Asian Journal of Law and Society (2024), 1–22
doi:10.1017/als.2024.3

RESEARCH ARTICLE

Obligation, Informed Consent, and Health-Care Reforms in China

Jia Liu

Institute of Public Policy, South China University of Technology, Guangzhou, Guangdong Province, China
Email: liujia@scut.edu.cn

Abstract

Drawing on recent jurisprudential literature that emphasizes the role and function performed by obligation, this article examines how the ethical doctrine of informed consent has been implemented in the context of health-care reforms in China. It argues that, while the Chinese incorporation of informed consent has sought to empower patients, the major medical laws and social policies fail to instantiate the obligations. Along with this failure, the Chinese medical laws have also failed to secure the bond of trust between them. This article also points out that a rounded analysis of the implementation of informed consent in China must take into account the obligation and function of the major components of the health-care delivery system other than physicians and hospitals, such as health-care insurance schemes.

Keywords: obligation; informed consent; medical law; health-care reform; China

1. Introduction

The doctrine of informed consent was introduced into the Chinese medical context in the 1980s. A key issue in ethical discussions is whether the Western value of individual autonomy promoted by informed consent is alien and incompatible with Chinese cultural and moral traditions, commonly described as communitarian, which emphasizes the importance of the state, community, and family rather than the individual (Nie, 2011, pp. 134–45). It is argued that clinical decisions should be made not only on the basis of the present desires of individuals, but also on the basis of the long-term, impersonally understood good. This understanding assumes the existence of an impersonal conception of the good related to clinical decisions that is generally accepted by communities, families, and individuals (Fan, 1997, p. 317).

Since the 1980s, Chinese medical law has been committed to protecting the right to informed consent. The key issue in legal discussions is the scope of information under the right to informed consent. For example, some scholars have argued that the right to informed consent includes the physicians' obligation to inform patients about the disease condition, the items to be examined, the principles of treatment, the potential dangers of different treatments, recommendations on treatment plans, the items to be concerned about during and after hospitalization, the time for follow-up examinations, and the like (Cong, 2004, p. 154; Raposo, 2019, pp. 17–30). Ruiping Fan and Mingxu Wang point out that, while contemporary Chinese informed consent law attempts to apply the doctrine of informed consent to the medical context, the result is confusion for patients, families, and physicians about the harmful consequences of individual consent decisions (Fan and Wang, 2015,

pp. 387–99). Some physicians simply comply with the informed consent law in a *pro forma* manner, allowing the patient's family to make decisions but still requiring the patient to sign the consent form.

This article takes a different perspective to examine the incorporation and implementation of informed consent from the perspective of obligation in the context of health-care reforms. Specifically, it examines the ethical standards of informed consent and how the medical laws and health-care policies—including the informed consent law, the health-care marketization, and the universal coverage of health care—have shaped the implementation of informed consent in China. This article argues that, while the notion of informed consent seeks to empower patients, key medical laws and social policies have failed to do so. Along with this failure, Chinese medical laws have also failed to secure the bond of trust between them against the backdrop of health-care reforms of marketization and universal coverage, allowing it to be eroded by the dual logic of bureaucratic control and market competitiveness.

In order to provide a better perspective on the foregoing observation, this article draws on recent jurisprudential work to shift the focus of analysis from the perspective of right to that of obligation. It is crucial to focus on obligation because it is the bond or tie that lies at the heart of obligation. Drawing on Roman Law, Scott Veitch points out that "this sense of tying or binding is a central component of understanding social and professional obligations, and indeed social and professional life" (Veitch, 2017, p. 416). By reference to Peter Birks's account of Roman Law that "[a]n obligation is a rope ... by which we are tied," Veitch points out that a person's legal obligation has "its antecedents in the fact that he was literally 'bound to' do it" (Veitch, 2017, p. 425). Solidarity, in the form of joint liability, is the bonding force that ties people together. In Roman Law:

> *obligation in solidum* defines the status of *joint liability* for a financial debt .... To be in solidarity means that a man is good for his debts and stands up to his obligations to others even when he has not benefited from them directly. To be the cosignatory of a loan means that one is liable for the reversals of fortune of another; that one's own economic well-being is no longer completely in one's own hands. (Veitch, 2021, p. 102, emphasis added)

What is emphasized here is not only how creditors and debtors create bonds between them, but also how the notion of joint liability plays the role of binding people together. In other words, it is the existence of joint liability that makes the collective greater than the sum of the individual parts of the collective. Drawing on these ideas, this article is interested not only in examining the substantive obligations that correlate with the right to informed consent, but also in analyzing the bonds that underpin the physician-patient relationship as well as the citizen-state relationship.

This article also discusses how trust can be established through informed consent between physicians and patients. According to Annette Baier, trust refers to the expectation of benefiting from the goodwill of others (Baier, 1986, pp. 234–5). The idea of trust is the bedrock on which social relations and other values are built. As Sisela Bok remarks:

> [i]f there is no confidence in the truthfulness of others, is there any way to assess their fairness, their intentions to help or to harm? How, then, can they be trusted? Whatever matters to human beings, trust is the atmosphere in which it thrives. (Bok, 1982, p. 31)

Niklas Luhmann also observes a conceptual link between trust and vulnerability in the sense that trust is seen as a way of overcoming the uncertainties of the future (Luhmann, 1982,

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

pp. 12–23). Uncertainty and vulnerability about the future explain the need for trust in interpersonal relationships and quality health care. In the medical context, trust is defined as a belief that the trusted would "act in the best interests of another (the trustor) in a given situation, even when controls are unavailable and it may not be in the trustee's best interests to do so" (Marsh and Dibben, 2005, p. 19). Four dimensions of physician-patient trust are critical, including physician fidelity, competence, honesty, and confidentiality (Yan, 2018, p. 8). The trust between them can be broken by intentional error or incompetence.

Thus, by reference to the perspective of obligations and the concept of trust, it not only helps to analyze the multiplicity of obligations that is crucial to understanding the practices of physicians and patients, but also matters to understanding the relationship between physicians and patients—in particular, whether physicians and patients constitute collectives that are more than simply the sum of individual physicians and individual patients. The remainder of this article is structured as follows. The following section explores some literature on the introduction of informed consent into the Chinese medical context—that seeks to ground the physician and patient obligations and the bond of trust between them. The third section turns to an analysis of how the laws and health policies in the context of the marketization of health care have contributed to the decoupling of physician-patient practice from the obligation required by the doctrine of informed consent. The fourth section examines the impact of the current round of health-care reform on the notion of obligation. Through an analysis of two examples—including the public hospital reform in Fujian and the systemic health-care reform in Sanming—the objective is to mark a shift from the notion of obligation that is sought to be established by the doctrine of informed consent. The article concludes with implications to highlight the obligations of physicians, patients, and other key components of the health-care system.

2. Ethical standards of informed consent

Since the late 1970s, Chinese medical practice has undergone a remarkable transformation. The overall goal of the health-care reform from 1978 and 2002 was medical modernization, with an emphasis on improving the supply side of health-care services—that is, developing well-trained and specialized medical professionals, emphasizing high-tech medicine, and relying on curative and tertiary care (Chen, 2001, p. 457). While the reform changed almost every aspect of the physician-patient relationship, as well as the relationship between medicine and society, the essence could be understood as the relationship between physicians and patients no longer being a one-to-one personal one, but between patients and many professionals with advanced medicine and tertiary care. The ethical doctrine of informed consent was introduced into the Chinese medical context at a time when physicians were almost seen as "strangers at the bedside" (Rothman, 2003, pp. 127–47). This section explains that the doctrine of informed consent was introduced into China in an attempt to incorporate a new type of professional physician-patient relationship into the Chinese medical context.

In the early 1980s, the central government shifted its focus from public health services to modernizing health services through market forces (Huang, 2003, p. 10). The Ministry of Health (hereinafter "MOH") regained its control over public health policy-making. While the State Council had the authority to set major guidelines for national public health, the MOH was entrusted with proposing the blueprints and implementation plans for public health (China Health Yearbook Editorial Committee, 1983, p. 3). In April 1979, Dr Xinzhong Qian was appointed Minister of Health and urged that "the phenomenon of replacing professional and scientific management with Party leadership should be eliminated" (China Health Yearbook Editorial Committee, 1983, p. 26). As a result, the MOH rapidly expanded its departments and staff. The MOH issued a series of regulations and policies on

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

medical and health-care work. Dr Qian stressed the importance of medical ethics (Qian, 1981, pp. 1–2). In June 1981, the first national meeting on medical ethics was held in Shanghai. The basic principles of socialist medical ethics were proposed at the meeting, marking the beginning of the Chinese medical community's recognition of the importance of medical ethics (Yixue Lunli Daode Xueshu Taolunhui Jiyao [Proceedings of the Colloquium on Medical Ethics], 1981). With the establishment of medical ethics courses in medical colleges and universities, a large number of medical ethics textbooks were published and many conferences were organized in the 1980s.

The Western doctrine of informed consent was introduced into China in this context (Wang, Ma and Yuen, 2013, p. 142).[1] It first appeared in scholars' translated works, textbooks, and academic conferences before being incorporated into Chinese law. In 1985, *Introduction to Medical Ethics* (医学伦理学概论), edited by Zhaoxiong He, was published, marking the beginning of the exploration of specific issues in medicine, such as human experimentation, patients' rights, clinical medicines, and the like. Drawing on the ideas of medical ethics developed in the US, it was explained that the doctrine of informed consent emphasized the value of patient autonomy and, as a patient right, included the right to accept or refuse medical intervention (He and Chen, 1985, pp. 30, 39). *Bioethics* (生命伦理学), written by Renzong Qiu, was published in 1987 and established a theoretical framework of bioethics (Qiu, 1987). Qiu further elaborated the legal doctrine of informed consent in *Patients' Rights* (病人的权利), which specified four core elements of informed consent: disclosure of information, understanding of the facts, voluntary consent, and the patients' ability to make a decision (Qiu, Zhuo and Feng, 1996, pp. 58–64).

The introduction of the doctrine of informed consent paved the way for such a doctrine to be enshrined in law. It was mandated by statutory requirements in China, including Article 40 of the 1982 Regulation on Medical Work,[2] Article 33 of the 1994 Regulation on the Administration of Medical Institutions,[3] Article 62 of the Detailed Rules on the Implementation of Regulation on the Administration of Medical Institutions enacted in 1994,[4] Article 26 of the Law on Medical Practitioners enacted in 1998,[5] and Article 11 of the 2002 Regulation on Handling of Medical Accidents (hereinafter "2002 Regulation").[6] According to these regulations, physicians are required to truthfully inform patients and/or their family members about the patient's condition without causing adverse effects to

[1] The surgical signature system had existed in China in the 1950s. In 1951, the State Council issued the Interim Regulation on the Management of Hospitals and Clinics (医院诊所管理暂行条例). Art. 17 of this regulation stipulated that, in the implementation of major surgery or in critical conditions, medical institutions must acquire the consent of the patient and his/her relatives but, in 1956, the MOH issued a document to abolish the surgical signature system.

[2] Art. 40.6 of the Regulation on Medical Work (Ministry of Health, 1982) (医院工作制度) stipulates that, before the a surgical operation, consent in writing must be sought from family members or work units of the patient (excerpt for surface surgery). When it is too late to seek consent from family members or units for an emergency operation, it can be signed by the attending physician and approved by the director of the department, the dean, or the deputy dean of the operation.

[3] Art. 33 of the Regulation on Medical Institution (State Council, 1994) (医疗机构管理条例) stipulates that "when administering 'operations, special examination, or special treatment,' the medical institution should obtain the consent of the patient and his or her family members or relatives."

[4] Art. 62 of the Rules for Implementing the Regulation on Medical Institutions (Ministry of Health, 1994) (医疗机构管理条例实施细则) specifies that "the medical institution should respect the patient's right to be informed of his condition, diagnosis and treatment, and, when administrating operations, special examination and special treatment, the medical institution should give the patient 'necessary explanations'."

[5] Art. 26 of the Law on Practicing Doctors of the People's Republic of China (1998) (中华人民共和国执业医师法) stipulates that "doctors should truthfully explain the patients' condition to the patients or their family members."

[6] Art. 11 of the Regulation on the Handling of Medical Accidents (State Council, 2002) (医疗事故处理条例) provides that "when providing medical treatment, medical institutions and medical practitioners should truthfully inform patients of their condition, treatment measures, medical risks and other information."

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

the patient. When the ethical doctrine of informed consent was first introduced into the Chinese health-care context, it was not so central to the physician-patient relationship. Originally a Western concept, informed consent was considered incompatible with Chinese cultural tradition.

In the Western context, informed consent was originally an ethical norm for medical research. As a legacy of the trials of Nazi scientists and physicians who conducted unethical medical experiments on human subjects, informed consent was mandated by the Nuremberg Code in 1947. Along with the patients' rights movements of the 1960s, informed consent became an essential ethical norm to protect patients from medical interventions involving coercion, deception, or force (Nie, 2011, p. 134).[7] Informed consent, with its Western origins, was basically justified by the notion of individual autonomy. However, due to cultural differences, many Chinese medical professionals resisted the incorporation of informed consent and even patients' rights in general into the Chinese context. Their argument against the inclusion of informed consent into Chinese medical practice is that the Western value of individual autonomy promoted by informed consent is alien and incompatible with Chinese cultural and moral traditions, which emphasize the importance of the state, community, and family rather than the individual (Nie, 2011, pp. 134–45). More fundamentally, the cultural difference argument also indicates different understandings of the principle of autonomy (Fan, 1997, p. 316). In the context of medical practice, informed consent as a Western ethical norm represents the notion of individual autonomy, while the principle of autonomy in the Chinese context requires family determination, which can be called the "family-determination-oriented principle." According to Faden and Beauchamp, autonomous action is defined in the Western context as follows:

> X acts autonomously only if X acts
>
> 1. intentionally,
> 2. with understanding, and
> 3. without controlling influences. (Faden and Beauchamp, 1986, p. 238)

Three features are key to understanding informed consent. First, whether X is intentional depends on whether the agent can do X as he plans or intends (Faden and Beauchamp, 1986, pp. 241–8). Second, a person has a complete understanding of an action when he or she fully grasps the statements that describe the nature of the action and the foreseeable results that follow from the performance and non-performance of the action (Faden and Beauchamp, 1986, pp. 248–255). The third condition means that actions are independent of controls on the agent—especially controls that deprive the agent of self-direction (Faden and Beauchamp, 1986, pp. 256–62).

By contrast, the Chinese principle of autonomy is positively expressed as follows: "Every agent should be able to make his or her decisions and actions harmoniously in cooperation with other relevant persons" (Fan, 1997, p. 316). It can also be negatively expressed like this: "No harmoniously made decisions and actions should be subjected to controlling constraints by others" (Fan, 1997, p. 316).

In the Chinese context, if a competent patient requests or refuses a medical procedure but the family member has a different opinion, the physician should not accept the patient's opinion. When the principle of autonomy is applied to informed consent,

[7] The Nuremberg Code identifies four essential elements of "valid consent"—namely "it must be voluntary (i.e. free from 'force, fraud, deceit, duress, overreaching, or other ulterior forms of constraint or coercion'), legally valid, informed, and fully comprehended by the subject)."

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

it requires that a family representative should listen to and discuss with the physician, communicate with the patient, consult other family members in making decisions, and finally sign the consent form (Fan, 1997, p. 319). Based on the different understandings of the principle of autonomy, they further make their argument as follows:

> *First premise:* Informed consent is a Western moral concept because, not only did it originate in the West, but its rationale is wholly based on the Western notion of individualism;
>
> *Second premise:* Chinese culture, represented by a communitarian Confucianism, is fundamentally different from Western culture with its individualist orientation;
>
> *Conclusion:* Therefore, the doctrine of informed consent is neither relevant nor applicable to China. (Fan, 1997, p. 135)

As a result, it is believed that informed consent should not be applicable to Chinese medical practice. Jingbao Nie challenges this cultural difference argument. He offers a two-part justification for the compatibility of informed consent with the Chinese culture and a critique of family consent. Nie's critique begins with an observation that informed consent has contributed significantly to the historical transformation of medical ethics from a paternalistic and physician-centred model to a patient-centred one in the Western context. Against the view that the doctrine of informed consent is fundamentally incompatible with the Chinese culture, Nie suggests that incorporating informed consent into the Chinese medical context is a way of empowering patients and protecting them from abuse of power by physicians. As has been observed during the patients' rights movement in Western countries, there is an unequal power relationship between physicians and patients in China. Protecting the right to informed consent is crucial to empowering patients in China by enabling them to participate in decision-making about medical interventions.

The second part of the justification suggests that, although informed consent is primarily justified by reference to individual autonomy, it is also a matter of the common good. By appealing to Joseph Raz's influential communitarian justification for rights, Nie clarifies that a right that ultimately benefits an individual has communal aspects. As he states: "rights by definition mean to hold someone or certain authorities to be under a duty so that rights and duties are correlative and never separable" (Nie, 2011, pp. 140–1). What is suggested here is Raz's point that rights have not only individualistic aspects (in the sense that it is individuals who ultimately benefit from participating in rights), but also communal aspects, in the sense that rights impose multiple kinds—rather than a single kind—of correlative obligations on a number of obligation bearers (Raz, 1984, pp. 199–200).

Informed consent also has a communal aspect in the sense of promoting trust between physicians and patients. By reference to Annette Baier's account, Nie analyses trust as "reliance on others' competence and willingness to look after, rather than harm, things one cares about" (Nie et al., 2017a, p. 60). Trust, by definition, is based on the goodwill or good faith of others. Accordingly, the relationship of trust between physicians and patients is based on the patient's confidence in the physician's expertise and willingness to provide health-care services. As Nie further notes, the relationship of trust is fragile in that the interests of patients can be overridden by physicians, but the fragility is inevitable because of the imbalance of power and knowledge between physicians and patients (Nie et al., 2017a, p. 60). As such, what really matters is to ensure that the interests of patients are not paternalistically overridden by physicians. Given that the doctrine of informed consent provides information that is crucial to fostering a trusting relationship between physicians and patients, informed consent can also be seen as a way to build trust between physicians and patients (Nie, 2011, p. 141).

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

In addition to the two-part justification for the compatibility of informed consent with Chinese culture, Nie also offers three arguments against family consent. The first is that withholding critical medical information from patients can cause them the pain of loneliness and emotional abandonment (Nie, 2011, pp. 123–5). Second, disclosure can empower family members to better meet the needs of patients and reduce feelings of abandonment and loneliness experienced by patients (Nie, 2011, pp. 125–6). Third, when there are unequal power relations among family members, it is precisely the negative effects of family consent that should be avoided, such as the economic burden of refusing necessary medical interventions (Nie, 2011, p. 144).

Nie offers a compelling argument against the view that informed consent is incompatible with the Chinese culture, but his argument can be strengthened on two points. First, Nie does not offer normative inquiries into what should be done to empower patients. Xiju Zhao's work can be used to strengthen Nie's theory. Zhao examines the physician's obligation to disclose alternative treatment options. In addition to noting that a number of obligations have been imposed on physicians to disclose information related to medical treatments and to obtain consent from patients and their family members, Zhao argues that the doctrine of informed consent should clarify the scope of the physician's obligation to disclose information, particularly therapeutic risks and alternatives to treatment plans (Zhao, 2013, p. 22).

Second, while Nie is correct in pointing out that informed consent helps to foster the bond of mutual trust between physicians and patients, he does not specify how trust can be established. The conventional understanding of informed consent is simply that competent patients should be allowed to make decisions for themselves about the course of their medical interventions, while physicians should communicate effectively with patients and/or their family members. Little has been said about what kinds of decisions should be made by patients, and whether patients should take responsibility for making decisions. Recent Western discussions of the idea of patient responsibility address these issues (Katz, 2002, pp. 130–64; Davies, 2020, pp. 300–3). Heather Draper and Tom Sorell argue that, although patients are vulnerable, their vulnerability does not confer inability to contribute to bad health. Nor does their autonomy insulate them from responsibility for the consequences of their decisions. Their discussions help clarify how the bond of trust between physicians and patients can be established. Draper and Sorell's idea of patient responsibility points to an ideal type of true partnership between physicians and patients in medical care, which demands a "joint responsibility for the outcomes, including cases where things go badly wholly as a result of these decisions, and the patient turns out to be harmed or disappointed" (Draper and Sorell, 2002, pp. 339–40). If patients are negligent in their decision-making, they may jeopardize their access to public health services. In this sense, Draper and Sorell's article complements Nie's argument that the fulfilment of duties contributes to the formation of the bond of trust between them. Physicians have obligations to be sensitive to patients, such as to truthfully inform patients or their family members of the patient's condition without causing adverse effects to the patient. Patients also have obligations to physicians, such as actively communicating with physicians, participating in decision-making, and accepting responsibility for the outcomes of decisions.

The above characterization suggests an ideal version of the physician-patient relationship that should be realized through the ethical doctrine of informed consent. The purpose of specifying this is not only to present an ideal theory, but also to emphasize that the key features of informed consent are worthy ideals. However, an observation of how the institutional mechanisms have been established to implement the doctrine of informed consent in China will reveal a deviation from the ideal and its connection to marketization.

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

3. Informed consent under the marketization of health care

The literature discussed in the previous section is essentially concerned with normative inquiries into the obligations of physicians and patients—namely, what obligations patients and physicians should have as required by the ethical doctrine of informed consent, what kinds of actions they should take, and what liabilities they may incur if they fail to fulfil those duties. What is missing from these discussions is an analysis of the relationship between informed consent and the marketization of health care. Yilu Zuo's article in this Special Issue provides such an analysis—the years after the adoption of the opening-up policy witnessed a severe negative consequence of the vacuum of value; to "put money above everything else" has even become the motto of many ordinary people in China (Zuo, 2024). Chinese medicine was marketized after the adoption of the opening-up policy. The term "marketization" is generic and can be understood in different ways. Marketization is defined in this place as "a politically shaped process of institutional change" including "both the expansion of market mechanisms into non-market coordinate social domains as well as their intensification in already market-dominated settings" (Ebner, 2015, pp. 369–70). When the health-care reform incorporated market mechanisms into the health-care context, policy instruments were designed to commodify health-care goods and services, with an aim to create profits for hospitals. The marketization of health care is important because it is precisely this issue that has re-emerged in today's context of health-care reform. In order to provide a more complete analysis of the obligations of physicians and patients, this section examines the relationship between informed consent, law, and health policy in the context of the marketization of health care.

In the context of the marketization of health care, physicians were obliged to think, and act, as if they were accountants, whereas patients were also obliged to act as consumers. This was against the backdrop of the health-care reform from 1978 to 2002. It seems that the Chinese government adopted the "trickling down" hypothesis of neoliberal economic theories—that is, as the economy continues to boom, all citizens of different social status will benefit and be able to afford health services out of their own pockets. Indeed, the high burden of disease in China did not justify optimism about the shift in the responsibility for health care from government to individuals (Wang, 2010, p. 245; Huang, 2013, p. 2). Influenced by the ideological transformation, however, the Chinese government continuously reduced financial resources to public hospitals, but it still expected that quality health-care services could be provided by public hospitals in an affordable way (Wang and Fan, 2013, p. 63; Wang, 2008, pp. 69–70).[8] To meet this expectation, the MOH learned from the reform model of state-owned enterprises (hereinafter "SOE"), granting public hospitals more autonomy to improve economic efficiency. The management autonomy created opportunities for public hospitals to pursue economic interests. Drug price markups of 15% were allowed for Western drugs and 25% for traditional Chinese drugs. Public hospitals were incentivized to prescribe expensive but unnecessary drugs. Over time, drug costs accounted for 60% of hospital expenses and became the largest source of hospital revenue (Liu and Hsiao, 1995, p. 1100). Because physicians' total compensation consisted of base salaries and bonuses derived from the revenue they generated for hospitals, they tended to increase revenue by prescribing more expensive drugs and using more high-tech equipment such as CT scans, ultrasound, kidney dialysis, and the like (Liu and Hsiao, 1995, p. 1100). Thus, in the context of the marketization of health care, public hospitals were obligated to maximize profits, public hospital managers were obligated to think and act as if they were running a business, and physicians were obligated to think and act as if they were for-profit health-care providers.

[8] Before 1978, 50% of the expense of public hospitals was from the state budget, whereas the percentage was reduced to 30% in 1980, 27% in 1985, 19% in 1987, and finally 6% in the late 1990s.

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

In the marketization of health care, patients were also increasingly becoming consumers. At a general level, as the market economy and a new culture of consumerism arose across China in the early 1980s, "all kinds of goods [were] available to whoever had the purchasing power, eliminating the previous privilege of the political elite who could enjoy special supplies from the centralized system of redistribution" (Kleinman et al., 2011, p. 18). The early 1980s also saw major changes in the health sector. While some pilot reforms had been initiated in urban areas since the late 1980s, substantive health-care financing reform did not begin until a social health insurance system, the Urban Employees' Basic Medical Insurance (hereinafter "UEBMI"), was introduced in December 1998. However, the implementation of the medical insurance reform was slow, and a large number of urban residents were not fully covered by the new medical insurance system (Gu, 2001, pp. 197–215). The employees in administrative and nonprofit units who were still covered by the old Government Insurance Scheme (hereinafter "GIS") and Labour Insurance Scheme (hereinafter "LIS") did not join in the new health-care insurance scheme (Gu, 2001, p. 211). As a result, more than half of the urban residents were not covered by any health-care insurance scheme (Liu, 2002, p. 135). The lack of access to free health-care services led to out-of-pocket payment at the point of health care becoming basically a common feature, exposing many residents to expensive health-care services bills (Hesketh and Zhu, 1997, p. 1616). Even those patients whose health-care costs were covered by health plans had to consider whether the particular health-care service was covered by their health plan (Cong, 2004, p. 166). Some patients even had to seek health-care services from unlicensed physicians outside major hospitals at reduced rates (Liebman, 2013, pp. 226–7). Thus, when health care was marketized and health-care services were characterized as commodities, patients' purchasing power became the primary consideration in selecting health-care services, while the quality of health-care services became secondary.

The foregoing view of physician and patient obligations suggests a different kind of relationship between obligation and informed consent than the ideal one identified earlier. As noted above, the doctrine of informed consent requires that physicians and patients share in the decision-making process and take responsibility for the decisions. The social goal of implementing informed consent is to empower patients and prevent abuse of power by physicians. In contrast, in the context of the marketization of health care, physicians were required to provide not only medical facts—the patient's diagnosis and prognosis, the nature of proposed medical treatments, the risks and benefits of medical treatments, and reasonable alternatives to medical treatments—but also the costs of proposed medical treatments, whether they would be paid out of pocket or covered by health insurance, and the like (Cong, 2004, p. 154). Physicians usually tended to inform patients of the cost of their care to ensure that their bills could be paid. This was because if medical bills were not paid, public hospitals often required the attending physicians and departments to cover the costs. This was especially true in public hospitals and clinics in poor areas (Nie et al., 2017b, pp. 30–1). In addition, although physicians were required to communicate with patients and their families, they did not disclose all the information about the actual conditions and tended to exaggerate the seriousness of the patients' conditions. This was to ensure that, when operations were not successful, the patient's family members could accept bad results, whereas when operations were successful, the patients and their family members would appreciate and show great gratitude to the physicians (Cong, 2004, p. 154). The physician's obligation to disclose information thus pointed primarily to the self-regarding dimension of the obligation, in the sense of avoiding unpaid health-care bills and potential conflicts of interest, thereby reducing the possibility of dissatisfaction, complaints, or lawsuits from patients and their family members, while the other-regarding dimension of the duty, which points to bonds or ties

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

with others, became secondary, for example, to choosing the best treatment plan for a patient, taking into account all relevant information.

Moreover, although informed consent was supposed to empower patients and increase their autonomy to choose the best way to promote their health, in reality it did not require patients to engage in self-reflection and communication with physicians about how best to promote their health. Patients were simply required to accept or reject certain medical treatments on offer. Their primary concern was the ability to pay out of pocket. While there was no compulsion to make certain choices, there was no escape from acting as rational consumers—that is, choosing the medical plans that best fit their economic circumstances. This was also observed by Kenneth Veitch in the British National Health Service context. Commenting on the marketization of health care, he notes that "while there is, for example, no compulsion to make particular kinds of choice in this regard, there is no escape from thinking of oneself, and acting as, a consumer—that is, from making some sort of choice" (Veitch, 2019, p. 281). In this sense, while the doctrine of informed consent sought to infiltrate patient autonomy into Chinese medical practice, the pursuit of autonomy also produced coercion. The core of this kind of patient-as-consumer obligation did not require self-reflection on whether the particular choice and decision regarding health care was best for his health, and it was not tied to accepting responsibility for the decision affecting his health (Veitch, 2019, p. 277). In the Chinese health-care context, when medical accidents occurred, the patient-as-consumer mentality simply compelled patients to protect their own rights without reflecting on their own responsibility for the outcomes. As a result, patients tended to resort to violence to deal with medical conflicts and accidents (Tang and Guan, 2018, p. 641). The Chinese physician-patient relationship was thus transformed by the policies of the marketization of health care into an "arm's length transaction" (Tang and Guan, 2018, p. 639). Physician-patient transactions in health care have been forced to evolve into simple encounters without real and empathetic interactions, similarly to market transactions. The information asymmetry in such market transactions created serious mistrust between physicians and patients. The physician-patient relationship became extremely poor; incidents of violence against physicians increased and became widespread during this period; and patients and their family members even gathered in hospitals to demand public apologies and compensation for medical malpractice (Nie et al., 2017b, p. 29). Thus, while the implementation of the doctrine of informed consent attempted to infiltrate an idealized version of the physician-patient relationship, emphasizing both the patient's and the physician's obligations to participate in decision-making, the policies of health-care marketization gradually forced their relationship to evolve into encounters between providers and consumers, leading to a decline in the trusting relationship.

If, in the context of the marketization of health care, there has been a decoupling of medical practice from its ethical obligations, such as those required by the doctrine of informed consent, how have the law and legal institutions responded? Have legal institutions restored the bond of trust between physicians and patients?

Before the promulgation of the 2009 Tort Liability Law, there were two ways of protecting the right to informed consent. The first was offered by three pieces of medical administrative regulation, namely the Regulation on Medical Institutions (1994),[9] the Law on Practicing Doctors (1998),[10] and the 2002 Regulation.[11] While the three regulations adopted different stipulations, they all recognized the protection of the right to informed consent. The Law on Practicing Doctors (1998) and the 2002 Regulation only subjected a breach of the obligation of information disclosure to administrative or disciplinary

[9] Art. 33 of the Regulation on Medical Institutions.
[10] Art. 26 of the Law on Practicing Doctors.
[11] Art. 11 of the 2002 Regulation.

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

punishment; they did not attach civil liability for the breach of the obligation. Article 37(8) of the Law on Practicing Doctors specified that the breach of the obligation to obtain the consent of patients or their family members for experimental clinical treatment might result in administrative punishment and criminal responsibilities.[12] Article 56(1) of the 2002 Regulation only provided for making corrections and administrative punishment for the breach of the duty of informed consent in serious cases.[13] The consideration behind this was that, given that the breach of the duty of informed consent did not fall within the scope of medical accidents, it did not result in civil liability under the 2002 Regulation. As Zhao Xiju comments, "when creating the notion of 'medical accident', legislators only envisaged the traditional context of diagnosis and treatment, with no awareness of the legal rule that breach of the duty to inform may result in civil liability" (Zhao, 2013, p. 326).

The second approach was provided by the General Principles of Civil Law (hereinafter "GPCL") implemented in 1987. If a physician failed to disclose information to a patient, which caused personal injuries to the patient, the physician would be exposed to tort liability for the breach of the obligation of information disclosure. Yet, given that the GPCL did not devote any specific provision to embrace informed consent, the tort liability for the breach of the obligation of information disclosure could only be provided by adopting the general approach to dealing with medical malpractice. There were three elements of proving the liability for the breach of the obligation of information disclosure, namely (1) a health-care service provider failed to inform patients of substantive facts related to the health-care treatment; (2) the patient suffered damage without being fully informed of substantive facts related to the treatment; and (3) if the patient had been informed of substantive information, a reasonably prudent patient in the same situation would not have consented to the treatment (Zhao, 2008, p. 108). Along with this line, while the rules of the GPCL provided compensation for the breach of the obligation of information disclosure, the compensation was to recover the patient's damages for personal injuries, instead of simply the breach of the obligation of information disclosure. Moreover, given that Article 119 of the GPCL did not devote any details to the standards regarding the determination of the amount of compensation, the vagueness of the GPCL led to the application of the Law of the People's Republic of China on the Consumer Rights and Interests Protection (hereinafter "Consumer Law") to decide the amount of compensation in some local judicial practices (Zhu, 2009, pp. 189–90).[14]

To rectify the limitation of the GPCL, the Consumer Law was applied by some local statutes and courts to provide for legal remedies for the breach of the obligation of information disclosure. For instance, local statutes of Zhejiang Province and Fujian Province explicitly recognized the protection of patients' rights by reference to the Consumer Law; in particular, they recognized the right to informed consent.[15] Patients were perceived by the local statutes as consumers whose rights to make choices on medical

[12] Art. 37(8) of the Law on Practicing Doctors.

[13] Art. 56(1) of the 2002 Regulation.

[14] Art. 119 of the Consumer Law (1993) stipulates that "anyone who infringes upon a citizen's person and causes him physical injury shall pay his medical expenses and his loss in income due to missed working time and shall pay him living subsidies if he is disabled; if the victim dies, the infringe shall also pay the funeral expenses, the necessary living expenses of the deceased's dependents and other such expenses," Consumer Law, adopted by the Standing Committee of the National People's Congress on 31 October 1993, revised on 27 August 2009 and 25 October 2013.

[15] See the Measures of Zhejiang Province to Implement "the Law of the People's Republic of China on the Consumer Rights and Interests Protection (浙江省实施《中华人民共和国消费者权益保护法》办法)" (2000) adopted by the Standing Committee of the People's Congress in Zhejiang Province on 26 December 1995, revised on 29 October 2000 and 30 March 2017; see also the Measures of Fujian Province to Implement "the Law of the People's Republic of China on the Consumer Rights and Interests Protection" (福建省实施《中华人民共和国消费者权益保护法》办法) adopted by the Standing Committee of the People's Congress in Fujian Province on 2 June 2005.

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

treatments were protected. The application of the Consumer Law, although it was not uncontroversial, was also not uncommon in local courts' judicial practices (Ding, 2007, pp. 184–94). Local courts referred to the Consumer Law to interpret patients' right to informed consent. Pursuant to the Consumer Law, Article 8(1) stipulated the right of consumers to obtain true information regarding commodities and services. Articles 19(1) and 32 also provided for the obligations of business operators and consumer associations to offer consumers authentic information regarding their commodities and services. The application of the Consumer Law could be illustrated by an appeal lawsuit that was heard by the intermediate court of Zhuhai City (hereinafter "Court") in 2004.[16] In this case, the Court found the physician and Zhuhai Hospital of Guangdong Provincial Hospital of Traditional Chinese Medicine had negligence in failing to perform the obligation to inform patients of necessary care after surgery. The Court also found causation between the negligence and personal injury caused to the patient. When dealing with the application of the law, the Court held that the 2003 Notice of the Supreme People's Court (hereinafter "SPC") stipulated that medical negligence should be dealt with by the GPCL but, given that Article 119 of the GPCL did not devote any details to the standards of determining compensation, the compensation should be decided in accordance with the Consumer Law. In this case, the Court's application of the Consumer Law was to determine compensation so as to rectify the limitation of the GPCL in failing to specify the standards for determining compensation.

While the Consumer Law protected consumers' rights to information disclosure, the obligations of information disclosure under the Consumer Law were different from those demanded by the doctrine of informed consent. As noted, the doctrine of informed consent requires patients and physicians to communicate and exchange related information so as to make the decision to provide the best health-care services to patients, which reflects the ethical nature of the obligations. From this standpoint, the doctrine of informed consent demands that ethical obligations should be performed by physicians and patients for the best interests of patients. The Consumer Law, however, attempts to protect consumers' choice between a range of existing medical treatment options, rather than demanding the disclosure to be measured by the health needs of patients. The key difference lies in the form and meaning of choice. Consumer's choice denotes "preference amongst pre-arranged alternatives," which is "a limited form of choice with a limited mode of expression" (Veitch, 2015, p. 155), while the choice to be pursued by the doctrine of informed consent is not limited to the pre-arranged alternatives, but requires disclosure of the information on alternative treatment options to best meet the health needs of patients. In this sense, when patients were perceived by the local statutes and courts as consumers of health-care services, their choices were deprived of the normative requirements of medical ethics, including those demanded by the doctrine of informed consent. When the practice of informed consent became a simple ritual, patients and their family members would frequently question the authenticity of the information and the intention of physicians. Especially when medical practices occurred, patients and their families would have strong feelings of betrayal and mistrust. Thus, while the application of the Consumer Law in local statutes and judicial practices is intended to protect patients' right to informed consent, it, in turn, deprived the core nature of the obligation—the ethical obligations for physicians and patients. The legal application of informed consent did not effectively restore the bond of trust either.

Thus, this section identifies that, from 1978 to 2002, the implementation of the legal doctrine of informed consent sought to incorporate a professional physician-patient relationship into the Chinese health-care context. While the implementation of the doctrine of informed consent attempted to infiltrate the ideal version of the physician-patient relationship, emphasizing both patient and physician obligations to engage in

[16] *Yan Longming and Others v. Zhuhai Hospital of Guangdong Provincial Hospital of Traditional Chinese Medicine* (严龙明等与广东省中医院珠海医院非医疗事故损害赔偿纠纷上诉案).

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

decision-making, the health-care policies of marketization gradually compelled their relationship to be developed into encounters between providers and consumers, similar to those in market transactions, worsening the trusting physician-patient relationship. It also identifies that, to the extent that the law and legal mechanisms protected the right to informed consent by reference to the Consumer Law, they failed in facilitating the ethical core of informed consent—that is, the joint liabilities of physicians and patients—and restoring the bond of trust between them.

4. Informed consent under the universal coverage of basic health care

Earlier, it was noted that, in the context of the marketization of health care, the practices of physicians and patients reveal a decoupling from the core of the obligation—the bond between physician and patient. To address the deteriorating physician-patient relationship and the weakened health-care system, the central government began to consider a new round of health-care reform in 2003. The doctrine of informed consent was revised. The Tort Liability Law (侵权责任法) was passed in 2009. The Civil Code of the People's Republic of China (中华人民共和国民法典, hereinafter "Civil Code") was enacted in 2020. The Tort Liability Law and the Civil Code have devoted specific provisions for informed consent, specified the physician obligations, and recognized the exposure of breach of informed consent to tort liability.[17] Apart from the revisions of the civil law, proposals for health-care reform had been under serious consideration since 2005 (Huang, 2013, pp. 68–72). After three years of debate, the new round of health-care reform was launched by the central government in 2009. The objective of the health-care reform was to realize the universal coverage of basic health care. This section analyses, by reference to two examples of health-care reform, the link between the policies of health-care reform and the obligations of patients and physicians. It tries to reflect on what implications the health-care and social policies have for understanding informed consent and the notion of obligation.

4.1 Public hospital reform and physician obligation

In January 2009, aware of the exacerbating physician-patient relationship and the need to reform, the State Council issued two documents, namely Opinions of the Central Committee of the Communist Party of China and the State Council on Deepening the Reform of the Medical and Healthcare System (中共中央国务院关于深化医药卫生体制改革的意见, hereinafter "Opinions on Deepening Reform") and the Notice of the State Council on Issuing the Plan on Recent Priorities in Implementing the Reform of Healthcare System (2009–2011) (国务院关于印发医药卫生体制改革近期重点实施方案 (2009–2011 年) 的通知, hereinafter "Implementation Plan").[18] The two documents outline the overall objective of the health-care reform—that each citizen is entitled to basic health-care services. Since 2009, to orient the public hospital management towards providing health care as a public good, policies were issued to increase the budget allocated to public

[17] While Art. 55 of the 2009 Tort Liability Act and Art. 1219 of the Civil Code have clarified the obligations and liabilities for breach of informed consent, they still do not recognize the value of informed consent as an independent ethical obligation. In other words, if there is no personal injury associated with the breach of the obligation of informed consent, it may be difficult to claim for liability.

[18] Opinions of the Central Committee of the Communist Party of China and the State Council on Deepening the Reform of the Medical and Healthcare System (中共中央国务院关于深化医药卫生体制改革的意见) issued by the Central Committee of the Communist Party of China on 17 March 2009; Notice of the State Council on Issuing the Plan on Recent Priorities in Carrying out the Reform of Healthcare System (2009–2011) (国务院关于印发医药卫生体制改革近期重点实施方案 (2009–2011 年) 的通知) issued by the State Council on 18 March 2009.

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

hospitals.[19] Apart from increasing the revenue received by public hospitals, civil-law and administrative measures were also taken to regulate the behaviours of public hospitals and physicians.

Fujian's health-care reform demonstrates a typical example of health-care reform through administrative measures. It sought to restore comprehensive command and control over public hospitals, cutting off the linkage between the compensations of physicians and profits generated to public hospitals. Before the start of the public hospital reform, much literature tended to assume that the Chinese health bureaucracy was incompetent to change the internal behaviours of physicians in public hospitals. This was because the earlier massive economic reform greatly reduced the government's investment in health care and granted much autonomy to public hospitals in personnel recruitment and appointment, thereby reducing the role and function of the health bureaucracy to merely technical supervision (Hisao, 1995, p. 1052). As suggested by Fujian's reform, however, a plethora of health policies could be effectively penetrated into the internal management of public hospitals. The key to success was the adoption of a key indicator management approach.

Five key indicators were prescribed by the Fujian Provincial Health Bureau to evaluate the performance of public hospitals in cost control—namely, average expense per outpatient visit (hereinafter "AEOV"), average expense per inpatient stay (hereinafter "AEIS"), appropriate drug utilization, positive rates of high-tech diagnostic tests, and accuracy rate of service billing. To prevent local discretion, concrete targets were defined to specify the ceilings of AEOV and AEIS (He and Qian, 2013, p. 951). Afterwards, the provincial health bureau's mandate was penetrated through municipal health departments to public hospitals. The managers of public hospitals further allocated quotas for cost containment down to different clinical departments. Within public hospitals, the five control indicators were also incorporated into their Hospital Management Assessment System (hereinafter "HMAS"). In addition to the indicator management, a sophisticated overall quantified evaluation was conducted by the provincial health bureau and the municipal health departments every June of the year. Drug procurement, prescription of antibiotics, workload, and the like were all assessed by the quantified evaluation system. The evaluation results even affected the ranking and reputation of public hospitals (He, 2011, p. 219). Since 2007, the cost-containment performance has been linked with the subsidies received by public hospitals (He, 2011, pp. 222–3). The externally mandated cost-containment policy instruments were thus penetrated into the internal assessment systems of public hospitals and, consequently, they substantially reduced the outpatient and inpatient expenditures (He, 2011, pp. 223–6).

What did the above health-care reform policies reveal about the notion of physician obligation and informed consent? First, in the example of Fujian's reform, whilst having to abide by the administrative mandates of cost control imposed by the health administration, public hospitals, hospital managers, and physicians still engaged in various unintended opportunistic practices to maintain profits (He and Qian, 2013, pp. 958–68). Drug income contributed approximately 40% of the total hospital income, diagnosis and treatment (hereinafter "D&T") income accounted for 50%, and government subsidies only contributed less than 10% (He and Qian, 2013, p. 958). In Fujian's reform,

[19] Implementation Opinions of the General Office of the State Council on Fully Promoting the Comprehensive Reform of All Public Hospitals at the County Level (国务院办公厅关于全面推开县级公立医院综合改革的实施意见) issued by the General Office of the State Council on 8 May 2015, available at –http://www.gov.cn/zhengce/content/2015–05/08/content_9710.htm (accessed 26 March 2021); Guiding Opinions of the General Office of the State Council on Urban Public Hospital Comprehensive Reform Pilot (国务院办公厅关于城市公立医院综合改革试点的指导意见) issued by the General Office of the State Council on 17 May 2005, available at –http://www.gov.cn/zhengce/content/2015–05/17/content_9776.htm (accessed 26 March 2021).

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

to maintain profits, hospital managers had to monitor income and benchmark the costs with the control targets of cost reduction. Under such a dual system, hospital managers typically manipulated the mix of drug and D&T incomes. For instance, if they were pressed by the hard requirements of cost reduction, physicians tended to cut off unnecessary high-tech tests but had to tolerate the overprescription of drugs to ensure that physicians could earn commissions from pharmaceutical companies (He and Qian, 2013, pp. 958, 964–5).

The above was also the case for physicians in other regions across China. In the context of public hospital reforms, physicians were still obliged to adhere to corporate mentalities. A physician described the following experience:

> The hospital demands that prescriptions drugs should constitute less than 30% of a patient's total medical costs. This means if the bill amounts to 100 *yuan*, the cost of drugs should be less than 30 *yuan*. If it exceeds 30 *yuan*—like 45 *yuan*—the hospital will deduct the extra sum from my own wages. But, to get around the policy, one can order more high-tech diagnostic tests to increase the total medical costs. So a good doctor should also be a good accountant, always calculating costs. (Nie et al., 2017b, p. 33)

In this example, overprescription of drugs was prohibited by the social policy of public hospital reform, but public hospitals still endeavoured to maintain profits. The physician, then, cut off the drug prescriptions but maintained the total medical costs by ordering more diagnostic tests. In this sense, while a demanding regulatory mechanism was effectively imposed on public hospitals, the accompanying obligations incumbent on physicians did not dispel their economic incentives to make profits. Their mentalities of thinking, and acting, as if they were a good accountant continued to distort their practices in the way that prioritized the maximization of economic interests.

Apart from maintaining corporate mentalities, physicians were also obliged to work under heavy pressure. Take the health-care reform in Xiamen as an example. Xiamen is one of the nine municipalities of Fujian Province. In Xiamen's reform, the drug income was delinked from the hospital income to curtail the overprescription of drugs. Yet, public hospitals tended to increase the volume of health-care services to generate revenue (He and Qian, 2013, p. 965). In effect, physicians were obliged to work under extremely heavy pressure. The heavy pressure and limited communication between physicians and patients further undermined their performance of the obligations of providing good communication with patients (He and Qian, 2016, pp. 365–6). As remarked by a physician, Dr Chen, who had experienced several medical disputes:

> Although the poor doctor-patient relationship is a complex function of various factors, I have to say that we [doctors] should be mainly held responsible. As far as I see, the problems are rooted in communication. The extremely short time that can be allocated to each encounter doesn't allow me to adequately communicate with patients and their family members. Most conflicts actually result from miscommunication rather than medical accidents. I feel that disputes are most likely to erupt when poor communication is coupled with issues related to fees. (He and Qian, 2016, p. 368)

As also shown by empirical research, poor communication was the primary factor that ignited violent conflicts between physicians and patients. The number of violent conflict incidents between medical staff and patients increased sharply from 10,248 in 2006 to 17,243 in 2010 (He and Qian, 2016, p. 362).

The preceding discussion reveals that, while physicians were obliged to abide by the administrative measures, they did not necessarily assume the ethical dimension of the physician obligations as demanded by the doctrine of informed consent. The ethical doctrine of informed consent requires physicians to respond to patients' needs, encourage

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

patients to voice their ideas, offer collaboration, and the like (Kaba and Sooriakumaran, 2006, p. 62). Rather, as shown in Fujian's reform, the obligations of physicians regulated by the rigorous monitoring and management mechanisms were bound up with mixed mentalities. On the one hand, physicians were obliged to accomplish the administrative targets assigned vertically by the provincial health bureau, municipal health departments, public hospitals, and clinical departments. On the other hand, they were also obliged to take every opportunity to generate profits by increasing the volume of health-care services, manipulating the number of drugs prescribed and diagnostic tests ordered, etc. As explained earlier, the second set of obligations concerns the compulsion of physicians to be profit-minded in the sense of thinking and acting like accountants in the context of health care. The first set of obligations, however, concerns the compulsion of physicians to improve their performance by accomplishing the numerical objectives defined by the administrative measures. Complying with the administrative measures, however, does not demand self-reflection on whether the compliance is bound up with judgement concerning the ethical nature of the measures. As Alain Supiot writes concerning the limits of governance by numbers: "[l]ogico-mathematic language ... is univocal and non-reflexive. The symbols used have one meaning, and one only, even if they can only be discussed in the natural languages on which they are based" (Supiot, 2017, p. 167). In light of Supiot's account, physicians regulated by the numerical targets and standards only seek to accomplish the targets without thinking about any real improvement in the health-care services they provide. Physicians always tended to circumvent administrative measures and continued to maintain profits to compensate themselves. Thus, the policies of public hospital reform and the accompanying obligations incumbent on physicians would not lead to physicians' performance of their ethical obligations. As a result, the physician practices of excessive prescriptions of drugs, together with their poor communications, further gave rise to poor health-care outcomes. Patients might doubt the intention of physicians to act in the best interests of patients, and this doubt would destroy fidelity and undermine patients' trust in physicians. That was where the mistrust between physicians and patients emerged. In this sense, the non-performance of the ethical obligations of informed consent undermined the fidelity of physicians and patients' trust in physicians.

Thus, by reference to Fujian's health-care reform, this section has explained that, while public hospital reform sought to curb the rampant cost increase in health-care services, the policies of public hospital reform could not effectively lead to their performance of the physician obligations as suggested by the doctrine of informed consent. Physicians continued to circumvent administrative regulations and maintain profits to compensate themselves and, consequently, the bond of trust between physicians and patients was not securely re-established.

4.2 Systemic health-care reform and obligation of health-care insurance schemes

Given that public hospitals were facing a multitude of systemic problems, policy-makers expected a systemic reform to restore the bond of trust between physicians and patients. Sanming's reform was typical of this feature. Rather than making the usual cost reductions, Sanming's reform attempted to tackle the root causes of the problems of the health-care system. By way of the example of Sanming's health-care reform, this section tries to discuss the systemic health-care reform and reflect on the implications it has for understanding the notion of obligation under the universal coverage of basic health care.

Sanming's reform was systemic and comprehensive in that the public hospital reform co-ordinated the regulation of behaviours of physicians with a health-care insurance reform and a drug procurement reform (Li and Fu, 2017, pp. 247–8). First, Sanming established a health-care insurance management centre (hereinafter "centre") to take over the management of three health-care insurance schemes (He, 2018, p. 1099).

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

The establishment of the centre produced positive effects. Merging the 26 insurance management offices into one centre reduced administrative costs. The consolidation of the three health-care insurance pools increased the financial security against deficit risks. Moreover, since public hospitals had to deal with a single health-care insurer that had stronger negotiation power, the behaviours of public hospitals could be better constrained (He, 2018, p. 1099).

Second, an accountability system was introduced to regulate the behaviours of public hospital directors. In Sanming's reform, directors of public hospitals were obliged to manage the performance of public hospitals. The centre introduced a new measurement system to rate their performance based on four categories of indicators, namely clinical quality, facility development, operation safety, and cost control (Fu et al., 2017, p. 1138). The annual payments of the directors were also determined by the hospital performance in relation to the targets set out by the agreements signed between the new commission and the public hospitals.

Third, the Sanming reform took measures to alter the structure of incentives for physicians. The income of physicians was delinked from the profits they generated. Before the start of the health-care reform, the physicians' bonuses were derived from profits, which provided incentives for them to overprescribe expensive yet unnecessary drugs and overuse diagnostic tests. In Sanming's reform, two crucial policies were issued. On the one hand, physicians were compensated with much higher basic salaries and bonuses based on performance. The bonuses were calculated under the point system that was created to distribute the revenue of the public hospitals, and the physicians' points were evaluated according to their performance, namely seniority, quality, and quantity of health-care services, and achievements of the targets such as cost control (Fu et al., 2017, p. 1138). The pricing schedule was thus adjusted to reflect physicians' labour inputs. On the other hand, the payment reform was co-ordinated with the removal of the margin for drugs and a case-based payment method to improve health-care quality and contain cost increases (Li and Fu, 2017, p. 248).

Sanming's systemic health-care reform adopted a demand-side approach, seeking to improve the capacity of the health-care insurance scheme as a third-party purchaser to provide health care as a public good. What can the systemic reform in Sanming reveal about the notion of obligation as discussed in this article? One way to perceive this is that, as Sanming's reform indicates, the analysis of the obligation must extend beyond the physician-patient relationship to encompass the new relations, such as that between citizens and the health-care insurance schemes. If the health-care reform policies in Sanming were implemented as planned, the health-care insurance management centre should play a dual role in the health-care reform, as both a regulator and a purchaser. As a purchaser, the health-care insurance management centre is obliged to procure health-care services from public hospitals on behalf of the residents. The health-care bills would be paid primarily by the health-care insurance scheme as a third-party purchaser. When all the residents were to be covered by the health-care insurance scheme, the expansion of the health-care insurance coverage would protect residents from the financial risks of diseases by building a stronger risk pool (Gu, 2009, p. 118). Thus, patients' obligations to think of themselves—and act—as consumers could be reduced by systemic health-care reform. As a regulator, the health-care insurance management centre should also play the role of exercising bureaucratic control over health-care costs. The income of physicians would be delinked from the profits they generated for public hospitals. Physicians were thus not obliged to be sensitive to the profits and costs of the health-care services they provided or recommended.

Sanming's systemic reform echoes the overall direction of the Chinese health-care reform underlying the universal coverage of basic health care. In January 2009, the State Council issued the documents of the Opinions on Deepening Reform and the

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

Implementation Plan. What underlines the two documents is that basic health care should be provided by the state as a public good. As put by then Vice-Premier Li Keqiang, "the core concept behind the healthcare reform was to provide a basic healthcare system as a public good" (Li, 2011, p. 6). The vision of the universal coverage of basic health care—that is, "where all people and communities have access to quality health services where and when they need them, without suffering financial hardship" (World Health Organization, 2021)—deposits the principle that all citizens should have access to basic health-care services irrespective of means. This principle was also borne out by the central commitment to playing a more important role in public health financing. In 2016, the central government integrated urban and rural health-care insurance schemes to establish a unified health-care insurance system.[20] The Law of People's Republic of China on the Promotion of Basic Medical and Healthcare (中华人民共和国基本医疗卫生与健康促进法, hereinafter "Basic Health Law") promulgated in 2019 formally mandates the state's obligation to finance the basic health-care provision.[21] The realization of the universal coverage of basic health care seeks an extension of the scope of trust to encompass the relations between citizens and the state. With universal coverage of basic health care in operation, citizens' feeling of financial anxiety and mentalities of thinking and acting as if they are rational health-care consumers when ill will be greatly reduced, if not eliminated. With the expansion and deepening of insurance coverage, health-care insurance schemes will also have the opportunity to use their expanded purchasing power to negotiate better terms of agreements with health-care service providers, which cannot be achieved by patients individually.

Despite this, the practice of weak and incompetent health-care insurance schemes points to a relationship between state and citizen that is different from the one proclaimed to be accomplished by the overall health-care reform plans. Again, take Sanming's reform as an example. In Sanming's reform, patients' choices and demands were also collected and transferred via the health bureau to public hospitals (Zhan, 2014, p. 82). When criticism was received from patients, the hospital dean's salary would be reduced (Zhan, 2014, pp. 82–4). While citizens had the right to give feedback on their experiences of receiving treatment, opinions about medical expenditures, etc., they did not have the right to participate in the public deliberation on making the standards and parameters within which public hospitals might compete with each other. The standards were made by the health-care insurance centre and public hospitals; citizens could not express their dissatisfaction with the performance of the health-care insurance centre by shifting to another purchaser. In this sense, the health-care insurance centre was not obliged to ensure the selection of the most effective health-care service in response to each particular health-care need of citizens (Ramesh, Wu and He, 2014, p. 669). In this sense, instead of sticking to the principle that access to the health-care services was on the criterion of basic needs, the operation of the health-care insurance scheme always tended to rely on the principle that access to health-care services was on the criterion of the financial security of the insurance fund.

This is simply one way to understand the insufficient responsiveness of the state to the health needs and interests of citizens. Political leaders in China have responded to the social needs out of a range of considerations, including local economic conditions, policy targets set by the central government, social risks, and the like (Huang, 2015, pp. 449–74).

[20] Opinions of the State Council on Integrating the Basic Medical Insurance System for Urban and Rural Residents (国务院关于整合城乡居民基本医疗保险制度的意见) issued by the State Council on 3 January 2016, available at –http://www.gov.cn/zhengce/content/2016–01/12/content_10582.htm (accessed 16 April 2021).

[21] Art. 5(1) of the Basic Health Law recognizes that all citizens have equal rights to basic public health and health-care services. Art. 5(2) further specifies the legal obligations of the state to ensure their access to public health and basic health-care services; see Law of People's Republic of China on the Promotion of Basic Medical and Healthcare (中华人民共和国基本医疗卫生与保健促进法) adopted by the National People's Congress on 28 December 2019.

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

Given that local political leaders have to take into account all the social, fiscal, and political factors, the competency of the health-care insurance scheme to effectively respond to the health needs of the local population are often cast in doubt. This was especially so during the COVID-19 pandemic. Since the outbreak of the pandemic, physicians have played crucial roles in containment, diagnosis, and treatment. Their commitment to treatment has demonstrated a selfless and heroic figure of benevolent saviours that has generated patients' trust in them (Qiushi, 2021). By contrast, the role played by the Chinese social health insurance was subject to criticism of sustainability (Sun et al., 2021, pp. 14–21). A document called the Opinions on Deepening Healthcare Insurance System Reform (中共中央国务院关于深化医疗保障制度改革的意见, hereinafter "Opinions") was issued by the CPC Central Committee and the State Council on 25 February 2020.[22] The Opinions outline the reform objectives to be reached respectively by 2025 and 2030, the measures to improve the security and sustainability of the social health-care insurance system, as well as the principles to enhance the competence of the health-care insurance reform. While the Opinions intended to increase the sustainability of the health-care insurance system, the fund of the health-care insurance schemes suffered a serious deficit during the pandemic. In this sense, fiscal security will continue to be the primary concern for the Chinese social insurance schemes.

Thus, as identified and discussed in this section, while the systemic health-care reform has sought to achieve the objective of expanding the bond of trust between physician and patient to encompass the relations between health-care insurance schemes and citizens via the universal coverage of basic health care, the health-care insurance schemes have been still incompetent and insufficient to perform the obligations and functions to realize the objective.

5. Conclusion

This article has sought to explain the ethical requirements of informed consent and the changing types of accompanying obligations in the context of Chinese health-care reforms. The changes in the obligations are the results of design—political choices made by the state. Since the early 1980s, Chinese medical practice has undergone a remarkable transformation. As the literature cited in this article attests, the doctrine of informed consent was incorporated into the Chinese medical context, seeking to empower patients and establish a bond of trust between physicians and patients. However, the public provision of health-care services was in tatters from 1978 and 2002. In the two rounds of health-care reform afterward, some economic and political factors—namely marketization of health care, public hospital reform, and systemic health-care reform—have deeply shaped the practices of physicians and patients. Despite the implementation of the right to informed consent and other legal mechanisms in the field of health care, the obligation practices hidden behind the incorporation of rights suggest that the bond of trust between physicians and patients threatened to collapse. After the initiation of the current round of health-care reform across China, although it intends to provide health care as a public good, the concrete health-care policies also reveal erosion of the obligation practices by the double logic of bureaucratic control and market competitiveness.

From this point of view, as China expands the pilot initiative of systemic health reform, it is necessary not only to improve the purchasing capacity of the medical insurance funds, but also to expand the roles and functions of the medical insurance funds to include the obligations of increasing their responsiveness to the health needs of patients. To this end,

[22] State Council, Opinions on Deepening Healthcare Insurance System Reform (中共中央国务院关于深化医疗保障制度改革的意见), available at http://www.gov.cn/zhengce/2020-03/05/content_5487407.htm (accessed 15 July 2022).

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

in addition to improving competition between health insurance schemes to provide better conditions for health services to their members, strengthening the performance of the other-regarding obligation can be linked to two aspects of concrete legal and policy proposals. On the one hand, the recent Opinions of the State Council highlight its emphasis on the regulatory obligations and roles of health-care insurance schemes to respond to the health needs of citizens. If the State Council's Opinions can be effectively implemented by concrete social and health-care policies as planned, then citizens' bond of trust towards the health-care insurance schemes may be improved; otherwise, to the extent that citizens have limited power to express their health needs and interests, their vulnerability to health-care providers will be aggravated and their sense of financial anxiety in case of illness may not be eliminated.

On the other hand, citizens should not be merely passive recipients of health care; rather, they have obligations to respect medical professionals and to save the health-care resources of the state. The Basic Health Law has engaged with what may be called the civic sense of individual obligation. By taking the form of normative specification, it specifies particular types of obligations that citizens as obligation bearers should have. For instance, citizens are required to respect medical professionals, reflect on their lifestyle, take measures that promote their health and prevent illness, and adopt preventive measures suggested by their physicians.[23] This set of obligations can be characterized as self-binding. The self-binding obligations also have the other-regarding dimension as they are related to the bond between citizens—which suggests that they owe obligations to other citizens who are bound together by the health-care insurance schemes with finite public resources (Evans, 2007, pp. 689–94; Brazier, 2006, pp. 397–422). For example, if someone is advised by their doctor to drink less or smoke less, and they disregard this advice when their health deteriorates, with the consequence that costly treatment and enormous health resources have to be invested to save them, their medical treatment is liable to the opportunity costs of other citizens. In this sense, the fulfilment of obligations derived from the idea of patients as citizens—for example, respecting physicians, following their advice to take preventive measures, and leading a healthy lifestyle—constitutes a form of solidarity among citizens in the context of health care. Since the fulfilment of these obligations by citizens also contributes to saving the health-care resources of the state, the bond between citizens and health-care insurance institutions is also strengthened.

Acknowledgements. The author appreciates Professor Li Chen, Professor Taisu Zhang, and other contributors to the Special Issue for their comments. The author also extends her thanks to the support by the Guangdong Planning Office of Philosophy and Social Sciences Planning for the project (广东省哲学社会科学规划2021年度青年项 目《疫情常态化下全球正义新理念及国际法治化实现框架研究》) (GD21YFX06).

References

Baier, A. (1986). "Trust and Antitrust." *Ethics*, 96(2): 231–60.

Bok, S. (1982). *Secrets: On the Ethics of Concealment and Revelation*. New York: Pantheon Books.

Brazier, M. (2006). "Do No Harm—Do Patients Have Responsibilities Too?", *Cambridge Law Journal*, 65(2): 397–422.

Chen, Meei-Shia. (2001) "The Great Reversal: Transformation of Health Care in the People's Republic of China." In W. Cockerham & D. Hendry, eds., *The Blackwell Companion to Medical Sociology*, 456–82. Hoboken: John Wiley & Sons.

China Health Yearbook Editorial Committee. (1983). *Zhongguo Weisheng Nianjian [Yearbook of Public Health in the People's Republic of China]*. Beijing: Renmin Weisheng Chubanshe [People's Health Publishing House].

Cong, Yali. (2004). "Doctor-Family-Patient Relationship: The Chinese Paradigm of Informed Consent." *Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy*, 29(2): 149–78.

Davies, B. (2020). "The Right not to Know and the Obligation to Know." *Journal of Medical Ethics*, 46(5): 300–3.

[23] Arts 57, 69 of the Basic Health Law.

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

Ding, Chunyan. (2007). "Yihuan Guanxi yu Xiaofeizhe-Jingyingzhe Guanxi: Jiekai Zhengyi de Miansha [Physician-Patient Relationship v. Consumer–Provider Relationship: Lifting the Veil of the Debate]." *Journal of Law and Medicine*, 14(3): 184–94.
Draper, H. & T. Sorell. (2002). "Patients' Responsibilities in Medical Ethics." *Bioethics*, 16(4): 335–52.
Ebner, A. (2015). "Marketization: Theoretical Reflections Building on the Perspectives of Polanyi and Habermas." *Review of Political Economy*, 27(3): 369–89.
Evans, M. (2007). "Do Patients Have Duties?" *Journal of Medical Ethics*, 33(12): 689–94.
Faden, R. R. & T. L. Beauchamp. (1986). *A History and Theory of Informed Consent*. New York: Oxford University Press.
Fan, Ruiping. (1997). "Self-Determination VS. Family Determination: Two Incommensurable Principles of Autonomy." *Bioethics*, 11(3): 309–22.
Fan, Ruiping & Mingxu Wang. (2015). "Taking the Role of the Family Seriously in Treating Chinese Psychiatric Patients: A Confucian Familist Review of China's First Mental Health Act." *Journal of Medicine and Philosophy*, 40(4): 387–99.
Fu, Hongqiao et al. (2017). "An Evaluation of Systemic Reforms of Public Hospitals: The Sanming Model in China." *Health Policy and Planning*, 32(8): 1135–45.
Gu, E. (2001). "Market Transition and the Transformation of the Health Care System in Urban China." *Policy Studies*, 22(3): 197–215.
Gu, E. (2009). "Towards Universal Coverage: China's New Healthcare Insurance Reforms." In Dali Yang & Litao Zhao, eds., *China's Reforms at 30: Challenges and Prospects*, 117–35. Singapore: World Scientific Publishing.
He, Alex Jingwei. (2011). "Combating Healthcare Cost Inflation with Concerted Administrative Actions in a Chinese Province." *Public Administration and Development*, 31(3): 214–28.
He, Alex Jingwei. (2018). "Manoeuvring within a Fragmented Bureaucracy: Policy Entrepreneurship in China's Local Healthcare Reform." *The China Quarterly*, 236: 1088–110.
He, Alex Jingwei & Jiwei Qian. (2013). "Hospitals' Responses to Administrative Cost-Containment Policy in Urban China: The Case of Fujian Province." *China Quarterly*, 216(216): 946–69.
He, Alex Jingwei & Jiwei Qian. (2016). "Explaining Medical Disputes in Chinese Public Hospitals: The Doctor-Patient Relationship and its Implications for Health Policy Reforms." *Health, Economics, Policy and Law*, 11(4): 359–78.
He, Zhaoxiong & Lixing Chen, eds. (1985). *Yixue Lunlixue Gailun [Introduction to Medical Ethics]*. Nanjing: Jiangsu Science and Technology Publishing House.
Hesketh, T. & Wei Xing Zhu. (1997). "Health in China: The Healthcare Market." *BMJ*, 314(7094): 1616–18.
Hisao, W. (1995). "The Chinese Health Care System: Lessons for Other Nations." *Social Science & Medicine*, 41(8): 1047–55.
Huang, Xian. (2015). "Four Worlds of Welfare: Understanding Subnational Variation in Chinese Social Health Insurance." *The China Quarterly*, 222: 449–74.
Huang, Yanzhong. (2003). *Mortal Peril: Public Health in China and Its Security Implications*. Washington, DC: Chemical and Biological Arms Control Institute.
Huang, Yanzhong. (2013). *Governing Health in Contemporary China*. New York: Routledge.
Kaba, R. & P. Sooriakumaran. (2006). "The Evolution of the Doctor-Patient Relationship." *International Journal of Surgery*, 5(1): 57–65.
Katz, J. (2002). *The Silent World of Doctor and Patient*. Baltimore: Johns Hopkins University Press.
Kleinman, A. et al. (2011) "Introduction." In A. Kleinman et al., eds., *Deep China: The Moral Life of the Person*, 1–35. Berkeley: University of California Press.
Li, Keqiang. (2011). "Buduan Shenhua Yigai Tuidong Jianli Fuhe Guoqing Huiji Quanmin de Yiyao Weisheng Tizhi [Continue to Deepen the Healthcare Reform, Promote the Establishment of the Medical and Health System that Suits the National Conditions and Benefits All the People]." *Qiushi*, 22: 3–10.
Li, Ling & Hongqiao Fu. (2017). "China's Health Care System Reform: Progress and Prospects." *The International Journal of Health Planning and Management*, 32(3): 240–53.
Liebman, B. L. (2013). "Malpractice Mobs: Medical Dispute Resolution in China." *Columbia Law Review*, 113(1): 181–264.
Liu, Xingzhu & W. Hsiao. (1995). "The Cost Escalation of Social Health Insurance Plans in China: Its Implication for Public Policy." *Social Science & Medicine*, 41(8): 1095–101.
Liu, Yuanli. (2002). "Reforming China's Urban Health Insurance System." *Health Policy*, 60(2): 133–50.
Luhmann, N. (1982). *Trust and Power: Two Works by Niklas Luhmann*. Chichester, New York, Brisbane, Toronto: John Wiley & Sons.
Marsh, S. & M. Dibben. (2005). "Trust, Untrust, Distrust and Mistrust: An Exploration of the Dark(er) Side." In P. Hermann, V. Issarny & S. Shui, eds., *International Conference on Trust Management*, 17–33. Berlin: Springer.
Nie, Jing-Bao. (2011). *Medical Ethics in China: A Transcultural Interpretation*. London: Routledge.
Nie, Jing-Bao et al. (2017a). "The Crisis of Patient-Physician Trust and Bioethics: Lessons and Inspirations from China." *Developing World Bioethics*, 18(1): 56–64.

https://doi.org/10.1017/als.2024.3 Published online by Cambridge University Press

Nie, Jing-Bao et al. (2017b). "The Vicious Circle of Patient-Physician Mistrust in China: Health Professionals' Perspectives, Institutional Conflict of Interest, and Building Trust Through Medical Professionalism." *Developing World Bioethics*, 18(1): 26–36.
No author. (1981). "Yide Lunli Daode Xueshu Taolunhui Jiyao [Proceedings of the Colloquium on Medical Ethics]." in Medicine and Philosophy, ed., *Yide Lunwen Ji [Collection of Essays on Medical Ethics]*, 6–9. Unpublished.
Qian, Xinzhong. (1981). "Yanjiu Yixue Lunlixue Tigao Yixue Daode Shuiping [Studying Medical Ethics Improving Medical Ethics]." *Yixue yu Zhexue [Medicine and Philosophy]*, 1: 1–2.
Qiu, Renzong. (1987). *Shengming Lunlixue [Bioethics]*. Shanghai: Shanghai People's Publishing House.
Qiu, Renzong, Zhuo Xiaoqin & Feng Jianmei. (1996). *Bingren de Quanli [Patients' Rights]* (病人的权利). Beijing: Beijing Medical University and Peking Union Medical College.
Qiushi. (2021). "Heros of the Fight Against COVID-19," http://en.qstheory.cn/2021–03/18/c_603662.htm (accessed 28 November 2023).
Ramesh, Mit, Xun Wu & Alex Jingwei He. (2014). "Health Governance and Healthcare Reforms in China." *Health Policy and Planning*, 29(6): 663–72.
Raposo, V. L. (2019). "Lost in 'Culturation': Medical Informed Consent in China (From a Western Perspective)." *Medicine, Health Care and Philosophy*, 22(1): 17–30.
Raz, J. (1984). "On the Nature of Rights." *Mind*, 93(370): 194–214.
Rothman, D. J. (2003). *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*. New York: Walter de Gruyter.
Sun, Shuangyi et al. (2021). "COVID-19 and Healthcare System in China: Challenges and Progression for a Sustainable Future." *Globalization and Health*, 17(1): 1–8.
Supiot, A. (2017). *Governance by Numbers: The Making of a Legal Model of Allegiance*. Oxford, Portland, OR: Hart Publishing.
Tang, Lu & Mengfei Guan. (2018). "Rise of Health Consumerism in China and Its Effects on Physicians' Professional Identity and the Physician-Patient Relationship and Communication." *Health Communication*, 33(5): 636–42.
Veitch, K. (2019). "Obligation and the Changing Nature of Publicly Funded Healthcare." *Medical Law Review*, 27(2): 267–94.
Veitch, S. (2015). "Common Good No More? Some Jurisprudential Reflections on European (Dis)Integration." In J. Ellsworth & J. ven der Walt, eds., *Constitutional Sovereignty and Social Solidarity in Europe*, 139–64. Baden-Baden, Germany: Nomos/Bloomsbury.
Veitch, S. (2017). "The Sense of Obligation." *Jurisprudence*, 8(3): 415–34.
Veitch, S. (2021). *Obligations: New Trajectories in Law*. London, New York: Routledge.
Wang, Mingxu, Ma Le & Yuen Hui. (2013). "Informed Consent in Chinese Medical Practice: The Whole Family as a Decision-maker." *International Journal of Chinese & Comparative Philosophy of Medicine*, 11(2): 141–5.
Wang, Shaoguang. (2008). "State Extractive Capacity, Policy Orientation, and Inequality in the Financing and Delivery of Healthcare in Urban China." *Social Sciences in China*, 29(1): 66–87.
Wang, Shaoguang. (2010). "China's Double Movement in Health Care." *Socialist Register*, 46: 240–61.
Wang, Shaoguang & Peng Fan. (2013). *Zhongguoshi Gongshixing Juece: "Kaimen" yu Mohe [The Chinese Model of Consensus Decision-making: A Case Study of Healthcare Reform]*. Beijing: China Renmin University Press.
World Health Organization. (2021). "Universal Health Coverage and Health Reform in China," https://www.who.int/china/health-topics/universal-health-coverage (accessed 28 November 2023).
Yan, Yunxiang. (2018). "The Ethics and Politics of Patient-Physician Mistrust in Contemporary China." *Developing World Bioethics*, 18(1): 7–15.
Zhan, Jifu (2014). *Sanmingshi Gongli Yiyuan Zonghe Gaige [Comprehensive Reform of Public Hospitals in Sanming City]*. Fuzhou: Fujian People's Press.
Zhao, Xiju. (2008). *Yishifa Yanjiu [Study on Medical Law]*. Beijing: Law Press China.
Zhao, Xiju. (2013). *The Duty of Medical Practitioners and CAM/TCM Practitioners to Inform Competent Adult Patients about Alternatives*. Heidelberg: Springer.
Zhu, Wei. (2009). *Shengming Lunli zhong de Zhiqing Tongyi [Informed Consent in Bioethics]*. Shanghai: Fudan University Press.
Zuo, Yilu. (2024). "Ideological and Cultural Policy as Speech Policy: An Overlooked Aspect of Speech Rights in China." *Asian Journal of Law and Society*, forthcoming.

Cite this article: Liu J. Obligation, Informed Consent, and Health-Care Reforms in China. *Asian Journal of Law and Society*. https://doi.org/10.1017/als.2024.3