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Governing Health in China: State Power, Ideology, and Public Health from Empire to Pandemic*

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This study traces the historical evolution of China's public health governance, arguing that healthcare has served as a societal technology for political legitimacy across imperial, socialist, and market-oriented regimes. Through a synthetic analysis of key historical phases—spanning late Qing hygiene reforms, Maoist collectivism, and post-1978 marketization to the SARS crisis and the COVID-19 pandemic—the study demonstrates how public health operates as a biopolitical instrument and a symbolic mechanism for state legitimacy. In the late Qing and Republican eras, Western hygienic norms were appropriated as a project of civilizational advancement aimed at asserting sovereignty and domestic order. Maoist socialism harnessed healthcare for mass mobilization, embedding care within collective structures that linked medical service to political loyalty. Post-1978 marketization, while dramatically expanding the clinical capacity in the country, commodified access and fractured the state-coordinated infrastructure—vulnerabilities catastrophically exposed by the 2003 SARS outbreak. In response, the Communist Party has sought to resolve the tensions between socialist rhetoric and marketized healthcare through authoritarian nationalism, a state-led strategy central to post-SARS restructuring and tested intensely against the COVID-19 pandemic. By situating public health as a site where ideology, governance, and state power converge, this study contributes to debates on how modern states deploy public health not merely as medical rationality but as a strategic extension of political authority.

Keywords China, Public Health Governance, State Legitimacy, Biopolitics, Authoritarian Nationalism, SARS, COVID-19

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I. Introduction

The history of public health in China is inseparable from the ideological imperatives that have governed the country through empire, revolution, and reforms. From the twilight of the Qing dynasty through the present, the development of China's health system has not merely reflected, but actively constituted, the shifting priorities of state power. This study argues that public health functions as a dual tool: a symbolic mechanism for state legitimacy and a biopolitical instrument for social control. However, this is not a static function. The relationship between public health governance and political authority has undergone distinct transformations from civilizational sovereignty and Maoist mass mobilization to contemporary authoritarian nationalism. Each transition has recalibrated the state's management of the population, redefining public health as a barometer of the regime's power. By foregrounding political ideology, this study traces how successive regimes have mobilized health policy as a marker of modernity and a fundamental mechanism for governing populations.

While late imperial and Republican reformers utilized "hygienic modernity" (Rogaski, 2014) to assert sovereignty against foreign incursion, the Maoist era reimagined health as an egalitarian project of mass mobilization. However, the post-1978 era of economic reform dismantled collectivist structures, realigning healthcare with market-oriented rationality, redefining healthcare as an economic commodity (Lakoff, 2005) while simultaneously eroding the collectivist safety net. The transition to a market-driven logic in the 1980s and 1990s saw a deliberate retrenchment of state responsibility. As the central government decentralized fiscal burdens, public health became a secondary concern to GDP growth, leading to a fragmented infrastructure that left the nation dangerously exposed. The outbreak of the Severe Acute Respiratory Syndrome (SARS) in 2003 exposed the vulnerabilities of this

market-driven system: decentralized fiscal responsibility that left epidemic surveillance underfunded, a fee-for-service model that disincentivized preventive care, and administrative secrecy that delayed critical outbreak reporting. This structural decay was the direct result of the governmental retreat from public health in the 1980s (Kleinman and Watson, 2006; Duckett, 2011; Long et al., 2013). In response, the state initiated renewed intervention, reasserting nationalist and authoritarian strategies to restore political legitimacy.

Existing scholarship on public health in modern China has made crucial contributions by examining hygiene as a project of modernization (e.g., Hanson, 2011; Rogaski, 2014), healthcare as a component of welfare provision (e.g., Sidel and Sidel, 1982; Duckett, 2011), and medical institutions as sites of professionalization and state capacity-building (e.g., Chen, 1961; Yang, 2004). While much of this literature has examined shifts in health governance in relation to broader political or economic transformations, less attention has been paid to the ways in which public health itself operates as a continuous ideological technology across regime changes, linking imperial sovereignty, socialist mobilization, and market reform within a single analytic framework.

Building on these foundations, this study positions public health as a central mechanism through which successive Chinese regimes have articulated political legitimacy and organized social order. Rather than treating healthcare as a neutral sphere of technical expertise, the analysis demonstrates how public health governance functions as an extension of state power, particularly in mediating tensions between socialist principles and market rationalities. Central to this analysis is the argument that authoritarian nationalism has emerged as the dominant framework for resolving these contradictions. Here, authoritarian nationalism refers to a state-led political logic that mobilizes national discourse, socialist symbolism, and centralized authority to preserve the governing monopoly of the Communist

Party of China (CPC) (Cabestan, 2005). Within the health sector, this logic operates through three interrelated mechanisms: crisis securitization, which frames health threats as existential national security imperatives to justify centralized intervention; infrastructure nationalism, which showcases public health achievements as empirical proof of civilizational superiority; and selective transparency, a strategy of disclosing data to project administrative competence while concealing systemic failures. These mechanisms enable the CPC to bridge the inherent tension between its socialist rhetoric and marketized healthcare delivery, maintaining legitimacy through the continuous performance of state capacity.

While this study focuses primarily on macro-level institutional and ideological shifts, it acknowledges that public health governance is simultaneously experienced and contested at the micro-level by patients, physicians, and local officials. This study does not claim to provide an ethnographic account of these lived experiences, but rather seeks to establish the structural and ideological framework within which such micro-level contestations occur. The analysis proceeds by first examining how "hygienic modernity" established the foundations for state sovereignty, before evaluating the rise and eventual stagnation of the Maoist collectivist model. It then traces the institutional fragmentation triggered by post-1978 marketization—the critical juncture that precipitated the post-SARS pivot toward authoritarian nationalism—and explores how this strategy was tested through the state's rigorous response to the COVID-19 pandemic. By positioning the pandemic as the most recent, and most intense, instantiation of these authoritarian mechanisms, the analysis assesses the implications of this strategic synthesis for twenty-first-century Chinese governance, demonstrating that the management of public health remains the primary barometer of the Party-state's enduring power.

II. Hygienic Modernity and the Foundations of the Modern State

The modernization of Chinese public health did not begin as a project of benevolence, but as a byproduct of imperial expansion and the violent arrival of "hygienic modernity." Beginning in the late 1830s, the Qing dynasty was besieged by successive invasions from Britain, Japan, and other imperial powers. Within this context of exploitation, European concepts of hygiene were imposed as a "civilizing" force, often used by imperial powers to justify intervention in Chinese sovereignty under the guise of medical necessity (Rogaski, 2014). As mortality from infectious and parasitic diseases climbed to four million annually (Chen, 1961), Traditional Chinese Medicine (TCM)—the long-standing monopoly over healthcare—was characterized as "unscientific" and insufficient to manage the rampant epidemics of the 19th and 20th centuries (Grant, 1960; Yu, 2014). In this context, for certain parts of China, this Western vision of hygienic health arrived, as Ruth Rogaski argues, "suddenly and violently" through the combined forces of modern imperialism (Rogaski, 2014: 164).

In response to these external pressures, Chinese reformists began to view Western medicine as a symbol of progress and a prerequisite for national survival. This shift marked the transition of health from a matter of personal management to a domain of state governance. The late Qing dynasty's establishment of a Department of Health Services under the Ministry of Police in 1905 signaled the first official attempt to manage the population's health to preserve productivity and military strength (Zhang, 2014). However, the implementation of such modern norms faced deep-seated resistance; in rural areas, Western physicians were often viewed with suspicion, their practices dismissed as witchcraft until the perceived efficacy of biomedicine eventually won over a small but influential group of Chinese elites and

officials (Grant, 1960).

The institutionalization of this new medical order was driven by a rapidly growing class of Western-trained professionals. From only several hundred in 1911, the number of biomedical doctors increased to 41,000 by 1950, primarily through the expansion of medical schools established under Western missionary and reformist auspices (Sidel and Sidel, 1982). Elite institutions like the Peking Union Medical College (PUMC) became the epicenter of this professionalization, collaborating with municipal governments to establish health demonstration stations for medical research and personnel training (Johnson, 2011: 144). These physicians worked to distinguish themselves from TCM practitioners, positioning themselves as the sole legitimate arbiters of modern science (Bullock and Andrews, 2014: 11). This created a new medical hierarchy that, while technologically advanced, remained largely concentrated in urban centers—a demographic imbalance that would become a central point of political contention during the later Maoist era.

By 1929, this professional class had successfully integrated into the state apparatus with the founding of the Ministry of Health. This period represented the first major effort to utilize public health as a formal tool for state-building and international legitimacy. Organizations like the Chinese Medical Association launched nationwide hygiene movements that focused on publicity and education campaigns addressing communicable diseases. Through these developments, Western medicine achieved dominance in China's official public health sector, effectively marginalizing traditional practices within the government's modernization agenda.

The era's most enduring legacy was the conceptualization of the first national five-year plan for public health in 1929. This ambitious framework aimed to provide clinical and preventive care across urban and rural divides through a three-tiered structure (Grant, 1960: 39). By creating a referral system where district centers coordinated county health units under provincial

oversight, the Ministry of Health designed a model for the equitable distribution of healthcare. Although the full implementation of this plan was interrupted by the war with Japan and internal civil strife, the infrastructure it proposed remained intact. Ultimately, this Republican-era county health-care system provided the essential backbone and organizational blueprint that the Communist government would systematically adopt and expand after 1949 (Grant, 1960; Chen, 1961).

III. Socialist Ideals and Collective Care: Public Health under Mao

The first national public health plan designed by the Nationalist government was never fully realized. Civil wars between the Nationalist and Communist Parties, along with the nationwide war against Japan, interrupted its implementation. After this prolonged period of warfare, the Chinese people witnessed the establishment of the People's Republic of China (PRC), marking a new chapter in public health development. The Communist Party of China (CPC) embarked on socialist construction after establishing the PRC, with Mao Zedong taking a paramount position in leading the socialist transformation. As Mao advocated, "The socialist camp headed by the Soviet Union is strong, and its ranks are united, while the imperialist camp is weak and beset by numerous insurmountable contradictions and crises" (Mao, 2004). Accordingly, the CPC sought to reduce Western influence and began learning from the Soviet Union as an experienced model.

Many Soviet systems had been transplanted to China, including central economic planning, heavy industrial foundations, educational systems, and advanced science and technology. The public health sector was no

exception. By embracing Soviet medical and public health concepts, the Chinese Ministry of Health actively participated in socialist transformation, with China's public health system coming under extensive Soviet medical and political influence. Medical professionals benefited from Soviet influence in another significant way. The CPC leaders and medical professionals frequently clashed over intellectual priorities, with Mao himself periodically condemning the Health Ministry for its focus on scholarly or "exotic research" (Lampton, 1974). However, under Soviet protection and influence, the Ministry of Health was able to continue pursuing various medical research initiatives (Gross and Fan, 2014).

Ideologically, the Chinese Health Ministry adhered to the notion of "medicine in the service of the people" as its primary medical ethic (Xi, 2014: 199). This foundation, strengthened by Soviet influence, prioritized spiritual rewards and wholehearted service over material gain for medical workers. However, this model of state-socialized medicine faced significant systemic tensions; while services were free to the public, the lack of a market mechanism resulted in widespread pharmaceutical waste and a decline in the quality of clinical care (Lampton, 1974). Despite these financial and qualitative difficulties, the "service" ideology remained the ultimate marker of socialist legitimacy, expecting doctors to work for low salaries as a sign of their commitment to the proletarian cause—a precedent that continues to influence the relatively low compensation of Chinese medical professionals today (Sidel and Sidel, 1982).

Based primarily on the Soviet model, the CPC established four basic guidelines for medical care organization at the first National Health Congress in 1950: medicine should serve workers, peasants, and soldiers; prevention should take priority over treatment; Traditional Chinese Medicine should be integrated with Western medicine; and mass health movements should be promoted. The CPC's emphasis on integrating TCM with Western medicine

aimed to maximize the utilization of China's limited medical resources. In accordance with the fourth guideline, Patriotic Health Campaign Committees were established at all levels of government to mobilize the masses for public health and sanitation campaigns and education (Sidel and Sidel, 1982).

Despite this complicated administrative situation, massive health campaigns produced remarkable results. The anti-schistosomiasis campaign exemplified mass participation, leading to the elimination of various parasitic diseases (Gross and Fan, 2014). In July 1958, Mao wrote a poem titled "Farewell to the God of Plague," praising the elimination of schistosomiasis in Yujiang County while launching the Great Leap Forward for industrialization (Mao, 1958). Beyond its public health success, this campaign illustrates how long-standing endemic diseases could be exploited for political legitimacy through CPC leaders' manipulation of health-related ideologies. Mass health campaigns were frequently associated with Mao's leadership and served to intensify the Mao personality cult, with Mao becoming virtually deified during the Cultural Revolution (MacFarquhar and Schoenhals, 2006).

The structural vehicle for this ideological mobilization was the People's Commune, which reorganized rural life into combined political-administrative and economic production units (Chow, 1987: 97-99). By abolishing private ownership and centralizing all resources, the state transformed the commune into a totalizing environment where labor, nutrition, and healthcare were managed through a single, Party-directed infrastructure. Each commune consisted of approximately seventeen production brigades, subdivided into production teams, where most daily activities—including dining, childcare, and medical care—were conducted communally (Chen, 1961). The people's commune was portrayed as an egalitarian and harmonious society, with practices like "eating together at communal dining halls for free" serving as a primary ideological practice of communism (Weigelin-Schwiedrzik, 2011). However, the

diversion of labor toward industrial goals like steel production during the Great Leap Forward resulted in nationwide food shortages and millions of tragic deaths, with estimates ranging from 15 to 43 million (Hua, 2011). This catastrophic failure shattered the CPC leadership's unity and forced Mao to temporarily withdraw from the front lines of governance, setting the stage for his eventual return via the Great Proletarian Cultural Revolution.

Even in this situation, healthcare resources were strictly controlled by the three-tier referral system: municipal clinics and county health centers at the lower level, county/district hospitals at the middle level, and specialized provincial hospitals at the top (Chen, 1961). In the commune system, rural areas replaced the lower tiers with commune health centers and brigade clinics. The commune ideology provided nearly universal free medical care, but many exploited the system while pharmaceutical supply could not meet demand (Lampton, 1974). The Ministry of Health was concerned about excess demand for medicines and medical services. Poor service quality in commune clinics led patients to seek higher-tier care, though referrals were strictly controlled (Lampton, 1974). Each commune's health clinic was funded by the commune itself, so decreased crop production during the Great Leap Forward directly reduced medical service funding.

Mao viewed the healthcare failures of the early 1960s not as a technical breakdown, but as a political betrayal by urban elites. His return to power was marked by fierce condemnation of the status quo: "Adopting the reactionary stand of the bourgeoisie, some leading comrades have enforced a bourgeois dictatorship and struck down the surging movement of the Great Cultural Revolution of the proletariat. They held facts on their heads and juggled black and white, encircled and suppressed revolutionaries, stifled opinions differing from their own, imposed a white terror, and felt very pleased with themselves. They have puffed up the arrogance of the bourgeoisie and deflated the morale of the proletariat" (Mao, 1994). He

successfully mobilized youth against the "Four Olds"—old ideas, culture, customs, and habits of the exploiting class—leading to the closure of schools in 1966 and the rise of the Red Guards (MacFarquhar and Schoenhals, 2006). All schools and universities closed in summer 1966, with students joining the Red Guards and devoting themselves to the Cultural Revolution. By 1968, schools resumed under a reformed system favoring the rural working classes (Teiwes, 1974; Bonavia, 1978). During this period, both Traditional Chinese Medicine and Western medicine practitioners were targeted as "old practices" or "bourgeois intellectuals," leading many doctors to be sent to the countryside for manual labor and medical service (Scheid and Lei, 2014).

To address rural medical shortages following Mao's directive, the CPC created "barefoot doctors"—peasant health workers trained within months to provide basic care while farming. This medical de-professionalization aimed to break doctors' monopoly on medical knowledge (Wilenski, 1977). Consequently, a considerable number of medical staff and resources, mostly concentrated within urban areas, were reassigned to rural areas and reorganized under the political cadre network. In urban areas, the state produced "Red Medical Workers"—often housewives trained for one month to provide primary care at Residents' Committee Health Stations (Liu, 2002; Eggleston, 2012). By embedding these workers directly into the Residents' Committees and rural brigades, the CPC successfully decentralized medical care while simultaneously centralizing political surveillance over the health and movements of the population.

While quality concerns and malpractice persisted due to radical de-professionalization, the widespread availability of basic healthcare and mass health campaigns successfully eliminated various infectious diseases, making China's system a potential model for other developing countries (Sidel and Sidel, 1982; Xing, 1999). Ultimately, the Maoist era demonstrated that public

health could serve as a powerful engine for state-building and legitimacy. This success, however, was inextricably tied to the collectivist structure of the commune; its subsequent dismantling during the post-1978 reforms would trigger a profound legitimacy crisis as the state retreated from its promise of universal care. In other words, the Party's legitimacy shifted from a promise of egalitarian care to a performance of economic competence, leaving public health increasingly subordinated to economic growth.

IV. Market Logic and Fragmented Care: Public Health under Economic Reforms

The death of Mao Zedong in 1976 and the subsequent rise of Deng Xiaoping marked a radical pivot from collectivist mobilization to market-oriented pragmatism. Under the "Opening-up" policy, the state dismantled the rural communes and urban neighborhood committees that had previously served as the primary funding vehicles for universal care. As the household responsibility system took hold, the robust three-tier healthcare network was crippled, and responsibility for health was transferred from the state to individual households (Mocan et al., 2000). While this era produced staggering GDP growth, it simultaneously saw a deliberate retrenchment of state responsibility; public health became a secondary concern to economic output, resulting in a fragmented infrastructure. Aggregate health indicators did improve—notably through rising life expectancy and increased hospital capacity (World Bank, n.d.)—but these gains concealed a systemic decline. The state-coordinated mechanisms essential for epidemic surveillance, preventive care, and equitable access had largely atrophied under this new economic paradigm.

The privatization of the medical sector fundamentally altered the

relationship between patients and providers through a fee-for-service model (Renshaw, 2014). While government subsidies for public hospitals plummeted—dropping from roughly 35 percent in 1995 to just 10 percent by the early 2000s—the state introduced a bonus system or performance-related pay to address mounting hospital deficits (Manuel, 2010). This mechanism theoretically aligned individual incentives with institutional financial health, but in practice, it forced doctors to operate with entrepreneurial mindsets. To maximize revenue, physicians began overprescribing high-markup Western pharmaceuticals and ordering unnecessary diagnostic tests, transforming the clinical encounter from one of medical necessity into one of financial consideration (Yip and Hsiao, 2008; Eggleston, 2012).

This commodification of health triggered a profound legitimacy crisis as out-of-pocket expenditures soared. By the late 1990s, the state's contribution to total healthcare spending had dropped to 17 percent, leaving approximately 90 percent of the rural population and 50 percent of urban residents without any health insurance coverage (Long et al., 2013). The resulting geographic and socioeconomic inequalities were stark; while urban hospitals attracted the best staff and generated high profits, rural facilities decayed, operating at less than 50 percent capacity (Renshaw, 2014). The public's frustration with the steep costs and restricted access to medical care posed a direct challenge to the CPC's socialist rhetoric.

Ideologically, the Party attempted to resolve these contradictions by framing market reforms as a temporary necessity on the socialist road to development. Following the 1989 Tiananmen Square protests, the CPC intensified central political control while simultaneously promoting nationalism to ensure state stability (Link, 2014). In the healthcare sector, this meant that the traditional ethical obligation to "serve the people" was increasingly compromised by profit-seeking behaviors encouraged by the state's own fiscal policies (Yang, 2009). The state strategically exploited

nationalism to bridge the gap between its pragmatic market actions and its constitutionally enshrined socialist identity (Zhou, 2011).

The vulnerabilities of this market-driven, fragmented system were catastrophically exposed by the SARS outbreak in 2003. The crisis served as a critical juncture, demonstrating that a weakened public health infrastructure and a lack of transparency posed a direct threat to the stability of the regime. The initial concealment of the outbreak led to a profound loss of international credibility, forcing the government to publicly acknowledge the limitations of its healthcare system (Kleinman and Watson, 2006). For a nation focused on global trade and international standing, the SARS crisis proved that domestic health failures had reached a scale that economic growth alone could no longer mask.

In response, the leadership under Hu Jintao transitioned toward a "Harmonious Society" framework, making a shift away from an approach centered on economic growth at all costs. This shift initiated a new wave of state intervention, including the New Rural Cooperative Medical Insurance Scheme and the 2009 comprehensive healthcare reforms (Barber and Yao, 2010). This transition did not represent a return to Maoist egalitarianism, but rather the emergence of "authoritarian nationalism"—a strategy that utilizes public health to restore state legitimacy and demonstrate state authority on both the domestic and global stages. Ultimately, the post-1978 era reveals that China's healthcare governance serves not only to treat the body but to stabilize a contested political order through the management of population health.

V. Crisis and Control: The SARS Epidemic and State Legitimacy

China entered the 21st century with a trajectory of economic development and international integration that was suddenly interrupted by the 2003 SARS outbreak. This crisis served as a critical juncture, exposing the systemic vulnerabilities created by two decades of market-driven neglect. The epidemic resulted in 648 deaths within China and spread globally, transforming what began as a domestic health failure into an international emergency (Kleinman and Watson, 2006). Most damaging to China's standing was the government's initial concealment of the outbreak, a choice that delayed global response efforts and allowed the virus to spread unchecked. This reality forced China to confront the international implications of domestic policy failures in an unprecedented way.

The crisis was compounded by systemic weaknesses in healthcare infrastructure and a lack of transparency (Kleinman and Watson, 2006). No established protocols existed for the novel coronavirus, and the healthcare system struggled with inadequate resources in primary and preventive care. This combination of clinical inadequacy and administrative secrecy culminated in a profound loss of international credibility (Zhang and Benoit, 2009). China eventually issued formal apologies and publicly acknowledged its limitations—a significant act for a regime where "losing face" represents a serious social and political failure. The timing was particularly sensitive, unfolding during the leadership transition from Jiang Zemin to Hu Jintao, adding domestic pressure to international embarrassment.

When Hu Jintao assumed leadership in 2003, he inherited a ruling philosophy of creating a "moderately prosperous" society. While this concept was rooted in Confucian ideals of social harmony where families live comfortably, Hu's interpretation marked a significant departure from his

predecessors' primarily economic focus (Xu, 2009). After two decades of rapid growth, China's economy had generated prosperity alongside serious social problems, creating a context that demanded a more nuanced approach to development. Issues such as stark wealth inequality, inadequate welfare, and environmental degradation had reached a scale that could no longer be addressed through GDP growth alone.

Recognizing this reality, the administration embraced a comprehensive vision of societal development, culminating in the 2006 "Resolution on Major Issues Regarding the Building of a Harmonious Socialist Society." This represented the CPC's official acknowledgment of growing social disparities. The "Harmonious Society" became Hu's signature policy framework, distinguishing his leadership from the growth-at-all-costs approach of earlier reforms (Xinhua News, 2006). While maintaining a commitment to "socialism with Chinese characteristics," it opened avenues for redistributive policies and reformed public finance, with healthcare emerging as a priority area requiring urgent intervention to restore social stability.

Healthcare reform became a cornerstone of this initiative, driven by both the lessons of SARS and the recognition of systemic decay. The government mandated that public hospitals modernize facilities and implement comprehensive safety systems. Institutional capacity was strengthened through the reinforcement of the Chinese Center for Disease Control and Prevention, enhancing the nation's ability to prevent communicable diseases. These infrastructure improvements were accompanied by ambitious financing programs designed to reconstruct the social safety net that had been dismantled during the 1980s and 90s.

The insurance expansion addressed decades of coverage erosion. Following the collapse of the commune system, the rural Cooperative Medical Scheme had disintegrated, and the Urban Employee Basic Medical Insurance launched in 1998 remained severely limited. By the late 1990s,

approximately 90 percent of China's population was without adequate health insurance (World Bank, 2010). The reforms under the "Harmonious Society" framework thus represented a fundamental reconstruction of China's approach to social welfare, aimed at stabilizing a population that had grown increasingly frustrated with commodified and stratified medical care.

The implementation of coverage began with the New Rural Cooperative Medical Insurance Scheme, addressing the rural void, followed by a voluntary insurance scheme for unemployed urban residents in 2007. These programs achieved remarkable statistical success, with the national insured rate surging from 23 percent in 2003 to 87 percent in 2008 (Barber and Yao, 2010: 37). This expansion resulted from coordinated central policy and substantial financial subsidies. However, these impressive statistics masked limitations in the quality and scope of coverage, as local officials often prioritized meeting numerical targets over the actual depth of clinical care provided (Liu and Darimont, 2013).

Despite expanded coverage, ongoing healthcare privatization created new challenges. Citizens' out-of-pocket spending continued to rise, suggesting that insurance benefits remained insufficient for actual medical costs. Furthermore, the expansion of choices inadvertently reinforced social stratification; wealthy patients gained access to premium providers, while those with limited means managed their health through a complex navigation of inadequate options. Rather than eliminating inequality, the reforms appeared to formalize a multi-tiered system differentiated by economic status, illustrating the tension between the state's socialist rhetoric and its reliance on market mechanisms.

Recognizing both the significant achievements and the persistent limitations of these initial post-SARS initiatives, China undertook a comprehensive evaluation process that included several pilot programs testing different

approaches to healthcare delivery and financing. The lessons learned from these experiments, combined with the foundational experience since 2003, informed a more ambitious reform agenda. In 2009, the CPC Central Committee and State Council jointly issued the "Opinions on Deepening the Health Care System Reform," which marked a significant policy recalibration (Liu and Darimont, 2013). This 2009 framework represented a notable shift in approach, explicitly reaffirming government responsibility for healthcare as a public good while rejecting the complete privatization and commercialization of public hospitals that some had advocated.

The reform outlined an ambitious timeline, aiming to establish a comprehensive basic healthcare system by 2011 through coordinated improvements in four key areas: public health infrastructure, service delivery mechanisms, medical security coverage, and essential pharmaceutical access (Barber and Yao, 2010). This holistic approach acknowledged that sustainable healthcare reform required simultaneous advancement across multiple dimensions rather than the piecemeal expansions that had characterized earlier efforts. While the long-term resolution of the tensions between market economy and socialist identity remained ongoing, this transition demonstrated the state's strategic re-assertion of control over the health sector to restore its role as a provider and maintain social stability. At this juncture, the logic of legitimacy changed once again. To remain credible, the Party now had to show not only that it could deliver economic growth but also that it could rebuild a basic health safety net.

VI. Pandemic Legitimacy: COVID-19 under Authoritarian Nationalism

The COVID-19 outbreak began in Wuhan in December 2019 as an unknown

viral pneumonia. It was clear that a novel coronavirus was spreading rapidly. The initial response replicated the SARS pattern: local officials tried to conceal the severity of the outbreak from the public and suppressed whistleblowers, contributing to a delayed national response (Liang, 2023; Yang, 2024). Dr. Li Wenliang, an ophthalmologist who warned colleagues about the outbreak on social media, was reprimanded by police for spreading rumors. He later died of the virus, becoming a martyr for transparency (Cao et al., 2022).

If the SARS crisis served as the "critical juncture" that exposed the fragility of the post-1978 marketized health system, the COVID-19 pandemic acted as the ultimate stress test for the authoritarian nationalism framework. While the pandemic was an unprecedented global health emergency characterized by the initial absence of vaccines and effective therapeutics, the state's reliance on authoritarian nationalism demonstrated that its underlying governing logic remained unchanged. Consequently, the regime resorted to the rapid escalation of its three primary mechanisms—crisis securitization, infrastructure nationalism, and selective transparency—to manage the crisis through the political mobilization of state power rather than clinical intervention alone.

The state's response—a radical recentralization of authority—marked a transition from prevention to performative legitimacy. By launching the "zero-COVID" policy, the Party mobilized its entire administrative apparatus to enforce lockdowns, mass testing, and digital surveillance, effectively framing the virus as a "people's war," reminiscent of Mao-era mass mobilization (Bai et al., 2022; 2023). This strategy was designed to showcase the state's capacity for order. During this period, the mechanisms of authoritarian nationalism were deployed in their most intense form. Crisis securitization elevated health threats to existential national security issues, justifying the suspension of civil liberties. Infrastructure nationalism saw China's digital health architecture showcased as a globally superior model of

smart containment. Finally, selective transparency meant that official data was curated to project administrative competence, even as independent verification remained strictly controlled.

However, the retreat from the zero-COVID policy in December 2022 revealed the inherent fragility of this framework despite its initial gains. Some experts argue that the policy had protected vulnerable populations from five global waves, prevented widespread infections from the original and Delta strains, and bought time for healthcare preparedness (The Lancet Regional Health – Western Pacific, 2023). However, when the Omicron variant rendered the performance of "elimination" impossible, the state was left with no secondary basis of legitimacy. The spontaneous protests that erupted in late 2022 signaled that the public's tolerance for authoritarian control was contingent upon the state's ability to deliver safety (BBC News, 2022). The abrupt abandonment of zero-COVID, followed by efforts to shape public narratives and archival memory of the pandemic, suggests that the state sought to control how the policy's failures would be remembered, thereby protecting the Party's governing legitimacy (CNA, 2020; Wall Street Journal, 2023).

Ultimately, COVID-19 demonstrates that while authoritarian nationalism is highly adaptable, it is not sustainable as a permanent source of legitimacy. By replacing socialist welfare with the performance of state capacity, the CPC has created a system that cannot afford failure. The pandemic confirms that public health in China remains the primary barometer of the Party-state's power; it is a technology of governance that works effectively until it encounters a crisis—like a novel pandemic—that performance alone cannot resolve.

VII. Conclusion: Public Health as Mirror of State Ideology

The historical trajectory of China's public health system reveals an underlying dynamic: the constant recalibration of legitimacy in response to health crises. This study has demonstrated that healthcare shifts in China are never merely clinical or administrative; they are fundamentally ideological and political. Each regime has utilized health as a dual tool—a symbolic mechanism for state legitimacy and a biopolitical instrument for social control.

The specific form of this function has evolved across three regimes. Under civilizational sovereignty from the late Qing to 1949, Western hygiene was appropriated to assert national survival against imperial encroachment. Under mass mobilization in the Maoist era, healthcare was embedded in collective structures that linked medical service to political loyalty, converting public health outcomes into a reinforcement of leadership authority. Under authoritarian nationalism from the post-SARS period to the present, the state has replaced socialist welfare guarantees with nationalist performance, operationalized through crisis securitization, infrastructure nationalism, and selective transparency. As this study has argued, these three mechanisms did not emerge in a vacuum; they were the institutionalized lessons of the 2003 SARS crisis, which the state subsequently refined and scaled to manage the unprecedented disruption of the COVID-19 pandemic.

The COVID-19 pandemic tested this authoritarian nationalism framework as no previous crisis had. In particular, the zero-COVID policy demonstrated the framework's spectacular potential: mass testing, digital surveillance, and lockdowns performed state competence on a global stage. However, the 2022 reversal exposed the framework's inherent fragility: when performance fails, there is no deeper legitimacy reserve to draw upon. This transition marks a crucial shift in the logic of legitimacy: while post-SARS interventions

sought to restore the Party's credibility through the structural reconstruction of health infrastructure, the COVID-19 response relied on the performance of state capacity to enforce absolute order, revealing the increasingly tenuous nature of this governing framework. The Party maintained its political position by pivoting toward memory management and international health diplomacy, but the long-term legitimacy costs remain significant.

This study contributes to broader debates on authoritarian governance by suggesting that performance-based legitimacy is inherently unstable. Unlike democratic systems that use electoral cycles to sanction failure, authoritarian systems rely on narrative control and coercion. When public health failures become impossible to hide, narrative control reaches its limits. In this sense, SARS and COVID-19 should not be viewed as isolated, consecutive emergencies, but as the opening and closing chapters of an era defined by the strategic deployment of authoritarian nationalism, where each crisis serves as a catalyst for deeper centralization and more rigorous narrative control. The Chinese case thus offers a cautionary lesson: authoritarian resilience is not inherent stability, but the capacity to survive from one crisis to the next, with accumulated legitimacy costs along the way. Ultimately, the history of governing health in China suggests that the state's sovereignty is increasingly tied to its biopolitical management of the population. In China, healthcare governance serves not only to treat the body but to shape citizenship, reaffirming state power and performing legitimacy on both domestic and global stages. In an era of pandemic volatility and ecological health threats, the ability to manage biological crises has become the ultimate test of authoritarian durability.

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