging and influential force since the millennium. Unproven and unconfirmed rumours (Ma, 2008; Zhou, 2003a, 2003b) quickly spread via the Internet, and official authority was challenged like never before. A turning point was the intervention of top Chinese leaders: former Chinese President Hu and Premier Wen adopted swift measures and removed the former mayor of Beijing and the Minister of Health from their posts in April 2003, also ordering a quick and accurate registration and report of any suspected and diagnosed SARS cases nationwide and promising a penalty for inaction and concealment of numbers and facts by local officials (Huang, 2006). Afterwards, the entire country had been mobilised to contain the pandemic, public anger and discontent lessened, and Chinese society gradually returned to normal.

Defence loopholes and insurance loopholes
Since the outbreak of the SARS pandemic, the entire Chinese nation has been involved in a national reflection movement, and critical voices and views have been raised. This kind of national reflection has also spread to academic and intellectual circles. Many experts, scholars and influential professors have been involved in this movement of self-reflection and self-criticism; even the transnational epistemic community of overseas Chinese have joined in the ensemble of reflective discourses and narratives on the Chinese public health service sector. Through the analytical review of different scripts, including academic journal articles, magazine reports, reports of think tanks, research institutes and international organisations as well as news media reports, I have identified some high-frequency terms such as ‘loopholes’, ‘gaps’, ‘blind spots’ and ‘blanks’. These key words reflect the acute social problems at an ontological level and the critical attitude of intellectuals at the level of subjective assessment. Scholars and experts peppered their reports and texts with the terms ‘loopholes’ and ‘gaps’ (in Mandarin: loudong) to highlight the underdeveloped and failing social and epidemiological institutions unable to offset the basic social needs after the outbreak of pandemics. Two types of ‘loopholes’ can be classified at the semantic-semiotic and substantial level: (1) the first relates to the context of epidemiology, including a repertoire of measures, policies, comprehensive management systems and structural arrangements to identify early, register and report suspected patients suffering from infectious diseases; an effective and early prevention system and prewarning system for new infectious diseases also belong to this institutional category; (2) the second type of ‘loophole’ concerns social protection, in particular, the health protection system, symbolically presenting the huge gaps in the Chinese health insurance system, incapable of providing even minimum protection for the majority of the population (Fu, 2003; Li, 2003; Wang & Zhao, 2004).

The epidemiological loopholes can be compared to the defence loopholes in a military fortress with various gaps and construction errors that enable external hostile forces (in this case: the virus) to easily break through, making the pre-planned defence project only exist nominally and symbolically. SARS-related reports are inclined to use
metaphors and phrases like ‘the sudden attack of virus’ and ‘the deficient defense system’, delineating an emergent state out of control and demonstrating a situation of disequilibrium between a powerful pandemic and a weak public emergency management system. The war-like phrases construct an abnormal state with an acute emergency; these views and debates justify launching an effective epidemic prevention and control system, still ‘toothless’ at that time. The defence loopholes call for a crisis and emergency management system to target risks in a special critical state. Social insurance loopholes revealed the huge systemic gap in the Chinese health protection system and particularly in the health insurance system, which only targets urban employees with a formal employment relationship, with poor urban residents and peasants categorically excluded from the social insurance program since the economic reforms. In the pre-crisis period, millions of employees in the urban formal sector were not covered by the health insurance system, and rural residents were the largest vulnerable group with no health insurance after the disintegration of the Maoist cooperative health service system. In 2002, nationwide, only 94 million urban employees in China were covered by the urban employees’ health insurance program, making up a small fraction of the entire population (National Bureau of Statistics, 2003). These huge insurance loopholes were blamed for massive problems related to medical diagnosis, testing of suspected cases and medical therapy and treatment in the case of SARS.

In November 2002, the sudden outbreak of SARS threatened the health, life, and normal life of the public, and even the safety of the whole society. Because the building of a social security system in China is still in the primary stage..., the normal social security operation system in dealing with the SARS incident is not fully effective. Therefore, it is necessary and mandatory to reflect and summarise the loopholes and problems of China’s social security system exposed in this crisis. (Wang & Zhao, 2004)

At the same time, the SARS epidemic has sounded an alarm to the employers who are still unwilling to [let their staff] participate in the basic medical insurance for urban workers. (Li, 2003)

At present, the Chinese medical insurance system is still medical insurance for a few people, and the health problems of 900 million farmers remain outside the system. (Li, 2003)

Without farmers’ medical and health protection, there will be no protective wall for the public health of the people across the country. At present, we must use rural health reform as a breakthrough to eliminate the blind spots in rural health and epidemic prevention and promote public health in the vast rural areas. (Deputy Director of Jiangsu Provincial Office of Health Zhao Yongjin, cited in the report by Xu & Li, 2003)

Fourthly, the public health management of the floating population has not been incorporated into the planning system, and there is a huge loophole in the protective wall for the national health and epidemic prevention. At present, the floating population in some big cities accounts for about one third of the total population. However, when constructing hospitals, arranging hospital beds, training health technicians, and setting up an epidemic prevention network, the demand of the floating population is not taken into account. The planned immunisation of children is not fully incorporated into local management. This ‘blank’ of epidemic prevention poses a great threat to the public health safety of cities. (Xu & Li, 2003)

These critical reviews from Chinese news media reports and academic journal articles not only questioned the social protection system from the holistic sense, but also linked the loophole-related angles to groups like migrant workers and children. According to their views, the failing social protection system had obviously increased
epidemiological risks; thus, insurance loopholes exacerbated the defence loopholes in the epidemic prevention and control system. Social policy became the Achilles’ heel of the epidemic defence system.

A report on reflection and systemic correction

In early 2003, as China was still deeply trapped in the SARS pandemic, the Social Development Research Department of the Development Research Center of the State Council (DRC) cooperated with the WHO to initiate a collaboration project on ‘China’s medical and health system reform.’ Experts and scholars from different institutes, such as the Institute of Health Economics of the Ministry of Health, the Beijing Center for Disease Control, the School of Public Health of Peking University and the Ministry of Labor and Social Security were included in the initiative. In June 2003, shortly after the final control of SARS pandemic, the DRC published a report on the review of the Chinese health reform since the economic reforms. This reflection report asserted that the reform of Chinese medical system since the economic reforms was basically unsuccessful. This general critical and negativistic assessment is unusual within a consensus-oriented society. The report successfully attracted the attention of the entire country and stimulated a national debate on the loopholes and blanks of the Chinese health system, which covers only a minority of the population. This report also pointed out that the current commercialization and marketization of the medical and health system was completely ‘wrong,’ violating the basic laws of medical and health services. In addition, the urban medical insurance system itself had obvious defects, and its development prospects were not optimistic. China’s medical and health system could look forward to changes (DRC, 2003). A core idea was conveyed through a metaphor: ‘The Chinese health system is infected with “American disease”’ (DRC, 2003). This metaphor relates to a double entendre: normally the health system cures sick patients; however, now, the Chinese health system itself is sick, and it is infected with a disease that leads to its deficiency, malfunction, and decoupling (from the demands of most people). The phrase ‘American disease’ is a metaphor associated with an over-marketized and over-commercialised model that misses the target for the basic aims of a health system: fairness, equity, and comprehensive protection for the entire population. The report discussed some key problems in the Chinese health system: health costs have risen sharply, medical and health services are very unfair, health resources are inefficiently used, and people’s health indicators have stagnated and even deteriorated (ibid.).

Global ranking as a critical method

During the pandemic period and in the post-pandemic period, a certain method has been frequently applied among critical experts – namely, using the international ranking of health protection systems published by international governmental organisations – particularly by the WHO – to underpin their arguments concerning the acute need for action and reform. The aforementioned key report published by the DRC of the State Council used an indicator that has also been used by many other reports, books, and academic publications. In 2000, the WHO assessed the equity of health financing and distribution in member states, and China ranked 188th in the ranking of the 191 member states, fourth from the bottom (DRC, 2003). An online report from the Xinhua-net refers to the same WHO indicator, concluding:

A shocking conclusion is: in terms of ‘equity of health financial burden,’ China ranks 188th after Nepal and Vietnam, and the fourth from the bottom. Together with Brazil, Myanmar and Sierra Leone, China is ranked as one of the most unfair countries in ‘health financial burden’! (Zhou, 2003a, 2003b)

These statements evoked strong resonance among the Chinese public. The reference to some of the least developed countries and some of the most unequal countries successfully created an atmosphere of crisis, making the status quo of the health system no longer tolerable to Chinese society. The ‘backward’ state of Chinese health protection system had crossed the psychological endurance capacity of the Chinese public. The Harvard professor Hsiao also used the same method:
I began to study China's public health situation in 1981, and at the same time conducted an in-depth comparative analysis of more than 30 countries. Studies have shown that some of the poorest countries in Africa have double the per capita health expenditures of China. In the 2000 ‘World Health Report’ of the World Health Organization, China ranked 188 in the health systems of 191 countries because of its unbalanced health systems and the government's inaction to improve people's health conditions. (Hsiao, 2003)

He also said: ‘In terms of public expenditure, China is among the lowest in the world. I think the Chinese government's investment in public health and medical care can be described as ‘sad’ (Hsiao, 2003, p. 28). The comparison with least developed countries and China's ranking below them created a sense of collective shaming and favoured fundamental and directional change.

Further, some reports referred to the ever-successful model of the rural cooperative medical care system in the 1960s and 1970s in rural China during the Maoist period, which had been identified as a model for developing nations by the World Bank and the WHO (Zhou, 2003a, 2003b). The sharp contrast between the current state and the past also justified the argument for urgent and necessary change in the deficient Chinese public health system.

3.1.2 | Crisis calls the state back

The public health crisis calls for a public service-oriented government. (Hong Yinxing, former vice president and economist of Nanjing University, quoted from the report of Xu & Li, 2003)

The SARS-related pandemic not only revealed the loopholes in the Chinese epidemic prevention and control system, but also changed the distribution of discourse power within the Chinese epistemic world. In the pre-crisis period, the market-liberal doctrines had moved beyond the boundary of the market economy and deeply penetrated different arenas of public policy. For example, ideas highlighting the precedence of efficiency and efficacy over justice and equity were transplanted from the economy into education and health insurance, stimulating local GDPism at all costs. The state retreated, while the market moved forward and dominated in many public areas. During the crisis, the destructive forces of epidemics overshadowed the entire economic and social order and caused unprecedented visual and psychological shock in Chinese society. The disequilibrium between economic growth and social balance had been fully visualised among the public and elites, functioning like an enlightenment based on negative events, causing people to rethink the nexus between state and society and to review the negative consequences of state retrenchment and market triumph. The pandemic as a special crisis and an acute emergency called the state back into the arena of public policy and social policy; the state needed quick action amid the crisis and long-term and step-by-step action in the post-crisis period to counter the miserable health status of millions of normal Chinese citizens, without any kind of health protection and social protection, and to close the gaps left by the dysfunctional epidemic-prevention and health protection systems. The Chinese government began to reconsider and redesign the development model and put forward the model of balanced economic and social development. In the post-crisis period, China's Hu-Wen government further put forward the script of the scientific outlook on development (kexue fazhanguan), which qualified and disenchanted the previous development model of GDPism and favoured an incremental growth of social investment for ordinary Chinese people (Ngok & Huang, 2014). Thus, the SARS pandemic reversed the neoliberal hegemony and marked a caesura in the priority of market fundamentalism. The discourses on the state's functions in regard to welfare policy were revitalised and welfare statism again became a competitive discourse among the Chinese epistemic world.
The outbreak of the COVID-19 pandemic was first reported on 26 December 2019, in Wuhan, Hubei Province. In January 2020, a large-scale of pandemic spread throughout Wuhan and other cities in the province. On 23 January, the Wuhan government decided to take drastic measures and implement a full lockdown to block the infectious chain between Wuhan and other cities; it was the first time in the history of modern public health that a large city with a population of 11 million had been completely quarantined. After the lockdown in Wuhan, many other cities inside and outside Hubei Province initiated strict measures to block and isolate the epidemic area. On 12 March, the National Health Commission of the People's Republic of China announced that, as a whole, the peak of the epidemic in mainland China had passed. On 23 March, Li Keqiang, Premier of China, and leader of the Central Epidemic Response Team, announced that the spread of the epidemic in China, with Wuhan as the main battlefield, had been contained. There have been several outbreaks since then, but they were all brought under control in the early stages. The fear of a second wave of infection persists among Chinese society.

3.2.1 | COVID-19, a second wave of national reflection movement

Emotional maelstrom

As with any other trajectory of epidemic events, Chinese society has experienced anxiety, panic, suspicion, and stigma during the COVID-19 pandemic. However, the sentiments of panic and fear are even greater than the SARS pandemic. People realised that a metropolis of 11 million with a key geo-economic position in central China was suddenly quarantined, and afterwards, nearly the entire Hubei province, comparable to a medium-sized European country, was quasi-quarantined and isolated from other Chinese provinces. Not only Wuhan city, but also Hubei province, have experienced stigmatisation. The Hubeinese (hubeiren), have become a collective stigmatised group during the crisis, experiencing distrust, suspicion, and special treatment from other regions in China. With the extension of quarantines to other cities and other provinces, the livelihoods of millions of Chinese residents were severely affected, and collective frustration and anxiety have spread nationwide. Local protectionism has dramatically increased since outsiders from other provinces and even from other cities have been critically scrutinised and suspected of being virus carriers. The fear and anxiety have also been translated into public resentment and collective discontent, which require channels of expression. Thus, the Internet has become a main battlefield of critical views and discourses. The critical discourses of public scholars, as well as public sentiments by netizens have exerted tremendous pressure on the government to act effectively and push the country back to a normal state. COVID-19 represents a new crisis event that has incited a new round of reflection, potentially generating a new round of social policy reform.

A ‘short board’ for epidemiological management and social protection

Compared to the SARS pandemic, the phrase ‘loophole’ has been less often used in the reports and articles related to COVID-19. The more frequently used term is ‘short board’ (duanban) which means ‘shortcomings’ and ‘weaknesses’ in Mandarin. The semantic shift also reflects the change in social structures and institutions. The background for this social shift is that the Chinese government has invested a great deal in epidemic prevention and also in social policy within the last two decades, gradually establishing the largest social safety network after the SARS pandemic, including a universal pension system (Liu & Sun, 2016a; Stepan & Lu, 2016) and a universal health insurance system (Yip et al., 2019; Yu, 2015); the latter comes close to covering the entire population. Nevertheless, a new pandemic and its outbreak was not prevented, the social order has been severely challenged, and the Chinese public and many experts ask why. Again, a large-sized pandemic has caused a new reflection movement nationwide. Experts, public intellectuals, and opinion leaders use the Internet and written documents as their spiritual ‘weapons,’ disclosing the ‘short board’ in the Chinese public policy system. Two types of ‘short boards’ can be differentiated. The first relates
to reflection on the epidemic management system; the major concern is the prevention and control of infectious diseases, as well as the problem of a sufficient public health system. The reflection reaches the deeper level of operation, organisation, dispatchment and delivery of public health resources, which help to smooth out the pandemic risks, and the shortage of personnel, technology and equipment has also been highlighted. Unlike the reflection during the SARS pandemic, the emphasis is not placed on launching a new system; on the contrary, it is rather on substantiating and concretizing the contents of the pre-existing epidemic management system, lengthening the ‘short board’ in an already established system (Liang, 2020; Wang, 2020).

The second type of ‘short board’ concerns social policy, health protection systems in particular. Though the established social insurance programs in the last two decades have achieved the social function of ‘stabiliser’, ‘safety network’ and ‘risk shock absorber’, some contradictions and shortcomings at the operational and systemic level have been critically reflected (Lu et al., 2020; Wang, 2020). For instance, who should bear the costs for the testing and diagnosis of suspected cases and patients? Who should bear the costs of medical testing and treatment for overseas Chinese who have returned and might not be covered by the national health insurance programs? Who should bear the costs for foreign citizens and migrant workers? The ‘short board’ in the Chinese health insurance system is not only related to reimbursement and cost-bearing for certain vulnerable groups; it also concerns the systemic architecture of the Chinese health insurance system. For instance, the planned tiered diagnosis and treatment system (fenji zhenliao zhidu) with a primary care system at the grassroots level has not been really enforced; thus, during the pandemic, many suspected COVID-19 patients rushed to modern and big hospitals in metropolises and these hospitals became overcrowded, with the inevitable risk of cross infection (Li et al., 2020). This problem exposed the uneven spatial distribution of medical resources between medical centres and peripheries in China as well as the deep distrust in the primary care system at the grassroots level. Currently, China has two basic medical insurance systems, one is the medical insurance for urban employees, and the other is the medical insurance for urban and rural residents. The payment standards of the two kinds of medical insurance vary significantly. In terms of the health insurance deductible, capped limit and outpatient and inpatient reimbursement ratio, the payment standard of medical insurance for urban employees is higher than that of urban and rural residents. Although there are significant differences in the payment standards of medical insurance among provinces and cities in China, the medical insurance for urban employees is generally more generous than that of urban and rural residents. Another problem is the household registration system (Hukou), which has bound residents to their local medical resources (Shi, 2021). The extra-city and extra-provincial residents cannot reimburse their costs for diagnosis and treatment in the cities where they temporarily live; they can only apply for an ex-post reimbursement after coming back to their hometowns. Hukou-related constraints also exacerbated the medical crisis at the beginning of the pandemic. As Wang (2020) has highlighted:

The social security measures adopted in epidemic prevention and control reflect the development achievements of China’s current social protection system and the advantages of a social security system with Chinese characteristics, but also reveal that there are obvious ‘short boards’ in the current social security governance, which puts forward new challenges to the current social security system.

A report from the China Youth Network (2021) has exposed the short board of epidemic prevention and control and the related problems of health services in rural China after the outbreak of Corona virus in the rural areas in Hebei province in January of 2021:

The epidemic situation in Hebei has sounded an alarm. “We believe that there is a high risk of virus transmission in cities and ignore rural areas”; said Wu Hao, an expert of the Disease Prevention and Control Advisory Committee of the National Health Commission and director of Beijing Fangzhuang Community Health Service Center, he also said that the delay means that the second or third
generation transmission may have started when the virus is found to spread in rural areas, so early
detection is still the top priority...

Gathering activities exacerbated the spread of the epidemic, the villagers' health awareness was low,
and the grassroots “health gatekeepers” were lost, resulting in the invisible spread of the virus...

“The abnormal epidemic situation in Hebei has exposed the rural ‘short board’ of epidemic preven-
tion and control,” said Li Xiaoyun, a professor at China Agricultural University. (China Youth
Network, 2021)

Since 85.5% of the infected people in Hebei in early 2021 are from rural areas, the dysfunctional gatekeeper to
the healthcare system in rural China has been revealed and transformed from a marginal to a central issue by the
Chinese expert communities. The ‘short board’ here means not only the short board of epidemic prevention and
control, but also the short board of rural medical and health protection system. At the same time, it also shows the
lack of public investment in the field of grassroots medical and health care.

Digitalization during the COVID-19 pandemic

Amid the COVID-19 pandemic, the previous ongoing trend of the digitalization of society has accelerated. Due to
large-scale rigorous measures of curfews and lockdowns, production lines have stopped, offline education has been
temporarily suspended, and millions of suspected patients are unable to visit doctors owing to the closing of hospi-
tals, clinics, and medical centres, even at the grassroots level. Many big cities seem to have pressed the pause button,
and all unnecessary offline activities have been halted, personal contacts have been minimalized, while social distanc-
ing has been enforced as a new social norm. In this extraordinary period, online activities have created alternative
venues for work, education, and medical treatment, enabling people to continuously connect to society through
home-office work, home education and online-treatment. The pandemic-related crisis has unintentionally created a
contactless interaction form in cyberspace to avoid the danger of infection and to keep economic, social, educational,
and medical communication running. During the pandemic, digital ways of interaction and networking have been
steadily thriving, and it is foreseeable that this trend will continue in the post-crisis period.

Digitalization during the pandemic has affected social policy in different ways. First, online medicine has
mushroomed through different platforms and apps such as the Chunyu Doctor, Doctor clove, WeDoctor, etc. Vari-
ous forms of online diagnosis and treatment have enabled patients to visit doctors or at least ask doctors to prescribe
medicine during the lockdown period; this is crucial for the chronically ill, and some Chinese cities started to include
e-healthcare to the general health insurance system since the outbreak of COVID-19 (Wang et al., 2021). Second,
various methods and digital tools of artificial intelligence (AI) have been applied to check the health status of people
and undertake effective screening of suspected cases of COVID-19, like the intelligent epidemic robots developed
by the Aridamo house. During the pandemic, Baidu has also launched an intelligent outbound platform for epidemic
prevention and control, using intelligent robots instead of artificial phones to quickly check the health conditions of
people in various communities. In China’s AI enterprises, the medical and health sector accounts for the largest pro-
portion, reaching 22% of the AI industry (China Academy of Information and Communications Technology, 2018).
The series of products launched by Ping An smart city have played a key role in epidemic prevention and control,
aiding front-line medical institutions, and helping enterprises return to work safely (China Newsnet, 2020). Third,
due to the minimization of social contacts, residents suffering from epidemic-related unemployment and the problem
of living and survival must rely upon online applications for unemployment benefits and Dibao-benefits (Dibao: Mini-
mum Living Standard Scheme) since many local social protection offices are closed. These online applications for
social benefits have been widely used to transfer cash to needy people. During COVID-19, 297 cities opened online
application platforms for unemployment insurance benefits (Guangming Daily, 2020). The pandemic has stimulated
digital social policy governance and accelerated the online application of welfare state clients.
3.2.2 | Recalibration without directional change

Unlike the SARS pandemic, the consequences of COVID-19 have not evoked discourses and narratives on fundamental change and path-breaking reform in the arena of social policy. They have rather accelerated the tempo of establishing an effective emergency response and management system, with a Chinese style appeal raised by public intellectuals to ‘make up the “short board”’ (buqi duanban in Mandarin means to make up shortcomings). The same trend has been identified in the arena of social policy. Social policy expansion itself has not been questioned; on the contrary, it has been considered an achievement and a favourable factor in containing pandemics. However, according to mainstream opinion, quality-related issues, including the generosity, equality, and equity of public health resources, primary care at the lowest community-level, should be urgently strengthened, and these issues are constructed as a top reform priority in the post-COVID-19 period. This sentiment reflects the social fact that universal coverage alone cannot solve complex problems; public health facilities, infrastructure, and good medical governance with more equalisation in public health services have become the central foci of social policy reform. As with the SARS pandemic, the state’s responsibility and obligation in public welfare have been further strengthened, and market-centered discourse in social policy has seen a downward trend. Similar to other critical events, the epidemics-related crisis benefits a model of ‘big government’, creating a favourable environment for state’s intervention in society, disfavouring the neoliberal doctrine.

4 | CONCLUSION

This article has elaborated two epidemic-related crises in the last two decades, including the SARS pandemic and the current COVID-19 pandemic, concluding that these two crises have played a key role in promoting social policy and reshaping its development trajectory in China. Crises and the related critical events and enormous social problems favour narratives on change in the status quo and more public investment in ordinary populations, as well as vulnerable and marginalised social groups in Chinese society. In this vein, crises related to pandemics have not dampened the willingness for social investment; rather, they act as an accelerator for social policy expansion, and they legitimate epistemic communities who plead for the building of a modern and comprehensive social protection sector with a central role of an enabling state. In contrast, narratives on dismantling of the welfare state have lost their discourse power, and the neoliberal hegemony with its ‘big society, small state’ model has lost its priority of interpretation in the epistemic world. Crises and their devastating and unpredictable consequences call the state back into the arena of public policy and social investment, strengthening advocacy groups in China who expect to construct and shape a more universal social protection program and weakening the forces who claim to embrace the approach of marketization. Pandemics have generated a broad and large-scale re-thinking and reflection on China’s development direction, raising a critical and sceptical attitude among public and intellectual circles toward a model of developmentalism at any cost. The race between state- and market-centered approaches has begun to turn against the latter. The retreat of the state from the public policy arena and the delegation of the state’s obligation to the market are to blame for the failing state response to crisis in the SARS pandemic, and the COVID-19 pandemic seems to have further strengthened the state’s obligation to and responsibility for public welfare, not the other way around. Crises have become driving forces for the building of the Chinese welfare state, they additionally have changed the discourse powers of different epistemic communities. Just like the current global COVID-19 crisis, in the unprecedented pandemic crisis, the ‘big government’ model has regained its esteem, while market fundamentalism has lost the power of discourses, and the power of the state has been strengthened during the crisis. From this point of view, crises do not always favour the ‘state retrenchment approach’, and large-scale crises may instead strengthen the legitimacy of the expansion of state power and broaden the scope of state regulation.

Comparing the two pandemics, this research reveals a different direction in reflections on social policy development in China. Since social protections programs had been underdeveloped, ‘scarce goods’ for a small fraction of
population until 2002, the SARS-related reflections concentrated on ‘loopholes’, ‘gaps’ and ‘blanks’ left by the immature social insurance programs, which only targeted a part of urban employees in formal sectors. The construction of systemic loopholes and the ‘failed health service reform’ has favoured a pro-establishment school consisting of influential experts, professors, officials and public intellectuals, whose aim is the building and rebuilding of a comprehensive social protection program covering the majority of the Chinese population, bringing China closer to a new universal welfare state. The reflection movement related to COVID-19 encounters a different macro environment in Chinese social policy: since Chinese social policy has steadily expanded, and the current repertoire of different health insurance programs has in fact approximately covered the entire population, criticism and self-reflection have now concentrated on the ‘short boards,’ ‘weak points’ and ‘deficiencies’ of the current Chinese social policy program. The direction of discourses and narratives have evolved into a call for the reform of unjust and irrational institutional arrangements and the correction of the inadequate structural pattern of Chinese social policy, including stratified health insurance programs with lower reimbursement rates for rural and urban residents compared to urban employees, the still-underdeveloped ‘tiered diagnosis and treatment’ system which seeks to introduce an OECD-style ‘gatekeeper model’ for medical treatment at the grassroots level and the outdated household-registration system (Hukou), which has constrained the use of local medical resources for migrant workers and residents. The discourses and narratives in the COVID-19 pandemic call upon more sophisticated reforms to improve the quality of the social protection programs and the primary health care in local communities (Wu et al., 2021), reducing the gap in access to medical resources by different social classes and in different social spaces including mega cities, medium-sized cities, small townships, counties, and villages. Therefore, different from the pro-establishment trend (for social policy) promoted by the SARS crisis, the discourses and reform scripts during the Corona crisis since 2020 focused more on the recalibration, readjustment and rescaling of the current social policy system, so that it can operate with higher quality and more pertinence and shift more resources to remote areas in the Chinese medical periphery.

ORCID
Tao Liu https://orcid.org/0000-0002-5279-7758

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