ORIGINAL ARTICLE

THE POLITICAL DETERMINANTS OF CHINA’S NEW HEALTH CONSTITUTION

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ABSTRACT
The Basic Healthcare and Health Promotion Law 2019 became the new constitution of China’s health system in June 2020, giving legal effect to ambitious health reform programmes like Healthy China 2030. The concurrent outbreak of coronavirus disease 2019 must not distract us from appreciating the fact that this Law will comprehensively overhaul the health regulatory framework of the world’s most populous country during the coming decade, if not beyond. This article offers an original evaluation of the Law in its political context. The Law commendably promises to safeguard the right to health, assist citizens to live a ‘complete cycle of life’, and promote health using the resources of the public health system. However, it is also deeply politicised, guaranteeing extensive and penetrative political control in health campaigns, digitalised health data, the governance of health institutions, and the resolution of medical disputes. This can be explained by the consequential roles played by epidemics in China’s historical dynastic cycles, but even more so by powerful tendencies of centralisation on the part of the Leninist Party-state. The Law’s potential is thus subject to the overriding caveat that the Party-state’s existence and influence over law and public health must be secured.

KEYWORDS: Basic Healthcare and Health Promotion Law, China, COVID-19, Healthy China 2030, Political determinants of health, Public health law,
loose by four decades of rapid economic modernisation, industrialisation, and urbanisation.\(^1\) The healthcare system is disjointed; at best its resources are concentrated in a small circle of elite tertiary hospitals;\(^2\) and at worst, they are ‘overloaded, ineffective, expensive and chaotic’\(^3\), where, for instance, a systematic infectious diseases prevention programme was not instituted even in the aftermath of the severe acute respiratory syndrome (SARS) epidemic between 2002 and 2003. Beijing has taken positive steps to address these issues by substantially improving the basic public health and social insurance systems and stabilising drug prices for public hospitals and primary healthcare providers.\(^4\) Faced with the viral outbreak of coronavirus disease 2019 (COVID-19) spreading from Wuhan, Hubei, its first recorded epicentre, since late 2019,\(^5\) China has executed plans that the modern global health community had not dreamed of, including quarantining cities of millions with the help of soldiers and law enforcement officers, imposing drastic social distancing decrees through community officials, building makeshift hospitals in a matter of days, mass mobilisation of healthcare professionals, stringent control of the media and Internet speech. The COVID-19 outbreak underscores how, in today’s interconnected global economy, any mismanagement in China’s health system, even by local authorities, can send shock waves throughout not only Chinese territories but also the inhabited world, within a short time.\(^6\)

On 28 December 2019, the Standing Committee of the National People’s Congress adopted the watershed Basic Healthcare and Health Promotion Law (the Law), which aims to guarantee basic medical services for all citizens, enhance healthcare delivery, and establish a ‘Healthy China’\(^7\) in accordance with the Chinese Constitution. Under the Constitution, the State is obligated to protect ‘the people’s health’ through developing health services and ‘mass health activities’ and establishing

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1 See J Xu and A Mills, ‘10 Years of China’s Comprehensive Health Reform: A Systems Perspective’ (2019) 34(6) Health Pol’y & Planning 403; L Li, X Li and B Wang, ‘Public Health Challenges in China’ in L Li and Q Jiang (eds), Introduction to Public Health in China (Springer 2019) 63; MN Islam, ‘Introduction’ in MN Islam (ed), Public Health Challenges in Contemporary China: An Interdisciplinary Perspective (Springer 2016) 1.
2 See P Chai and others, ‘Health System Productivity in China: A Comparison of Pre- and Post-2009 Healthcare Reform’ (2020) 35(3) Health Pol’y & Planning 257.
3 X Zhou, ‘Coronavirus: China’s Health and Politics Have Always Been Linked’ South China Morning Post (7 February 2020) <https://www.scmp.com/week-asia/opinion/article/3049393/coronavirus-chinas-health-and-politics-have-always-been-linked> accessed 15 August 2020.
4 See Q Meng and others, ‘What Can We Learn From China’s Health System Reform?’ (2019) 365(12349) BMJ 5.
5 See J Riou and CL Althaus, ‘Pattern of Early Human-to-Human Transmission of Wuhan 2019 Novel Coronavirus (2019-nCoV), December 2019 to January 2020’ (2020) 25(4) Euro Surveill 1.
6 Y Huang, Governing Health in Contemporary China (Routledge 2013) 141; see MM Kavanagh, ‘The Right to Health: Institutional Effects of Constitutional Provisions on Health Outcomes’ (2016) 51 St Comp Int Dev 328.
7 Basic Healthcare and Health Promotion Law of the People’s Republic of China (Adopted by the Fifteenth Meeting of the Standing Committee of the Thirteenth National People’s Congress on 28 December 2019), art 1.
Taking effect on 1 June 2020, the Law governs all aspects of the promotion, monitoring, and management of medical and health care in the country, which is supposed to be ‘people-oriented’, ordered to the ‘people’s health’, and underpinned by a commitment to the public interest. In this sense, the Law may be viewed as a *de facto* constitution for the health system of China. It is ironic that a health charter’s enactment should have coincided with the initial outbreak of COVID-19, which has dwarfed it in terms of global attention. Nevertheless, the global community of health experts and policy-makers simply do not have the luxury of ignoring the ongoing evolution of China’s healthcare system, which affects at least one-fifth of the world’s population.

This article is one of the first critical evaluations of the Basic Healthcare and Health Promotion Law. It calls attention to the potential consequences of this Law as a major global determinant of health, as setting up legal rules and frameworks impacting the underlying socio-economic causes of disease and injury in China. It argues primarily that the Law cannot be understood separate from its political determinants. China’s new health constitution, therefore, remains fundamentally an instrument of politics, designed to consolidate the Party-state’s pervasive control of the health system, and ultimately securing the Party’s long-term survival. The article proceeds by expounding the close relationship between health and state security in China. It then explains how the law is being deployed by the current leadership as a tool to promote an expansive concept of state security that encompasses public health, so as to justify more combative and technologically advanced measures of social control. Section III anatomises the Law in terms of its promises and implications on the politicisation of health, the governance of health institutions, the resolution of medical disputes, and its own enforcement. Section IV concludes with a summary of findings, suggesting that without momentous reforms in the wider legal and political system, which is increasingly improbable under a centralising leadership, the Law is unlikely to achieve its full potential in realising a legally enforceable right to health.
II. THE POLITICS OF HEALTH, LAW, AND STATE SECURITY IN CHINA

The social determinants of health are susceptible to political interventions,\(^\text{16}\) hence modern public health is vulnerable to political cycles, whether in democracies or non-democracies,\(^\text{17}\) and reactions to major epidemics are typically ‘deeply political’.\(^\text{18}\) Governments can improve the health of their people with policies that deliver healthcare and public health measures, like pollution control and safe drinking water. Legislatures and executive agencies can promote health and safety with legal instruments mandating protection of individuals, like seat belt laws.\(^\text{19}\) However, authoritarian states’ provision of health is ultimately paradoxical. On the one hand, unlike democratic leaders, autocrats and their core support bases tend to have sufficient resources to prevent their own premature mortality; the immediate survival of their regime does not depend on offering health-enhancing resources to those outside their ruling circles.\(^\text{20}\) And, of course, they cannot be electorally removed from office for public health policy failures and so can afford to pay relatively little attention to health issues.\(^\text{21}\) Because autocrats have radically less or no incentive to compete for popular votes, they have correspondingly little incentive to distribute health care universally across the country. In fact, it is arguable that autocrats have an incentive to suppress human development, given that enhanced health security might empower the masses to vigorously resist authoritarian rule.\(^\text{22}\) Public health obligates the people to involved in tackling threats to their health, yet such involvement cannot be meaningful without freedom of association and speech.\(^\text{23}\) On the other hand, poor population health can severely impact upon political stability and state security.

Traditional Chinese political thought views the course of history as a succession of dynastic cycles, each of which typically ends with rebellion, sometimes even from within the imperial court, fuelled by popular discontent in response to plagues and famines.\(^\text{24}\) The historical writings of Imperial China tend to credit the influence of epidemics in propelling the dynastic cycles by inciting civil wars in famine-hit rice-

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16 C Bambra, D Fox and A Scott-Samuel, ‘Towards a Politics of Health’ (2005) 20(2) Health Promotion Int’l 187, 187.
17 DE Dawes, The Political Determinants of Health (Johns Hopkins Press 2020); D Montoya-Williams, ‘Political Determinants of Population Health’ (2019) 2(7) JAMA Network Open e197063; MC Sendall, ‘Political Determinants of Public Health’ in P Limputtong (ed), Public Health: Local and Global Perspectives (2nd edn, CUP 2019) 160, 162.
18 I Kickbusch and GM Leung, ‘Response to the Emerging Novel Coronavirus Outbreak’ (2020) 368 BMJ m406.
19 JM Shultz, LM Sullivan and S Galea, Public Health: An Introduction to the Science and Practice of Population Health (Springer 2021) 152–54.
20 S Wigley and A Akkoynulu-Wigley, ‘The Impact of Regime Type on Health: Does Redistribution Explain Everything?’ (2011) 63(4) World Pol 647, 671.
21 T Besley and M Kudamatsu, ‘Health and Democracy’ (2006) 96(2) Am Econ Rev 313, 314.
22 Kavanagh (n 6) 300.
23 MM Kavanagh and others, ‘Biometrics and Public Health Surveillance in Criminalised and Key Populations: Policy, Ethics, and Human Rights’ (2019) 6 Lancet HIV e51, e53.
24 R Sterckx, Ways of Heaven: An Introduction to Chinese Thought (Basic Books 2019) 40.
growing areas. Whether or not one accepts the traditional explanation, there exists a strong correlation between rapid population growth and dynastic heydays, and vice versa. Paradoxically, given the devastating Great Famine of 1959–1961, Mao Zedong understood the centrality of health care to the legitimacy of the Communist victory and the new People’s Republic, especially in the eyes of rural peasants. Mao instructed the National Health Congress in 1950 that preventative medicine must take priority, and that medicine must serve the workers, peasants, and soldiers primarily, with mass migration being integrated into the new healthcare system. Similarly, the promotion of health under Deng Xiaoping was used to cancel out the grievances unleashed by his historic market-oriented economic reformation. As a result, the average life expectancy of the Chinese population rose from 67.9 years in 1981 to 76.5 years in 2016; maternal mortality fell from 88.9 per 100,000 in 1990 to 19.9 per 100,000 in 2016; and infant mortality dropped from 34.7 per 1,000 in 1981 to 7.5 per 1,000 in 2016.

After the SARS epidemic exposed the perils of poor health risk protection, China, then led by Hu Jintao, began to systemically realise the security dimensions of epidemics. Whilst this crisis provoked some dissatisfaction with the authoritarian secrecy of the political system, it did spur the Ministry of Health to devise regulations to hold government officials accountable for cover-ups of disease outbreaks. Public health was taken more seriously; for instance, the National Expanded Programme on Immunisation was launched in 2007 and provided free vaccines for 15 infectious diseases. In 2009, as part of a comprehensive healthcare system reform, basic public health services began to be supplied in relatively equitable ways to all urban and rural residents free of charge, enabling residents to enjoy equal access regardless of local economic development. Public health surveillance of non-communicable diseases and their risk factors accelerated at the same time.

In response to the 2030 United Nations Sustainable Development Goals, and with the support of the World Health Organization and the World Bank, a Healthy...
China 2030 initiative of 29 chapters was promulgated in October 2016 by the Chinese government as the country’s ‘constitution’ to meet the healthcare needs of individuals and families in the context of a ‘health-based’ economy. Ultimately, the initiative is clearly aimed at promoting political stability. According to a 2017 article published in the official journal of the State Council’s Chinese Academy of Governance, health inequities in the country could fuel social conflict, whilst chronic diseases, occupational diseases, and mental illness could ‘destabilise society’s foundations’. In his well-publicised writings, President Xi defined ‘health’ not just as ‘a must for promoting well-rounded personal development, a prerequisite for social and economic development’, but also as ‘a symbol of national prosperity and strength, and a common pursuit of the people’; indeed, to protect public health is to pursue ‘national independence and people’s liberation’. Hence, the Party-state attaches great importance to its leading role in the health system. For the General Secretary, healthcare workers should practice core socialist values; that is, the Marxist–Leninist ideology of the Communist Party, interpreted through the lens of Xi’s thought. To improve industrial and occupational safety in such ‘key fields as transport, manufacturing, fire prevention, and hazardous chemicals, guarding against serious accidents’ is, according to Xi, part of China’s plan ‘to provide the materials, technologies, equipment, expertise, legal guarantees, and mechanisms required for safeguarding national security’.

Law is utilised as a master tool in the Party-state’s toolbox for building state security, and its institutions enable Beijing to enforce its own preferences over contrary ones of local public and private actors. The Party-state has embarked on an ambitious legal reform programme over the past 40 years, resulting in an ‘explosive growth’ of formal statutes enacted by the National People’s Congress and its Standing Committee regulating the training of professional legal practitioners, procurators, and judges; the development of a court system made up of administrative, civil, criminal, and even environmental courts; and an ongoing programme to promote civic consciousness of law. Concomitantly, the Party-state has become increasingly ‘relentless, determined, and unforgiving, sophisticated in how it does it but uncompromising in what it does’. Some recent examples include the sweeping National Security Law 2015 defending the Party-state’s survival, the Counterterrorism Law 2016 that vested ‘unprecedented powers’ in the police and other law enforcement agencies to combat
terrorism’, loosely defined, and the Cybersecurity Law 2017, which codified government regulations restricting the expression of views by China’s 800 million netizens through blogs, chatrooms, and other social media.44 In the 2018 amendment of the Constitution, a new Article 1 proclaimed that ‘[t]he leadership of the Chinese Communist Party is the defining feature of socialism with Chinese characteristics’.45 In particular, the National Security Law expressly defines public health and food safety as national security concerns,46 and the National Security Commission of the Party, chaired by none other than the General Secretary himself, has taken up supreme leadership over these areas, amongst a number of other ‘non-traditional’ security domains.47

Notwithstanding Deng’s reformation, the official nature of law in China has remained Marxist–Leninist:48 ‘the expression of the will of the classes which has won the victory and kept the governmental power in their hands’.49 Laws of this nature are therefore a tool to effectuate the supreme will of the Party-state,50 which, according to Leninist doctrine, must act as ‘a centralized organization of force’ to lead the people and crush their enemies.51 Chinese legal orthodoxy dictates that, for all practical purposes, rights merely specify benefits conferred at State discretion and are always conditional upon the satisfaction of certain standards of performance by its subjects.52 Legalism is a means of achieving government efficiency, and there is virtually no distinction between the people’s courts and the Party-state.53 One must, therefore, not assume that a ‘legalistic authoritarian’ state like China is automatically ‘less oppressive for the common citizen’ than those which rely less habitually on legality to channel political will.54 Against the backdrop of these political determinants, the Basic Healthcare and Health Promotion Law, whose content is anatomised in the next section, was adopted.

44 W Wo-Lap Lam, The Fight for China’s Future: Civil Society vs. The Chinese Communist Party (Routledge 2020) 101.
45 Constitution of the People’s Republic of China (n 8), art 1.
46 National Security Law of the People’s Republic of China (Adopted at the Fifteenth Session of the Standing Committee of the Twelfth National People’s Congress of the People’s Republic of China on 1 July 2015), arts 22 and 29.
47 H Fu, ‘China’s Imperatives for National Security Legislation’ in C Chan and F de Londras (eds), China’s National Security: Endangering Hong Kong’s Rule of Law? (Hart Publishing 2020) 41, 46.
48 See WE Partlett and EC Ip, ‘Is Socialist Law Really Dead?’ (2016) 48 NYU J Int’l L & Pol 463.
49 V Gsovski, ‘The Soviet Concept of Law’ (1983) 7 Fordham L Rev 1, 3.
50 M Loughlin, Foundations of Public Law (OUP 2010) 321.
51 WA Joseph, ‘Ideology and China’s Political Development’ in WA Joseph (ed), Politics in China: An Introduction (3rd edn, OUP 2019) 157, 162.
52 PB Potter, China’s Legal System (Policy Press 2013) 187.
53 EC Economy, The Third Revolution: Xi Jinping and the New Chinese State (OUP 2018) 46.
54 Zhang and Ginsburg (n 41) 361.
III. THE POLITICAL ANATOMY OF THE BASIC HEALTHCARE AND HEALTH PROMOTION LAW

A. Overview

The Basic Healthcare and Health Promotion Law ambitiously declares that both ‘State and society’ shall ‘respect and protect citizens’ right to health’; effectuate the Healthy China 2030 initiative; popularise knowledge about health; optimise delivery of health care; and, most importantly, enhance citizens’ level of health in the ‘complete cycle of life’. A draft of the Law was first introduced for discussion to the permanent Standing Committee in December 2017 by the Education, Science, Culture and Public Health Committee of the National People’s Congress, and the ensuing consultation took in over 57,000 comments. The bill, which was enacted into law 2 years later, had 110 provisions divided into 10 chapters—on general matters, basic medical services, medical institutions, medical personnel, guarantee of the supply of drugs, healthcare promotion, guarantee of funding, supervision and administration, legal liability, and supplementary matters. It therefore covers almost all domains that had been discretely dealt with by the earlier health laws. The following subsections layout the Law’s undoubtedly significant, yet seemingly conflicting, promises regarding protection of the right to health and the public health and healthcare system paradigm. These promises are embedded in a matrix of control mechanisms to ensure the primacy and supremacy of the Party-state over the ideological content of public health, its governance of health institutions and the resolution of medical disputes, and the weak accountability provisions that forestall any rigorous enforcement of the Law against the Party-state, should it be inexpedient to do so.

B. The Promises

Before the Basic Healthcare and Health Promotion Law, the ‘right to health’ existed in Chinese civil law in the form of a negative right that mandates no one, not even the officially Marxist–Leninist State, to positively promote and protect the provision of medical services. The current Chinese Constitution, ratified in 1982 under the auspices of Deng Xiaoping, affirms the general line of the Party as the guiding ideology of the State and the nation, featuring a number of positive rights such as the right to work and rest, the right to education, the right to social insurance, and the rights of women and the handicapped, as articulated in Articles 42 through 49. The Constitution makes no explicit mention, however, of the right to health, which may be inferred, at best, and not without an interpretive stretch, from Article 21, which mandates the State to develop and promote medical and health services, modern and

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55 Basic Healthcare and Health Promotion Law (n 7) art 4.
56 Z Zhao, ‘Recent Legislative Progress on Healthcare Law in China: Establishing “Right to Health” as a Basic Right’ (Oxford Human Rights Hub, 2018) <https://ohrh.law.ox.ac.uk/recent-legislative-progress-on-healthcare-law-in-china-establishing-right-to-health-as-a-basic-right/> accessed 25 Apr 2020.
57 ibid.
58 Whether these rights are enforced or enforceable in practice is a separate question. See Q Zhang, ‘The Constitution of China’ in R Masterman and R Schütze (eds), The Cambridge Companion to Comparative Constitutional Law (CUP 2019) 171, 183.
traditional medicine, mass health campaigns, and the establishment of health facilities by State and non-state actors, ‘all for the protection of the people’s health’.  

The new Law fundamentally altered the legal position by declaring that from 1 June 2020, citizens will be entitled to ‘basic medical services’ provided by both State and society, defined as ‘disease prevention, diagnosis, treatment, nursing, rehabilitation’ and other services delivered with ‘drugs, appropriate technologies and . . . equipment’ suitable for the maintenance of human health of a quality sensitive to two principles in mutual tension: ideal equity and the actual progress of socio-economic development. Basic medical services are to be provided free of charge, by governments at county level or above, through the establishment of professional public health facilities in the form of disease prevention and control centres, specialist treatment clinics, health education institutions, first-aid centres, blood banks, and the like, as well as grassroots medical installations, such as health centres in villages and towns, community health service centres, village health rooms, dispensaries, outpatient departments, local clinics, and so on, plus all of the hospitals and medical service outsources. The State must also guarantee the supply, safety, and effectiveness of essential drugs and their reasonable prices. ‘Medical reserves’ are to be provided by the State at both central and local levels to support emergency responses to ‘major’ disasters and epidemics, and the State is to set standards and specifications governing medical devices that enhance their safety and effectiveness. State health agencies may fine possession of or confiscate ‘illegal gains, drugs and medical devices’ and suspend operations of medical organisations that violate the terms and conditions of the Law.

Other sections of the Law provide that the central authorities and all local governments are obligated to disseminate health knowledge amongst the public; non-state medical, education, sports, publicity, and grassroots bodies are all enlisted to carry on ‘scientific and accurate’ health propaganda. Designated the primary actors responsible for their own health, citizens are enjoined to ‘actively learn health knowledge, improve their health literacy, and strengthen health management’ and family members to care for each other so that all may develop a ‘healthy lifestyle that suits their own and family characteristics’. Citizens are admonished to respect one another’s right to health. The State is to undertake public health surveillance at both individual and population levels to discover and collect health status statistics; to evaluate health

59 Constitution of the People’s Republic of China (n 8) art 21.
60 Basic Healthcare and Health Promotion Law (n 7) art 5.
61 ibid, art 15.
62 ibid, art 107.
63 ibid.
64 ibid, art 18.
65 ibid, art 58.
66 ibid, art 107.
67 ibid, art 63.
68 ibid, art 65.
69 ibid, art 99.
70 ibid, art 67.
71 ibid, art 69.
72 ibid.
performance; and to fashion laws and regulations to respond to such problems as are identified.73 Local governments at county level and above are required to assist the central government to monitor, investigate, and assess ‘risk factors of diseases and health’, as well as providing ‘comprehensive prevention and control measures’ and adopting ‘measures to prevent and control diseases related to environmental problems’.74 This serves the long-standing convention that plenary public health policy-making authority is centrally vested in Beijing to spearhead national health legislation and regulations, policies and national coordinative plans, and even the setting of specific targets for localities in light of their peculiar characteristics.75 Likewise, responsibility for formulating health rules for the People’s Liberation Army and the paramilitary Chinese People’s Armed Police Force has been retained by the State Council and the Central Military Commission, both led by members of the Party-state’s ultra-elite Politburo Standing Committee under the chairmanship of Xi Jinping.76 The Law, nonetheless, delegates some rule-making to local authorities to take specific health measures ‘in light of the reality’ on the ground.77

The new Law also lists a number of apparently self-conflicting demands; for instance, on the one hand, it codifies a policy of giving ‘equal importance’ to ‘traditional Chinese and Western medicine’, yet it also purports to ‘maximise the unique role of traditional Chinese medicine’, on the other.78 It enjoins ‘rationally’ distributing medical resources with attention to the needs of the grassroots,79 but simultaneously gives priority to the needs of the politically symbolic ‘old revolutionary base areas’.80 Then it exhorts individuals and organisations to form medical institutions, make donations, and grant subsidies, notwithstanding that the new Law expressly consigns health care to State control.81 The State is to encourage collaboration and exchange with foreign experts in medicine and health care, yet such external activities must be carried out consistently with laws and regulations, the final interpretation of which is at discretion of the political authorities in Beijing, such that they must visibly cohere with the political buzzwords ‘sovereignty, security and public interests’; in a Party-state context, this can take on unimaginably many and varied meanings.82

At the population level, the State is obligated to enhance public health emergency preparedness by laying contingency plans, providing for rescue medical treatment, investigating health issues, and, among other things, providing psychological assistance in response to emergencies,83 such as natural disasters, accidents, public health incidents, social unrest, and whatever else may threaten ‘the life and health of the people’.84 Power is vested in the State to memorialise medical personnel—physicians, assistant medical practitioners,
registered nurses, pharmacists, laboratory and image technicians, village doctors and other local professionals,85 and any other relevant persons—who give their lives in a public health emergency as ‘martyrs’,86 deemed of comparable status to the martyrs of the Chinese Communist Revolution of 1949. The State is further mandated to lay plans to prevent or quell infectious diseases by issuing early warnings, prioritising preventive measures, coordinating joint actions, blocking routes of transmission, and safeguarding vulnerable groups.87 Individuals and organisations are obliged to accept and collaborate with public health surveillance and medical observation measures adopted under the law. To be inoculated under a legally mandated immunisation programme provided by the State free of charge, is to be both a right and duty of citizenship.88

The Law gives legal teeth to the Party-state’s penetrative public health policies against non-communicable diseases: legal measures must be adopted to attenuate ‘the harm of smoking to the health of citizens’, especially by the regulation of smoking in public places and the printing of warnings on tobacco packages, and the prohibition of sales to minors;89 and, amid motivating employers to make conditions of work more conducive to health, to encourage employees to participate in ‘fitness activities’ and to implement regulations on labour health and safety.90 Similarly, resources must be dedicated by the State to the prevention and cure of ‘chronic non-infectious diseases’ and related pathogenic risk factors in a timely manner, especially amongst high-risk groups.91 More specifically, the State is to take up responsibility in promoting amongst employers occupational safety and health to prevent occupational illnesses;92 provide health care for women and children, including common disease prevention and control services; particularly to women, it is to address pre-marital, maternal health care, reproductive health, and the prevention and treatment of birth defects.93

Central and local governments are to integrate the ‘health management of senior citizens’ into ‘basic public health service items’.94 The State is to promote ‘disability prevention and recovery’, including of children,95 and provide ‘timely, standardised and effective first-aid services for patients suffering from emergencies, and critical and severe diseases’,96 and to advance the contracting of family physician services by grassroots medical institutions.97 The State has a duty to almost micromanage a system to treat mental illness, coordinate delivery of mental health education, psychological assessment, counselling and treatment, and provide mental health services to minors, the disabled, and the elderly people.98

85 ibid, art 107.
86 ibid, art 50.
87 ibid, art 20.
88 ibid, art 21.
89 ibid, art 78.
90 ibid, art 79.
91 ibid, art 22.
92 ibid, art 23.
93 ibid, art 24.
94 ibid, art 25.
95 ibid, art 26.
96 ibid, art 27.
97 ibid, art 31.
98 ibid, art 28.
The Law requires the State to set up ‘basic medical insurance funds’ within a ‘multi-level medical security system’ that is ‘supplemented with commercial health insurance’ to pay ‘basic medical service fees’ and medical investment platforms in the light of socio-economic development. It must define and record data on health indicators, *inter alia*, average life expectancy, maternal mortality, infant mortality, and mortality of children under 5 years old, and to budget fiscal outlays for ‘guaranteeing the basic medical services, public health services, basic medical guarantee, and [for the] construction, operation and development of medical institutions founded by governments’. These provisions echo China’s attempts, since 2009, to introduce a universal health insurance scheme to lower the proportion of spending out of pocket and widen access to health services. Health expenditures on the poor remain high, and the vicious cycle in which poor health plunges poor people into deeper poverty, causing even poorer health, has yet to be broken.

C. Persistent Politicisation of Health

The framers of the Basic Healthcare and Health Promotion Law clearly had no intention to de-politicise health. Instead, and consistent with the perspectives outlined in Section II earlier, the Law retains health as a decisively politicised and ideological area of social life. Accordingly, the State is to ‘vigorously carry out patriotic health campaign[ s]’ and ‘mobilise the masses to control and eliminate health risk factors, improve the environmental sanitation conditions, and build healthy cities, villages and towns and communities’. The Great Patriotic Health Campaign was a 1952 Maoist initiative that rallied Chinese citizens of all ages to clean up their homes and communities, attend ideological classes covering epidemiological topics, and eliminate mosquitoes, flies, rats, and sparrows, as part of a wider movement against the USA. It is, however, questionable if the Chinese people are still as mobilisable as the millions who worked unceasingly together during Mao’s campaign, or if the Party-state’s ideology still stands for the actual public interest in the 21st century when people across the country, especially the thriving *nouveau riche* and middle classes are much more geographically bonded and much less by common ideas.

The Campaign still exists and is now managed by the National Patriotic Health Efforts Office under the Planning, Development, and Informatisation Department of the National Health Commission in Beijing, which is more akin to an in-house think tank of the Chinese government, whilst continuing its traditional work in health

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99 ibid, art 83.
100 ibid, art 82.
101 ibid, art 107.
102 ibid, art 80.
103 H Fang, ‘Enhancing Financial Protection under China’s Social Health Insurance to Achieve Universal Health Coverage’ (2019) 365 BMJ I2378.
104 ibid.
105 Basic Healthcare and Health Promotion Law (n 7) art 72.
106 L Bu, *Public Health and the Modernization of China, 1865-2015* (Routledge 2017) 224–25, 232; J Yang, JG Siri and JV Remais, ‘The Tsinghua-Lancet Commission on Healthy Cities in China: Unlocking the Power of Cities for a Healthy China’ (2018) 391(10135) Lancet 2140.
107 KA Mason, *Infectious Change: Reinventing Chinese Public Health After an Epidemic* (Stanford UP 2016) 22–23.
propaganda and mobilisation for environmental hygiene.\textsuperscript{108} The new Law’s continuation of the adjective ‘Patriotic’ in the name of the campaign has rich political connotations, which heavily stress the Party’s leadership role in protecting the people from foreign humiliation.\textsuperscript{109} This patriotism or State-sponsored nationalism treats the nation as a political-territorial unit whose interests always come before those of actual individuals and has become an ever more powerful tool for stirring up anti-American sentiment in the Cyber Age.\textsuperscript{110} It keeps in check the patriotism that emerges from the bottom up in society, as witnessed by the four rounds of anti-Japan protests between 1985 and 2012. The Party would only tolerate the early stages of patriotic protests and would work to ensure that they would not impact its foreign policy.\textsuperscript{111} The Patriotic Health Campaign can only be understood as an instrument for cementing the Party’s rule by controlling the ideological content of community-level public health movements. It reflects the current leadership’s keenness to tighten ideological control in virtually all policy domains, mainly by compelling adherence to ‘Xi Jinping Thought on Socialism with Chinese Characteristics for a New Era’, which was codified into the Constitution in 2018, with a view to enforcing unity under his unified leadership of the Party.\textsuperscript{112}

D. Political Control of Health Institutions

The Basic Healthcare and Health Promotion Law charges the State with a legal duty to render ‘safe and effective basic public health services’, control risk factors affecting health, and strengthen the prevention and control of diseases.\textsuperscript{113} Governments at all levels, from the centre down to the township, are to prioritise the people’s health in their administrative targets and policies strategically. The State must be in command of all efforts to prevent diseases, promote health, devise and implement action plans relating to health, promote ‘national fitness’, assess health quality, and elevate major health indicators.\textsuperscript{114} In fact, the Law charges the Central People’s Government and all of its local agents to ‘lead’ medical and healthcare promotion work, with Beijing at the helm of ‘overall planning and coordination’.\textsuperscript{115} The State is to erect institutions that are to play the main role in delivering basic medical services, although ‘medical institutions founded by social forces’ are to be given incentives to provide the same services too.\textsuperscript{116} The medical service system is defined by the Law as an entity set up by the State consisting of grassroots medical institutions, hospitals, professional public health

\textsuperscript{108} See H Wang and L Lv, ‘Chinese Report: Building a Social Collaboration Network for Improved Health’ in China Development Research Foundation (ed), Reforming China’s Healthcare System (Routledge 2018) 187.

\textsuperscript{109} X Zhang, The Transformation of Political Communication in China: From Propaganda to Hegemony (World Scientific 2011) 169.

\textsuperscript{110} LR Luqiu, Propaganda, Media, and Nationalism in Mainland China and Hong Kong (Lexington Books 2018) 24.

\textsuperscript{111} ibid, 25.

\textsuperscript{112} K Brown and UA Bërzića-Cerenkova, ‘Ideology in the Era of Xi Jinping’ (2018) 23 J Chinese Pol Sc 323, 338.

\textsuperscript{113} Basic Healthcare and Health Promotion Law (n 7) art 16.

\textsuperscript{114} ibid, art 6.

\textsuperscript{115} ibid, art 7.

\textsuperscript{116} ibid, art 29.
institutions and the like, scattered over rural and urban areas, the components of which are meant to ‘complement ... each other’. The Law thus reserves to the Party-state universal and supreme jurisdiction over all things medical.

Medical regulation, in the provisions of the Law, is supposed to be governed by four principles: institutional autonomy, industry self-regulation, State administration, and social supervision. These principles are, however, subject to the important caveat that governmental health agencies at some levels must ‘conduct territorial supervision and administration of the whole medical industry’. These powerful agencies are in charge of evaluating the performance of medical institutions, assessing the quality of medical services, regulating medical technologies, overseeing the usage of drugs and medical devices, supposedly with the participation of ‘industrial organisations and the public’, although no exact procedures of participation are set out in the Law. The so-called ‘medical security’ agencies are to practise strict ‘supervision and administration of medical service behaviours’ and regulate the ‘rational use, safety and controllability of basic medical insurance funds’. There is, therefore, unlikely to be any meaningful autonomy of the medical profession from the Party-state.

The State has a legal duty, in accordance with the Law, to encourage citizens and organisations to ‘conduct social supervision’ of medical work and health promotion by reporting misconduct to a higher authority. Yet, without credible protections for whistle-blowers, any ‘social supervision’, whatever that might mean, is unlikely to involve genuine scrutiny of health care by a vibrant press and thriving civil society. Freedom of speech is necessary for effective social supervision, but this has been put in doubt all over the country by the passing of Dr Li Wenliang, an ophthalmologist from Wuhan, on 7 February 2020 from COVID-19. Li was one of the earliest of the whistle-blowers of novel coronavirus who were silenced by the local authorities. The Constitution expressly qualifies the freedom to criticise State institutions by the injunction that people ‘must not fabricate or distort facts for purposes of libel or false incrimination’, which can be interpreted flexibly by political officials. A more realistic understanding of ‘social supervision’ is the use of civil society and co-opted local elites by local officials as tools of informal control. The Party’s domination of society has always hinged on the power to infiltrate its complex fabric. Civil society’s hands are more and more tied by rigid new laws and regulations that often make it difficult or impossible to provide social services—even basic health care—which they were once able to offer.

117 ibid, art 34.
118 ibid, art 86.
119 ibid, art 91.
120 ibid, art 87.
121 ibid, art 97.
122 Ip (n 12).
123 Constitution of the People’s Republic of China (n 8) art 41.
124 DC Mattingly, The Art of Political Control in China (CUP 2020) 181.
125 X Yan, ‘Engineering Stability: Authoritarian Political Control over University Students in Post-Deng China’ (2014) 218 China Q 493, 511; G Yang, ‘Policy Case Study: Internet Politics’ in Joseph (ed) (n 51) 440, 451.
126 J Schwartz, ‘Coronavirus and China’s “Authoritarian Advantage”’ (Diplomat, 8 February 2020) <https://thediplomat.com/2020/02/coronavirus-and-chinas-authoritarian-advantage/> accessed 25 April 2020.
The Law mandates the State to prevent illegal collection, use, or transmission of citizens’ ‘personal health information’ by any person or organisation that, however, does not include the state itself.\textsuperscript{127} However, health and medical security agencies at the county level and above must set up ‘credit recording systems’ for medical institutions and medical professionals to inform disciplinary decisions against them, which is to be absorbed into a ‘national credit information sharing platform’.\textsuperscript{128} These systems chime with the ‘social credit system’ rolled out by the central authorities in June 2014, the official objective of which is the promotion of citizen compliance with the law, dubbed ‘trustworthy behaviour’.\textsuperscript{129} In the meantime, Beijing relies mainly on human, not digital, tactics to maintain social control.\textsuperscript{130} There are, nonetheless, indications that social credit eventually will utilise big data and algorithms to modify citizen behaviour according to the needs and agenda of the Party-state’s agenda and to the detriment of privacy rights and freedoms.\textsuperscript{131} Indeed, Article 49 of the Law charges the State to develop big data sufficient for artificial intelligence in health care and medical treatment; to speed up construction of an infrastructure for medical information by setting standards for the analysis, storage, and exploitation of relevant data; and to disseminate high-quality medical knowledge with the aid of information technology. The ambit of surveillance and data collection mandated by this provision is so wide that it will leave the intimate information of hundreds of millions inadequately safeguarded against State functionaries.

E. Political Control of Medical Disputes

Medical disputes have become one of the most pressing socio-political conundrums of the day.\textsuperscript{132} The State, according to the Basic Healthcare and Health Promotion Law, is to maintain a so-called ‘medical order’ by creating a mechanism for ‘medical dispute prevention and treatment’.\textsuperscript{133} Users of medical services are to be deemed as human persons with dignity and entitled to respect from, and care and fair treatment by, medical institutions.\textsuperscript{134} This is evidently a response to widespread distrust of the healthcare system due to corruption and other questionable practices,\textsuperscript{135} leading to commonplace experiences of negligent care and encounters with doctors who are more interested in earning money than relieving suffering. The resulting distrust of

\begin{itemize}
\item \textsuperscript{127} ibid, art 92.
\item \textsuperscript{128} ibid, art 93.
\item \textsuperscript{129} Yang (n 125) 451.
\item \textsuperscript{130} Mattingly (n 124) 182.
\item \textsuperscript{131} K Li, X Wong and AS Dobso, ‘We’re Just Data: Exploring China’s Social Credit System in Relation to Digital Platform Ratings Cultures in Westernised democracies’ (2019) 4(2) Global Media & China 220, 228.
\item \textsuperscript{132} BL Liebman, ‘Malpractice Mobs: Medical Dispute Resolution in China’ (2013) 113(1) Colum L Rev 181, 193.
\item \textsuperscript{133} Basic Healthcare and Health Promotion Law (n 7) art 96.
\item \textsuperscript{134} ibid, art 33.
\item \textsuperscript{135} Liebman (n 132) 191.
\end{itemize}
doctors has reached ‘crisis proportions’ and puts the legitimacy of the state and its health system directly to the test.

The Law broke significant new ground in protecting a right to informed consent relating to diagnosis and treatment plans, medical risks, medical expenses, and so on. It imposes on medical professionals a duty to explain the risks and alternatives to plans of treatment to patients in a timely manner, a duty that should be discharged to the ‘close relatives of the patient’ if it is not possible or appropriate to do so to the patient, which relatives are entitled to consent on the patient’s behalf. This duty is strikingly similar to the ‘prudent patient standard’ or ‘duty of material risks disclosure’ adopted by common law apex courts, such as the Supreme Court of the United Kingdom in the case Montgomery v Lanarkshire Health Board (General Medical Council intervening) and the High Court of Australia in Rogers v Whitaker, under which courts are more careful to find what a reasonable patient would wish to know than what a reasonable doctor would prefer to disclose. Yet the Law cannot be simplistically interpreted as a victory of patients over medical professionals. Despite the rhetoric, the opposite may be true.

The Law is evidently more concerned with medical personnel not being given the respect to which they should be entitled. It confronts the profusion of medical disputes that often result in violence and disorder, so much so that the Chinese government has had to add security staff to hospitals. Four days prior to the adoption of the Law, an emergency doctor in the Beijing Civil Aviation General Hospital was brutally murdered by a patient’s relative, reflecting a broader trend of physical assaults and verbal insults on healthcare workers on a daily basis. The radical anti-medical activists sometimes hired by dissatisfied patients and families even have a name, yinao, which may be translated as ‘medical disturbers’, ‘medical harassers’, or ‘medical mobs’. Whether they are genuine victims of malpractice or not, they have few inhibitions about staging protests or even riots in the hopes the authorities will offer compensation. The Law thus clearly favours medical and healthcare professionals, not necessarily for their own sake but as a side effect of the Law’s overall purpose to conserve the Party-state’s security. It enjoins citizens, when using medical services, to

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136 S Greenhalgh, ‘Why Does the End of the One-Child Policy Matter?’ in Rudolph and Szonyi (eds) (n 15) 183, 192.
137 Liebman (n 132) 252.
138 Basic Healthcare and Health Promotion Law (n 7) art 32.
139 ibid.
140 Montgomery v Lanarkshire Health Board (General Medical Council intervening) [2015] UKSC 11.
141 (1992) 175 CLR 479.
142 LC Edozien, ‘UK Law on Consent Finally Embraces the Prudent Patient Standard’ (2015) 350 BMJ h2877.
143 Liebman (n 132) 248.
144 JD Tucker and others, ‘Patient-Physician Mistrust and Violence Against Physicians in Guangdong Province, China: A Qualitative Study’ (2015) 5(10) BMJ Open e008221.
145 S Lu and others, ‘China Legislation Against Violence to Medical Workers’ (2020) 7(3) Lancet Psy e9.
146 See Tucker and others, (n 144).
147 AJ He and J Qian, ‘Explaining Medical Disputes in Chinese Public Hospitals: The Doctor-Patient Relationship and Its Implications for Health Policy Reforms’ (2016) 11(4) Health Econ, Pol’y & Law 359, 369.
‘comply with the rules on diagnosis and treatment, maintain the order of medical services, and respect medical personnel’. If this were not enough, the Law enshrines in Article 57 the cardinal, collectivist, decree that the ‘whole society shall care for and respect medical personnel, maintain a sound and safe order of medical services, and jointly form a harmonious doctor-patient relationship’. This entails that the ‘personal safety and personal dignity of medical personnel’ and their ‘rights and interests [as] protected by law’ must not be violated; no person or organisation may ‘threaten and endanger the personal safety of medical personnel’ or do anything ‘infringing upon [their] personal dignity’.149 Security personnel are empowered to inflict ‘public security administration punishment’ on assailants who disturb the premises of a medical institution, threaten the personal safety of or infringe upon the personal dignity of medical personnel, or illegally collect citizens’ personal health information.150 A violation of this provision of the new health constitution may result in a criminal conviction, and if the violation also involves personal or property losses, the accused assumes civil liability as well.151

To maintain political stability, local governments have sometimes resorted to pressurising hospitals to simply pay off malcontent patients,152 and these hard-line provisions respond to the lack of civility by patients in medical disputes,153 who are prone to commit violence on doctors and hire hooligans to harass hospitals.154 As for most authoritarian polities, suppressing public dissent in the form of unlawful protests and demonstrations, whether peaceful or not, is a top priority.155 A vicious cycle of distrust, protest, and concession combined with a healthcare system widely seen as focused on profit rather than patient care, and a lack of social security provision, could destabilise any polity.156 The Law’s new provisions place the regulation and resolution of medical disputes firmly in the hands of the Party-state to contain them lest they snowball into mass social unrest.

F. Enforcement Mechanisms of the New Health Constitution

The problem of political control is acute in authoritarian states, especially a Leninist Party-state, which reaches deep into people’s everyday lives, impacting on everything from reproductive choices to property ownership and Internet speech and where citizens have fewer legal channels to hold officials accountable than in most liberal democracies.157 The Basic Healthcare and Health Promotion Law provides few rigorous legal mechanisms to hold the State to account among its provisions. The Law is fixated on holding individuals, not agencies of the State, to account, not by courts or relatively independent watchdog bodies, nor the people, but by bureaucrats. Healthcare

148 ibid, art 33.
149 ibid, art 57.
150 ibid, art 105.
151 ibid, art 106.
152 Y Yan, ‘The Ethics and Politics of Patient-Physician Mistrust in Contemporary China’ (2018) 18 Developing World Bioeth 7, 12.
153 ibid, 13.
154 See Tucker and others (n 144).
155 Mattingly (n 124) 9.
156 Liebman (n 132) 254–55.
157 Mattingly (n 124) 1–2.
professionals who pursue illicit interests by taking advantage of their positions, leaking citizens’ personal health data, or failing to comply with applicable legal and ethical standards for medical research or delivery of medical services are to be directly punished by a health agency at the county level or above.158 ‘Directly liable persons’ employed at any level of any health agency of the state who abuse their powers, neglect their duties, practise favouritism, or commit fraud are to be ‘given disciplinary actions according to law.’159 Such persons are disciplinarily accountable to their administrative superiors, rather than the general public.

There are several potential conflicts of interest in these arrangements. First, any personal relationships subsisting between the official complained of and others in an agency under internal review, if strong enough, are likely to taint objective evaluation of the latter’s actions with favouritism and other irrelevant factors.160 A state may lack incentive to penalise malfeasant officials, insofar as its own authoritative rule relies on the solidary support of these same officials who exercise the coercive power of the state.161 Secondly, upper-level administrative agencies often lack the resources or time to monitor, much less discipline, subordinate bodies that exercise substantial discretionary power.162 Even in the context of the national will to tackle HIV/AIDS, the changes wrought by four decades of fiscal and political decentralisation have made provincial governments increasingly autonomous from Beijing, in the teeth of the nation’s unitary Constitution.163 Thirdly, free speech and consequential competitive elections are practically the only sufficient incentives for local officials to accurately and responsively report local abuse and neglect or even local disease outbreaks to their superiors.164 The central authorities are arguably the chief victim of the Party-state’s own propaganda; local authorities are constantly tempted to delay their response to novel and rapidly changing public health situations, until instructions come down from the centre, likely on the basis of incomplete information.165 As witnessed in the SARS and HIV/AIDS epidemics, it is difficult to carry nationwide solutions to health crises over bureaucratic barriers without a very strong central political will.166

Had the people and central authorities been notified earlier of the outbreak of SARS, and, arguably to a lesser extent, COVID-19, through accurate reporting of their geographic spread, and had evidence-based prevention guidance not been hindered by censorship and restrictions on press freedoms, they could have taken more precautions, and Beijing could have delivered better coordination and preparation to the healthcare system.167 The bureaucratic delay about COVID-19 at its epicentre,

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158 Basic Healthcare and Health Promotion Law (n 7) art 102.
159 ibid, art 98.
160 See J Chen, Chinese Law: Context and Transformation (2nd edn, Brill Nijhoff 2016) 314.
161 Y Cai, State and Agents in China: Disciplining Government Officials (Stanford UP 2015) 7.
162 X He, ‘Administrative Law as a Mechanism for Political Control in Contemporary China’ in S Balme and MW Dowdle (eds), Building Constitutionalism in China (Palgrave Macmillan 2009) 144, 148–49.
163 J Kaufman, ‘Policy Case Study: Public Health’ in Joseph (ed) (n 51) 399, 409.
164 T Saich, ‘Is SARS China’s Chernobyl or Much Ado About Nothing?’ in A Kleinman and JL Watson (eds), SARS in China? Prelude to Pandemic? (Stanford UP 2006) 71, 95.
165 MM Kavanagh, ‘Authoritarianism, Outbreaks, and Information Politics’ (2020) 5(3) Lancet Public Health PE135, PE135.
166 Kaufman (n 163) 413.
167 JP Ruger, ‘Democracy and Health’ (2005) 98(4) QJM: Int'l J Med 299, 301–02.
Wuhan, Hubei since early December was a singular blunder. First came the silencing of the whistleblowing doctors in late December; then the censoring of the outbreak from the front pages of a best-selling newspaper; and finally the convening of a perplexing hyper-banquet participated by 40,000 families to set a world record just days before the lockdown of the entire city in late January. Throughout that month, the Wuhan Municipal Health Commission reported that almost no evidence of human-to-human transmission, or of infection amongst healthcare professionals, had been found, and that the severest cases of COVID-19 caused by SARS-CoV-2 were limited to the elderly and frail persons. Yet, official COVID-19 statistics released shortly afterwards on 7 March 2020, detailed that at least 49,912 cases and 2,370 deaths in Wuhan had been confirmed only three months after the initial outbreak.

The Law makes no mention of the possibility of aggrieved parties bringing administrative lawsuits, sometimes rendered in English as judicial review of administrative action, against governmental agencies that breach the Law’s provisions, not even for failure to effectuate the right to health held so dearly by the Law’s drafters. This is yet more evidence buttressing the inference that absolute control over the health system by the Party-state is the Law’s primary purpose. The people’s courts of China, for all their problems, have benefitted immensely from numerous initiatives to professionalise judges, punish judicial corruption, and enhance the quality of rulings; all of which facilitated the greater judicial scrutiny of arbitrary local decision-making. The authority of the courts is strengthened by Article 131 of the Constitution, authorising them to ‘exercise adjudicatory power independently in accordance with the provisions of law, not subject to interference by any administrative organ, social group, or individual’. What is more, the Supreme People’s Court, which sits at the apex of China’s judiciary, has over the years grown more aggressive, promulgating instance after instance of judge-made legal norms misleadingly framed ‘judicial interpretations’, which thickly gloss many of the statutes passed by the National People’s Congress or its Standing Committee.

Without an explicit mandate in the Law, however, it would require considerable audacity by the Supreme People’s Court to ‘judicialise’ the Law into an instrument available to victims against malfeasant administrative agencies. This is not entirely unimaginable even in China’s Leninist polity. Over the past 20 years, the Court has expanded its powers into previously unauthorised areas, such as judicial review of local administrative monopolies or powerful collusive local fiefdoms years before any explicit statutory authorisation, but it would be difficult to maintain that judicial review necessarily applies to the Basic Healthcare and Health Promotion Law. The

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168 Kavanagh (n 165) PE135.
169 See He (n 162).
170 EC Ip, ‘The Supreme People’s Court and the Political Economy of Judicial Empowerment in Contemporary China’ (2011) 24(2) Colum J Asian L 367, 374–75; see B Ahl, ‘Retaining Judicial Professionalism: The New Guiding Cases Mechanism of the Supreme People’s Court’ (2014) 217 China Q 121.
171 See EC Ip, ‘Judicial Review in China: A Positive Political Economy Analysis’ (2011) 8(2) Rev L & Econ 331.
172 See EC Ip and KHF Kwok, ‘Judicial Control of Local Protectionism in China: Antitrust Enforcement Against Administrative Monopoly on the Supreme People’s Court’ (2017) 13(3) J Comp Law & Econ 549.
courts would be especially wary of imposing legal obligations on local authorities who fail to provide positive healthcare services to claimants. Judicial overreaches could all too easily boomerang on the courts as political retaliation. The provision of public services, even basic health care, in the Party-state’s ‘top-down’ model, would likely be seen by most actors as endowments from the State to citizens, rather than inherent entitlements of human dignity. And, one must not over-estimate the powers of reviewing courts should the Law be one day invoked as a ground for administrative litigation. One chief judge of a provincial high people’s court’s administrative division reported, in a 2018 study, that approximately two-thirds of all suits against public authorities failed in his jurisdiction. Administrative litigation entails not just constraints on the Party-state’s supremacy but also considerable costs, time, and effort on the part of litigants.

IV. DISCUSSION AND CONCLUSION
The Basic Healthcare and Health Promotion Law adopted in late 2019 is the de facto legal constitution of China’s health system. The Law in many ways formally overhauls existing health law, codifying the various ambitious health reform programmes of the previous decade, especially the Healthy China 2030 initiative. This article has provided an original critical evaluation of the Law’s most important provisions, with particular emphasis on its political context and nature. It is in the interests of the global health community to heed the provisions of this Law, as they comprehensively express, in statutory form, the Chinese state’s health policies for the world’s most populous country over the coming decade, if not beyond. The SARS and COVID-19 outbreaks seem to suggest that health incidents in such a vast nation can unforeseeably spill over onto the rest of the world, with unpredictable consequences for the global political economy in its trade, geo-political, and human rights dimensions.

There is much to commend in this Law of 110 provisions contained in 10 chapters. These include solemn promises by the Party-state to help its citizens live a ‘complete cycle of life’; to promote ‘the people’s health’, both physical and mental; to provide public health services and immunisation programmes free of charge, to guard patients’ right to be informed and healthcare professionals’ right to be respected; and to advance occupational health, the health of minors, and the disabled and elderly. The express emphasis on the right to health is broadly in line with international trends and the Sustainable Development Goals. However, the Law cannot be adequately understood in isolation from its political context. The protection and promotion of public health by authoritarian states is a paradox. Whilst rulers have many incentives to enhance the health of their population, such as long-term survival, it is often in their short-term interest to give other matters priority. Worse still, local authoritarian politics may inhibit a rapid response to an emerging pandemic like COVID-19. In the
light of the role of plagues and famines in propelling the collapse of dynasties in Chinese history, it should be no surprise if the current leadership, which has adopted an overarching policy ‘to securitise the Party state and to govern primarily from the perspective of national security’, sees in health a security issue intimately bound up with their political survival.

Political determinants crucially shape the Basic Healthcare and Health Promotion Law, as evidenced by its guarantees that health campaigns must be aligned with the Party-state’s guiding ideology, effectively meaning Xi’s Thought; by the tight political control of the Party-state over medical disputes and medical institutions; and by the lack of enforcement mechanisms like an independent health authority or an autonomous judiciary to hold administrative agencies accountable for breaching healthcare rights enshrined in the Law. China’s impressive legal reforms notwithstanding, its courts are still remarkably weak compared to entrenched Party-state and commercial interests at local level. The Law undoubtedly carries important symbolic meanings, crowning decades of efforts in healthcare reform, but it is, in itself, unlikely to revolutionise the health landscape of China. Chinese health reformers must be vigilant in order to evade the ‘depressingly familiar cycle’ of a ‘burst of enthusiasm’ and ‘rising online activism’ amongst ‘netizens’ and scholars at the beginning of a major reform, only to be greeted by resistance from the old guard, marginalising the original supporters of the reform whilst damping the central authorities’ appetite for implementing it.

In order to gain true momentum in actualising the right to physical and mental health, additional institutional devices are needed to better shield health administrators from the influence of special interests. These must vest review powers in the judiciary to hold health agencies to account for failure to honour the right to health, delegate broader autonomy to self-mobilising health-promoting civil society organisations, and tolerate investigative journalism that exposes medical scandals, including cover-ups of infectious disease outbreaks. These or similar recommendations present a conundrum to authoritarian rulers everywhere, who have remained surprisingly resilient notwithstanding successive waves of global democratisation. On the one hand, they will be able to reap the rewards of enhanced population health, such as accelerated productivity and social stability, if these recommendations are implemented. They must, on the other hand, relinquish a large measure of control over law and public health, in order for these reforms to be genuinely carried out, contrary to the logic of authoritarianism. Absent unforeseen changes to the current political determinants of health, the Basic Healthcare and Health Promotion Law’s potential in realising its lofty aims will constantly remain conditioned by the overriding imperative to conserve the Party-state’s penetrative and centralising control of the nation’s massive health system at all costs.

Conflict of interest statement. None declared.

178 Fu (n 47) 46.
179 CF Minzner, ‘China’s Turn Against Law’ (2011) 59(4) Am J Comp L 935, 947.
180 Ip (n 12).
181 CF Minzer, End of an Era: How China’s Authoritarian Revival is Undermining its Rise (OUP 2018) 77.
182 Huang (n 6) 143.
183 A Kendall-Taylor, N Lindstaedt and E Frantz, Democracies and Authoritarian Regimes (OUP 2019) 101.