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Interactions of Actors and Local Institutions in Policy Process – From Patriotic Health Campaign to Healthy City in Shanghai

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Submitted by:

Jiaying Lin

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Jiangsu, China

Reviewers:

Prof. Dr. Dr. h. c. Bernhard Müller, Technische Universität Dresden, Germany

Prof. Dr. Zhiqiang Wu, Tongji University, China

Univ.-Prof. Dr. Matthias Naumann, Alpen-Adria-Universität Klagenfurt, Austria

Date of defense: 19/03/2021

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SUMMARY

The majority of the world's population lives in urban areas, and more and more people are migrating to urban areas. However, the health hazards of urban life affect the population as well. They often suffer from non-communicable diseases, cardiovascular diseases, cancer and psychosocial problems. To address the increasing concerns about urban health, the WHO developed health promotion initiatives, known as the Healthy Cities programmes in 1986, which aim to place health high on the agendas of decision-makers and to promote comprehensive local strategies for health promotion and sustainable development. It successfully engages local governments in health development from thousands of cities worldwide in both developed and developing countries, including China.

In 1994, China started to develop Healthy City pilot projects in the name of Healthy Cities with the suggestion of the WHO. However, the Chinese government started related activities about the environment and health long before WHO introduced the concept of Healthy Cities. The Patriotic Health Campaign was launched in 1952; despite it being a social movement that was not exclusively oriented to urban areas, it paved the way for Healthy Cities programmes in China. Since 1984, the National Government developed more than 40 policies and National Hygienic Cities to improve the urban environment and support Healthy Cities-related activities. However, the implementation of national policies depends on local level actions where collaboration across sectors is problematic, especially since different ministries tend to work separately according to their own prioritized programme.

Shanghai is the first mega-city in China to initiate the action for Healthy City development. It was successful in raising high standards for the health status of the population and improving the urban environment in a quantitative way. However, institutional change, especially intersectoral collaboration remains a big challenge for the implementation. Therefore, it would be interesting to know how the local actors develop the Healthy City programme in the specific context of China.

However, there is a lack of empirical studies on the Healthy City programme, and few studies focus on intersectoral relationships in Healthy City development; some researches only include limited actors, and some fail to identify the local institutional settings and connect with the international context. On this background, it looks into the policy making processes of making different programmes at different stages as well as the respective modes of policy implementation. This research aims to unfold how local actors develop the Healthy City programme in Shanghai.

Two propositions are guiding the analysis: first, whereas policies in China are mainly developed on a national level where everyday challenges of individual local level entities do not play a decisive role, Healthy City policies are implemented on the local level (of cities or city districts) where municipal specificities and local conditions heavily influence the action potentials and actions of authorities and other stakeholders. Second, whereas Healthy City-oriented policies are comprehensive in nature, their implementation is rather fragmented and sectoral.

The study applies an approach that is influenced by the discussion about actor-centered institutionalism. The interpretive lens of actor-centered institutionalism is taken to identify the main actors, analyse how they interact with each other, and the underlying institutional settings that are crucial to interpreting policy making and policy implementation. The study will also find out whether the actor-centered institutionalism approach is fully applicable under the conditions of China, or whether certain modifications are to be made.

The research follows a qualitative approach, collecting data from multiple sources such as documents, including historic documents in archives, and interviews, combining a variety of research methods including stakeholder analysis, discourse analysis and network analysis. Shanghai is used as a case study as it has the longest experience with the implementation of Healthy City programmes in China, and was also the first to issue a Healthy City Action Plan in 2003. It established the first municipal committee for health promotion in 2005. Whereas the older programmes are analysed based on documents, the latest Healthy City programme is scrutinised by employing document analysis and interviews of different stakeholders in order to get an in-depth understanding of the policy making and implementation processes.

This thesis aspires to contribute to the empirical knowledge of the development of public policies, the understanding of actors and actor constellations in Healthy City programmes with reference to specific institutional settings in China, and examining the compatibility and limitations of this interpretive lens in the Chinese context. Moreover, policy recommendations related to practice in Shanghai are provided as further motivation and commitment to Healthy City development in China.

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ABBREVIATIONS

CCGCEP	Central Commission for Guiding Cultural and Ethical Progress
CHSMG	Citizen health self-management group
GASC	General Administration of Sport of China
HCAP	Healthy City Action Plan
HCP	Healthy Cities Programmes
HDAP	Healthy District Action Plan
HPC	Health Promotion Committee
MOH	Ministry of Health
NCC	National Civilised City
NHC	National Hygienic City
NHCPRC	National Health Commission of the People's Republic of China
NHFPC	National Health and Family Planning Commission
OECD	Organization for Economic Co-operation and Development
PHC	Patriotic Health Campaign
PHCC	Patriotic Health Campaign Committee
SMAS	Shanghai Municipal Administration of Sport
SMHPC	Shanghai Municipal Health Promotion Committee
SMPG	Shanghai Municipal People's Government
SPHCC	Shanghai Patriotic Health Campaign Committee
UN	United Nations
WHO	World Health Organization
WPRO	WHO Western Pacific Region

1 INTRODUCTION

This chapter introduces the background of urbanisation and health in the Global Era. Reactions to urbanisation include international movements, such as Healthy Cities by the World Health Organization, and local adaptions in mega-cities like Shanghai. After describing the state of the problem, research gaps are identified within the chapter, and research objectives are defined. The chapter closes with a presentation of the overall thesis structure.

1.1 BACKGROUND

> *As the place of possible cures, it creates illness; as the last hope of the hopeless, it is the citadel of death.*
>
> *- Greer, 1983, p. 7*

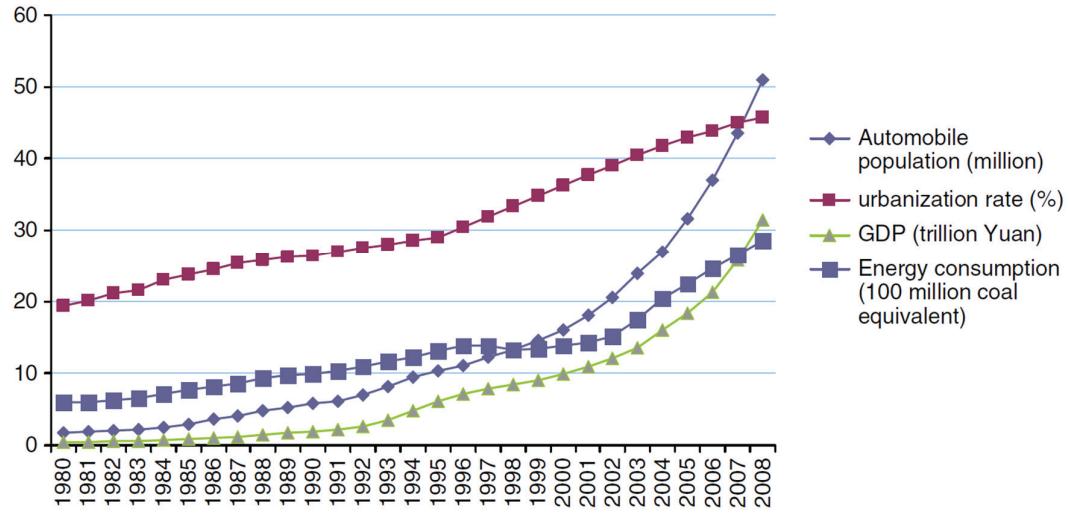
1.1.1 Urbanisation and health

There has been a long history where people clustered in small areas with high population densities. In 1400, more than 350 million people occupied land of 11 million square kilometres; only 2% of the earth's surface. Even nowadays, 70% of the world's population still lives in those same areas, which includes China, India and Europe (Marks, 2006).

In the last 100 years, the world has experienced rapid urbanisation. In 1900, only 17 cities had more than 1 million inhabitants. This number increased to 380 cities in 2000 (Satterthwaite, 2007). There were only 2 mega-cities in 1950 with populations of 10 million or more (UN, 2006). In 2014 this number had increased to 28 and was expected to reach 41 by 2050 (UN, 2014). Among these mega-cities, 6 were located in China alone (UN, 2014). A report by the OECD suggests the number may even exceed 15 megacities when considering functional urban areas (OECD, 2015).

Urban development in China is scaling at an unprecedented speed (see Figure 1.1). In 2011, more than half of the Chinese population lived in cities, compared to 18% in 1978 (Xinhua, 2016), More than 500 million people moved into the cities over the last three decades. Further growth of 240 million is likely to be seen by 2050 when the urbanisation rate is predicted to reach around 75% (OECD, 2015).

Figure 1.1 Urbanisation rate in China



Source: Kan, Chen and Tong (2012)

However, a side effect of the country's meteoric economic rise in recent decades has been severe pollution in major cities (in air, water and soil). This has led to increased public dissatisfaction that has unnerved the ruling Communist Party. Around two-thirds of China's soil is estimated to be polluted, and 60% of underground water is too contaminated to drink (Kaiman, 2014). Corruption and politically weak local environmental protection bureaus have contributed to the fact that China is the world's largest emitter of greenhouse gases, and many firms cut regulatory corners (Agence France-Presse, 2015).

In many Chinese cities, air quality is extremely poor. After the Government released the revised air quality standard in February 2012, all cities at the prefecture level or above were to be scaled up to the standard by 2015. To date, two-thirds of cities do not meet the new national standard (WHO Regional Office for the Western Pacific, 2016). In the 25 cities at or above the prefecture level in the Yangtze River Delta, only one city met the mean annual PM2.5 concentration standards. PM2.5 was deemed as the primary pollutant on the largest number of days throughout the year 2014, followed by O3 and PM10.

In December 2013, a lack of cold airflow, combined with slow-moving air masses carrying industrial emissions, collected airborne pollutants to form a thick layer of smog over the region. The Eastern China smog affected East China, including all or parts of the municipalities of Shanghai and Tianjin, and the provinces of Hebei, Shandong, Jiangsu, Anhui, Henan, and Zhejiang. Levels of PM2.5 particulate matter averaged over 150 micrograms per cubic metre; in some areas, they were 300 to 500 micrograms per cubic metre, which is 'severely polluted' according to the Air Quality Index (Li *et al.*, 2015) in

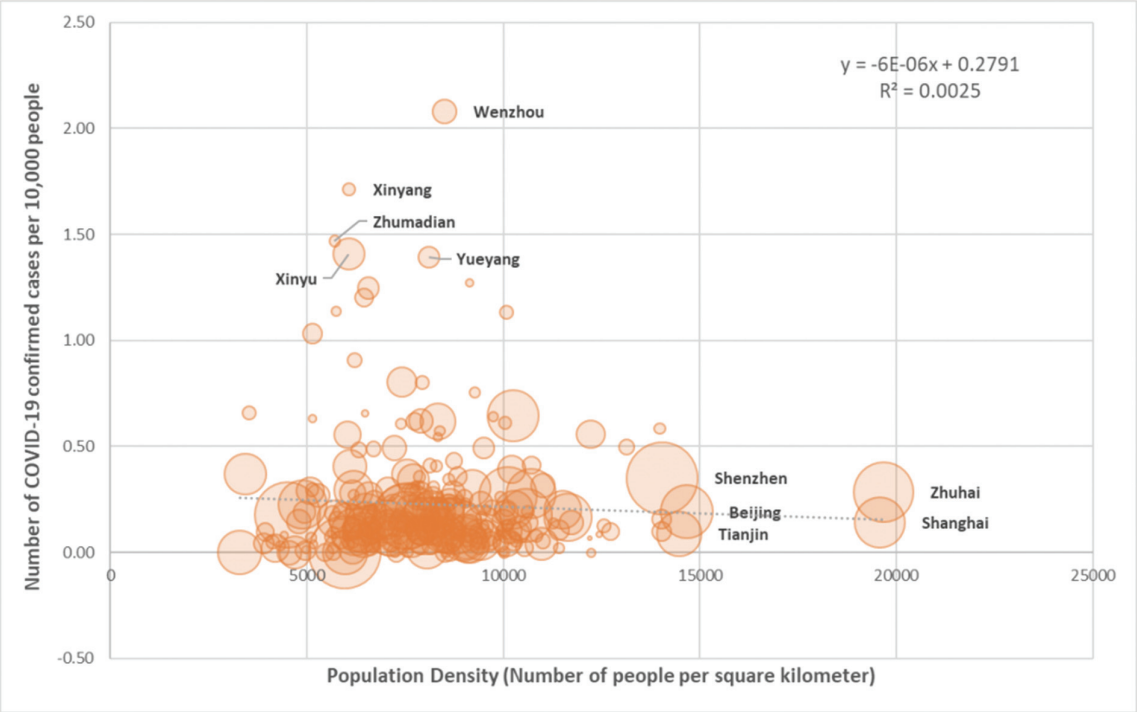
China, *20 times* the value of WHO air quality guideline (24-hour concentration of particular matter 2.5: 25 μg/m^3).

Air pollution has a huge adverse health effect on the world's population. A considerable number of deaths are attributable to modifiable environmental risks, with 23% (95% CI: 13–34%) of all deaths, and 22% (95% CI: 13–32%) of the disease burden in DALYs (Disability Adjusted Life Years) (Prüss-Üstün *et al.*, 2016). More than 5.5 million people globally die prematurely every year due to household and outdoor air pollution (Brauer et al., 2015). Increased exposure to air pollution was found to be associated with significant mortality risks and respiratory diseases (Shang et al., 2013) (Gong et al., 2012). Premature deaths owing to outdoor air pollution are estimated at 400,000 per year in China (OECD, 2015). An increase in outdoor air pollution (PM10, SO2, and NO2) corresponded to increases in daily mortality in Shanghai, for all causes examined (Wong et al., 2008).

Furthermore, health has a large impact on the economic aspect. On the one hand, the economic and human costs of environmental risks are high and rising: it was estimated that the total economic cost of health impacts due to particulate air pollution in urban areas of Shanghai in 2001 was approximately 625.40 million US dollars, accounting for 1.03% of the gross domestic product of the city (Kan and Chen, 2004). On the other hand, the World Bank and Harvard University estimated that 8% to 10% of global economic growth in the last 40 years was contributed by the improvement of population health. 30 to 40% of the economic miracle in Asia came from the improvement of local people's health (Wang, 2012b).

In the recent case of the worldwide COVID-19 pandemic, public concerns that population density is linked with COVID-19 cases and deaths have been raised. However, evidence from China and the USA show that density is not a key determinant of coronavirus transmission risk. Data collected from 284 Chinese cities show that cities with the highest coronavirus infection rates are those with relatively low population densities; cities with very high population densities such as Shanghai, Beijing, and Shenzhen have had far fewer confirmed cases per 10,000 people (see Figure 1.2). The group of dense cities have higher GDP per capita, which possibly allows them to mobilize enough financial resources to cope with the coronavirus (Fang and Wahba, 2020). Similarly, research in 913 metropolitan counties in the United States finds that counties with higher densities have significantly lower virus-related mortality rates than do counties with lower densities, possibly due to superior health care systems (Carozzi, Provenzano and Roth, 2020; Hamidi, Sabouri and Ewing, 2020).

Figure 1.2 Infection rate of coronavirus and population density of Chinese Cities



Source: Fang and Wahba, 2020

These findings suggest that connectivity matters more than density in the spread of the COVID-19 pandemic. While urbanisation brings a higher density of population and better connectivity to the urban areas, large metropolitan areas with a higher number of counties tightly linked together through economic, social, and commuting relationships are the most vulnerable to the pandemic outbreaks. Therefore, urban planners should continue to advocate for dense development as long as better health care systems are provided (Hamidi, Sabouri and Ewing, 2020).

1.1.2 International movement of Healthy Cities

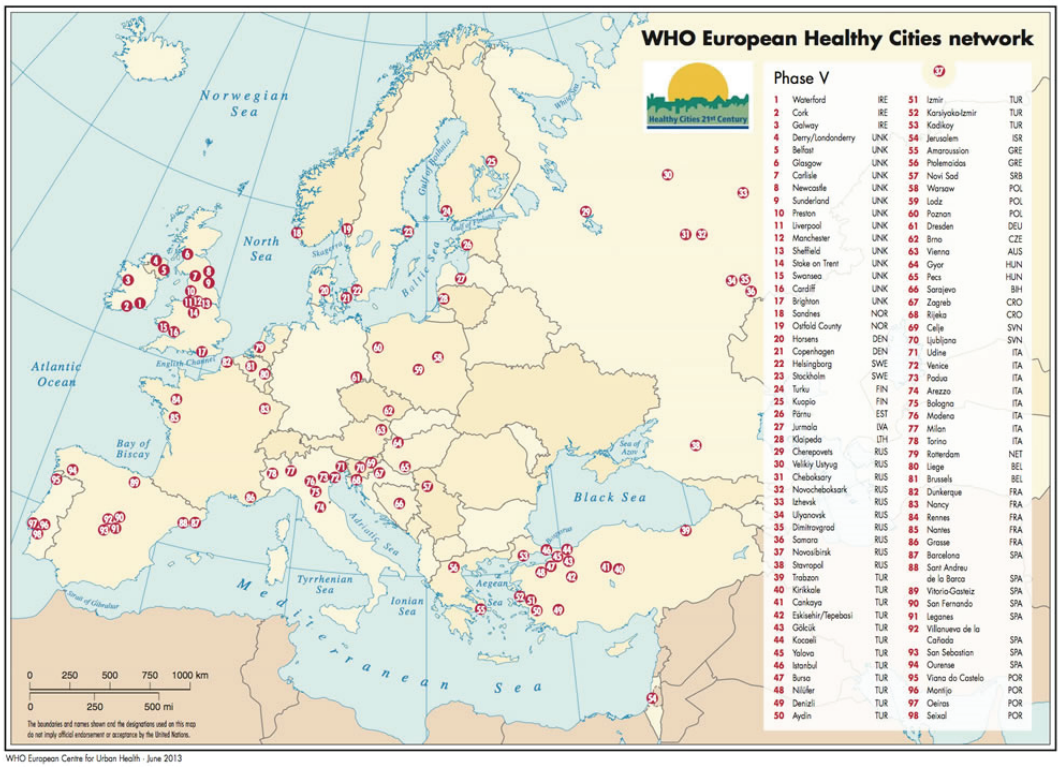
The WHO European Healthy Cities Network was formally launched in 1986 to improve the health of cities and their citizens, and to bring the WHO strategy 'Health for All' to the local level. It is based on the recognition of the importance of local action in all aspects of developing health; the specificity and importance of urban settings for health and well-being; the key role of local governments in creating conditions and supportive environments for healthy living for all (Tsouros, 1991a; Tsouros, 2015).

The creation of the WHO European Healthy Cities Network was inspired and influenced by several international and local developments including Health for All, the Ottawa Charter for Health Promotion and important initiatives in Canada and England (Tsouros, 2015). The "Beyond Health Care" conference held in Toronto in 1984 provided the

platform for the beginning of a new synthesis bringing an ecological and holistic approach to health together with the WHO strategy of Health For All based on health promotion (Ashton, Grey and Barnard, 1986).

In January 1986, a small group of health promoters gathered at the WHO Regional Office for Europe in Copenhagen to plan a WHO Europe Healthy Cities project (HCP). The WHO Europe HCP began with a Healthy Cities symposium in Lisbon in April 1986, attended by fifty-six participants from twenty-one cities and seventeen countries. Eleven cities were selected for the WHO project in 1986, growing to thirty-five cities by 1991 (Hancock, 1997). There are now thousands of cities worldwide participating in the Healthy Cities network, with more than 1,000 cities in the WHO European region alone (see Figure 1.3) (Agence France-Presse, 2015).

Figure 1.3 Cities in WHO European Healthy Cities network Phase V



Source: WHO European Centre for Urban Health, 2013

The first International Conference on Healthy Cities and Communities held in San Francisco attracted nearly fourteen hundred participants from dozens of countries and helped to stimulate wider international activity, as well as more activity in the United States. By then, national networks had also developed in countries such as Iran, Saudi Arabia, Egypt, Yemen, Tunisia, and Morocco, and regional networks were developing in Africa, Southeast Asia, and the West Pacific.

In November 2016, the 9th Global Conference of Health Promotion, co-organized by WHO and the National Health and Family Planning Commission of the People's Republic of China, was held in Shanghai. Leaders from governments and international organisations, mayors, and health specialists from around the globe formed two landmark commitments to promote public health and eradicate poverty: the Shanghai Declaration on Health Promotion, which committed to form bold political choices for health, stressing the links between health and well-being, and the United Nations 2030 Agenda for Sustainable Development and its Sustainable Development Goals and the Shanghai Healthy Cities Mayors' Consensus, that contains a commitment by more than 100 mayors to advance health through improved management of urban environments (WHO, 2016).

1.1.3 Local actions in Shanghai

The rapid urban growth and transformation of Shanghai is not a simple result of imposed globalisation from the outside, but rather conditioned by and filtered through local development. Globalising cities are actively promoted by their local agents, especially growth-oriented governments at both national and local levels (Wu, 2000).

Globalisation mobilizes a new mode of urban governance. There has been a shift in Shanghai's accumulation strategy, from the production-oriented view of economizing urbanization to the improvement of services provided (gateway of China) and urbanism (image creation and town beautification). Globalisation, rather than being a definite outcome, is a political discourse embedded in a complicated process. (Wu, 2000).

In the new century, Shanghai has experienced fast economic growth but the subsequent problems grow more serious each day. For example, issues with urban and suburban eco-environment, residents' health needs, unhealthy living habits, and the challenge of medical care and hygiene services brought by changes in the ageing and disease spectrum.

As a result, the importance of promoting people's health, improving the city environment, raising people's health level, and enlarging people's horizons became formally acknowledged. The Patriotic Health Campaign, a movement for improving urban and rural health settings, was launched more than 60 years ago. It needed to be changed and reformed according to the new challenges in urban health. In the 21st century, as part of the national strategy, Shanghai had announced a development programme to build an international modern megalopolis with one harbour and four centres. The city was aiming to increase its comprehensive competence by building a Healthy City with a harmonious society, environment and residents.

Shanghai was the first megacity in China to start a Healthy City movement. The first three-year plan for the Healthy City Action Plan (HCAP) was issued in 2003, initiating 8 programmes; these included building a healthy environment, providing healthy food and promoting a healthy lifestyle for city inhabitants. Practices were drawn up following the action plan. The first focused on government guidance and the cooperation among different government sections. The second was to motivate social participation and build a diverse guarantee system. Thirdly was to improve the project management and establish rules to implement the system. The fourth was to develop an inclusive human-oriented atmosphere.

From a global perspective, HCP started comparatively late in China. A large population, rapid urbanisation, and unsustainable development all pose more challenges to the construction of Healthy Cities. Currently, the Health Promotion system features government-led, intersectoral collaboration and public participation. By building a mature platform and system of intervention, Shanghai provides an example to address the city's potential health-threatening factors. Projects such as the Citizen health self-management groups (CHSMG), the Fitness for all programme (FAAP), and the government-financed 'health gift pack' (health reading material and health instruments) demonstrated innovative ways of health promotion.

During the COVID-19 pandemic in 2020, Shanghai introduced public health actions such as testing, contact tracing, isolation and quarantine in a timely manner, and combined these with physical distancing and mask-wearing. These measures have been effective in containing early outbreaks of the virus, despite high density increasing the risk of infection.

The effective work at the community level was essential to the city's success in public health programmes. One of the local actions was realised under the structure of *"xiaoqu"*, which are residential conglomerates in which organized committees promote community cohesion and a sense of belonging; they also ensure that the rules are followed at the neighbourhood scale (e.g., garbage collection, safety, community health). During the pandemic, these neighbourhood committees were responsible for taking the temperature of the people at the entrance of each residential compartment as well as attending to the most vulnerable inhabitants (den Hartog, 2020 cited in Fransen, Ochoa and Sonneveld, 2020).

The case of Shanghai indicates that higher population densities can be a blessing rather than a curse in fighting epidemics. Due to economies of scale, cities often need to meet a certain threshold of population density to offer higher-grade facilities and services to their residents. For instance, in dense urban areas where the coverage of high-speed internet and door-to-door delivery services are conveniently available at competitive prices, it is

easier for residents to stay at home and avoid unnecessary contact with others (Adlakha and Sallis, 2020).

1.2 PROBLEM STATEMENT

In this section, problems in health city development are identified, including the interdependent actors, the fragmented actions, and the authoritarian institutions.

1.2.1 Interdependency of actors

To improve the health of a city, a coalition of partners from many different sectors must be forged. The health care sector is but one partner among equals, rather than being the dominant force (Hancock, 1997). Interdependencies among actors in policy networks don't receive the attention they deserve (De Bruijn and Ten Heuvelhof, 2008; Klijn and Koppenjan, 2015), while the close interdependency between the interests of local government actors and other actors needs special attention (de Jong et al., 2016).

It is in the city that the greatest variety of skills, resources and talents are available. City governments are often the closest level of government to residents that have the mandate, the authority and the administrative resources needed to bring together the wide variety of skills and resources needed for a multi-sectoral approach to health (Hancock and Duhl, 1986).

For example, Shanghai is often considered the role model for other cities in China, as a major city with the biggest contribution to GDP in China. The municipality is not only learning from the best practices in the world but also developing standards sometimes higher than in developed countries. At the 9th Global Conference of Health Promotion, the Shanghai model of Healthy City development got praised by the Director-General of World Health Organization Margaret Chan as "Public participation, the way to health".

However, the local government sometimes plays a conflicting dualistic role - as the manager of the local economy, and as the vanguard for shouldering environmental responsibilities (Xu, 2015a). It is for this reason that it is difficult to implement public policies related to environmental issues at the local level.

In the case of the Healthy City Programme, the implementation role of local government is clearly defined in the guidance from the international community (e.g. Regional Framework for Urban Health in the Western Pacific 2016-2020 by WPRO). In practice, however, a Healthy City as a whole-of-local-government responsibility remains an elusive challenge for national governments (Tsouros, 2015). Shanghai is not an exception.

1.2.2 Fragmented actions

Most stakeholders in health promotion partnership agree that the partnership is both a process and a product; it is hard work to build and maintain the partnership and to have it deliver its intended outcomes (Lipp, Winters and de Leeuw, 2013).

Fragmentation in the horizontal level among different ministries and the subordinate municipal departments also contributes to the problem of coordination. In China's policy regime, 'fragmented authoritarianism' of attributes to cross-sectoral rivalries, results in sheer intricacy in real-world practice (Xu, 2015a).

Since there are many parallel national programmes from different ministries going on, among which there are Garden City, Eco-city, Smart City, etc., it is easy to imagine the workload and the fragmentation among municipal departments. Challenges were identified including lack of motivation for Healthy City development, restraint within the health sector regardless of the emphasis on multi-sectoral collaboration; low research level compared to the high demand of development; and declining coordination ability of Patriotic Health Campaign work (Luo, 2011; Wang, Xie and Sheng, 2016).

In some respects, cities may be seen as the potential or actual "victims" of national and international policies. A gap exists between high-level national policies and local practice implementation (de Jong et al., 2016). For instance, although Shanghai was initially chosen by the national government to be the pilot project in 1994, the lack of support from the ministries has placed challenges on the compliance of different sectors in the following implementation.

Evaluations done on Shanghai Healthy City development have shown the imbalance in the intersectoral collaboration and the reaction of the public to the policy outcome of different sectors. Representatives of governmental sectors also expressed the difficulties in intersectoral coordination (Liang *et al.*, 2009). In the process of making the first two rounds of the Shanghai Healthy City Action Plan, government departments are still the most decisive part, especially the officers who are in charge of the health promotion committee. The other participants including citizens, NGOs, and expert consultant groups have less of an impact on policy changes (Gu, 2009).

A consensus-oriented approach among relevant stakeholders and a responsive government with an active citizenry were not observed; the level of integrated implementation leaves much to be desired (de Jong, 2013). Even in Shanghai, it is still restrained by the regulatory style which can be characterized as formal in requirements, agency-dominated in the regulatory process, legalistic in enforcement, with informal politics being the substance of regulation (Lo, Yip and Cheung, 2000).

1.2.3 Authoritarian institutions

China is a bureaucratic-authoritarian one-party state, in principle highly centralised but in practice substantially decentralised. China's system is bureaucratic-authoritarian, which means it is not an individual leader but the Communist Party that has the ultimate authority over the land and the people, directs the government and military, and selects leaders who are subject to limited terms. Although legally there are other parties, China is in reality a one-party state, and the Communist Party heavily influences or directly controls all organised activities (Kroeber, 2016).

Under this premise, the conflict between the authoritarian institution and effective governance concentrates on the tense incompatibility between the central control and the local governance. The central government tends to retain the power and resources, reducing the ability for problem-solving of the local governments and the effectiveness of authoritarian governance. Meanwhile, the local governments tend to be uncoordinated and out of the control of the central government, which threatens the authority of the central government (Zhou, 2017).

Two major institutions are embedded in the authoritarian state: bureaucracy and uniformed ideology. Both are difficult to maintain. The bureaucratic system cannot afford the growing functions of the governance, while the uniformed ideology is challenged by the diversity within society. A series of mechanisms are developed to deal with the tension: unified decision-making and flexible implementation, dynamic balance among multilevel agencies, the ritualisation of political propaganda, and the correction mechanism of campaigns (*ibid.*).

Although these mechanisms aim to resolve the conflicts between authority and effectiveness, there are still potential crises underlying these mechanisms. First, the state is constantly balancing between extremes: centralisation and decentralisation, fame and reality, deviation and correction. These can easily turn into social instability. Second, the logic of the system restrains the innovation and potential of the institutions, making the process of legislation, rationalisation, and professionalisation difficult (*ibid.*).

1.3 RESEARCH OBJECTIVES

Generally speaking, very few investigations exist into the disciplinary area of urban policy (Cui and Yang, 2007; Zhang, 2016), especially for HCP as a combination of complex urban issues. Studies about Healthy Cities in China have not developed substantially on a theoretical basis. Theoretical background for such studies is either limited or the analytical tools need adaptation according to the context of China, such as the health promotion

checklist (Gao *et al.*, 2012; Peng *et al.*, 2012; Zhao, 2010) and SPIRIT framework (Huang et al., 2011).

Economic reforms in China have triggered a significant shift of power from the central to the localities. In large cities such as Shanghai, power has been further decentralised to district governments. For example, the establishment of urban land leasing has introduced various actors into the game of urban development. Globalisation reinforces the form of urban governance, which is characterised by more decentralised, fragmented, ambiguous and constantly redefined power relationships between various levels. Therefore, studies are needed to examine the change in urban governance, in particular, how globalization interacts with the legacy of socialist development and how a range of local institutions such as the administrative system, fiscal relationships, and urban politics are remoulded under globalisation (Wu, 2003).

More empirical studies on the policy process of HCP in China are needed. Most evaluations conducted on HCP focused on the improvement of the health effect from a medical perspective (Gao *et al.*, 2012; Zhang, Cao and Li, 2012; Zhao, 2010), and most analyses are contextual and evaluative (Chen, 2010; Gu, 2009; Luo, 2011). The effectiveness of government departments and community participation were evaluated separately (Gu *et al.*, 2009; Liang *et al.*, 2009; Yang, 2010), but to the author's knowledge, the mechanism of the institutions behind Healthy City programmes has not been studied yet.

The investigations discussed above provide useful background for the current study. However, there are still some research gaps in the previous literature surrounding Healthy City development in China. For example:

- Some studies only include limited actors, for example only governmental departments (Liang *et al.*, 2009), or within the health sector (Peng *et al.*, 2012), although Healthy City requires more sectors to involve;
- Few studies focus on intersectoral relationships in Healthy City development, which are an important factor in the successful implementation of the Healthy City programme;
- Different countries have different institutional contexts, which current studies on Healthy City programmes in China failed to identify and connect with the international context;
- There is a lack of empirical evidence on Healthy City programmes; some of them only rely on literature, others fully rely on quantitative analysis, and in-depth qualitative studies are limited.

Discussion of the Healthy City programme in this study includes consideration of the initiatives made by the Chinese government from the Patriotic Health Campaign in the

1950s, National Hygienic Cities in the late 1980s, until the latest Healthy Cities in the 1990s. This has been based on the challenges identified in the Healthy City development in China, and the fact that the majority of policy-focused publications failed to report on how the process of policy making to implementation unfolded. It is now imperative to conduct empirical studies to generate evidence of implementation practices in public policy (Chircop, Bassett and Taylor, 2015). Ahlers and Schubert (2015) suggest focusing on the interactions between the different administrative tiers to understand local policy implementation in terms of procedural and outcome effectiveness.

The main research objective of the current thesis is to understand the policy interaction of actors and the institutions they are embedded in, as concerns the gaps in implementation. The Healthy City programme in Shanghai is taken as the case study. Two propositions guide the current analysis: First, whereas policies in China are mainly developed on a national level, where the everyday challenges of individual local level entities cannot play a decisive role, Healthy City policies are implemented at the local level (of cities or city districts), where municipal specificities and local conditions heavily influence the action potentials and actions of authorities and other stakeholders. Second, whereas Healthy City-oriented policies are comprehensive, their implementation is rather fragmented and sectoral.

There are two perspectives involved in understanding the development of Healthy City programmes in Shanghai:

1. **Time perspective**

Key policymakers and the people and institutions tend to disagree on the time frame of evaluating the actions. Time can certainly alter the perceptions of the outcome of a public policy or project; the standards for judging the policy outcomes also change as the process unfolds. In addition, the lifetime of a policy or programme may deviate from the intention. Therefore, the analysts should go beyond the original mission statements of policymakers and continue to monitor the effects (Hart, 2017).

The temporal objectives of policies may vary in terms of scope (short-term, medium-term, long-term policies are quite common in economic policy planning, e.g. the Annual report, Five-Year Plan, and 2040 master plan) and quality (unique/non-recurrent versus permanent/iterative policies) (Hart, 2017 e.g. the).

Many policies rely on short-term and quantifiable indicators to measure their impact, which is likely to result in negative evaluations. It often happens that policies aimed at short-term effects are continued beyond their original term of operation. The policy in question may have become embraced by powerful institutional interests (Hart, 2017).

2. Scale perspective

Scales are amongst the fundamental categories and concepts that social actors use to make sense of and construct their worlds. Actors perceive their social worlds by imagining them as consisting of hierarchically ordered structures of space – scales – to which they assign labels such as the 'local', 'national' or 'global' (Papanastasiou, 2017). Empirical case studies of policy actors' accounts of their implementation work in China also show that hierarchical scales, from central to local and horizontal scales spread among different ministries, are categories of scales used by actors to make sense of and strategically construct their social worlds (de Jong *et al.*, 2016; Zheng, De Jong and Koppenjan, 2010).

Scale also allows insights into how, under conditions of multi-level governance, divergent discourses can be linked to different policy arenas, constituting complex and possibly unequal opportunity structures for different groups of actors (Feindt and Oels, 2005, p.168 cited in Xu J., 2015). The changing relations between the centre and subnational authorities evolve dramatically and have been the centre of debates and research (Cartier, 2011; Li and Wu, 2012).

From the institutional point of view, institutions vary in different contexts (Scharpf, 1997). Regarding the formal institutions, the state power is exercised through people's congresses at national and various local levels (National People's Congress, 2021). An intersectoral programme such as Healthy Cities in Shanghai also requires collaborations at the horizontal level among different ministries and the subordinate municipal departments (see section 1.2.2). Therefore, besides the vertical categories from central to local, the horizontal categories covering different ministries and subdivisions at the municipal level are also included (Zheng, De Jong and Koppenjan, 2010).

To understand whether there is a process between collaborated and fragmented actions at different administration tiers during policy making to policy implementation, the matrix below is created to guide the research.

Table 1.1 Research matrix

		Time	
		Policy making	**Policy implementation**
Scale	**Vertical**	Local/Central	Local/Central
	Horizontal	Collaborated/Fragmented	Collaborated/Fragmented

Source: own compilation

The time perspective refers to the process from policy making to policy implementation, the objective is to analyse how the comprehensive approach in policy agenda becomes

fragmented in policy implementation, and how this condition evolves during the development of Healthy City programmes.

The space perspective is defined by two settings of policy networks in China (Zheng, De Jong and Koppenjan, 2010): the vertical one is the hierarchy from central government to local governments; the horizontal one is spread among different ministries at the national level and commissions at the municipal level. From the aspect of competing institutional logics, this perspective is to analyse how implementation gaps in Healthy City programmes occur.

1.4 STRUCTURE OF THE DISSERTATION

The following two chapters explain the background of the current research, both in practice and in theory. The current chapter gives an overview of urbanisation and health in globalisation, and how the Healthy City movement developed as a reaction to this. The main challenges are identified, the rationale of the research is provided, and the research objectives based on these phenomena are formulated.

Chapter 2 reviews the theoretical consideration of interaction-oriented research. This moves from new institutionalism to game theory. Then, it explains the major concepts in the analytical framework of actor-centered institutionalism and establishes the research questions and corresponding propositions that guide the empirical analysis.

Chapter 3 focuses on the research design and methodological approach. After an introduction of the research design, an overview of the research area is presented. Next are data collection methods, as well as the sampling process and data analysis methods.

Chapters 4, 5 and 6 deal with the main research questions separately.

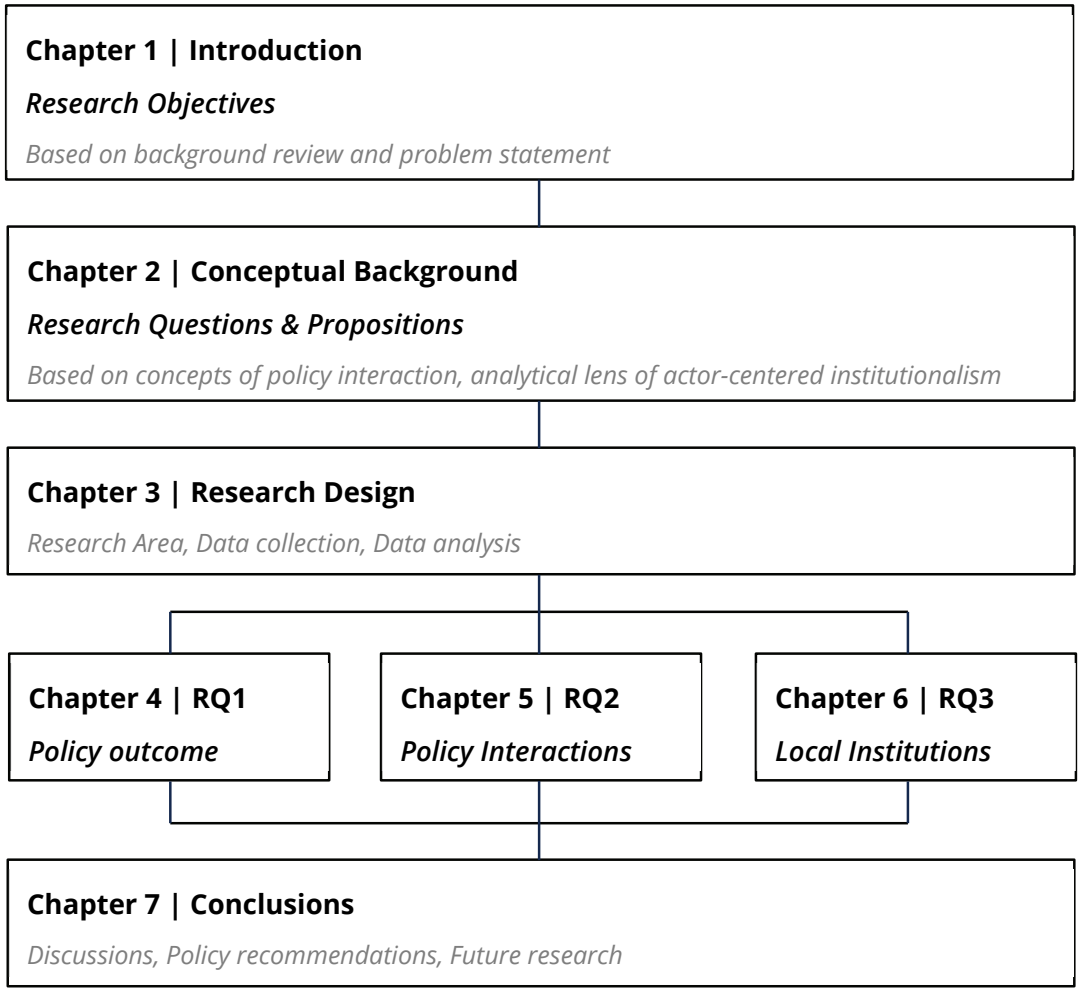
Chapter 4 identifies the convergence and divergence of Healthy City discourse in the international and Chinese contexts. The history of Healthy City development is reviewed both as a WHO movement and a local campaign.

Chapter 5 identifies the main actors in the Healthy City programme from different levels. The modes of interaction are mapped on the actor constellations in the Healthy City programme. The actors' orientations on Healthy City programmes and their capacities are analysed.

Chapter 6 gives an insight into the institutional settings in both formal and informal aspects, to understand the local context in China and Shanghai, thus explaining the patterns of actors and actor constellations.

Chapter 7 discusses the results of the research. Recommendations on policy making to implementation are provided, limitations of the current study are reflected and future directions for research are suggested.

Figure 1.4 Structure of the thesis



Source: own draft

2 CONCEPTUAL BACKGROUND

The previous chapter presented the background of the research and the research objectives. This chapter aims to provide an overview of existing knowledge regarding the research subjects within academic research. The theoretical lens taken in this research will be presented. Furthermore, the sensitising concepts which form the analytical framework will be explained. The chapter concludes with the research questions and propositions to guide the empirical analysis.

2.1 LITERATURE REVIEW

This section provides an overview of the research on Healthy Cities in China and other countries. It is then put into the context of policy research. Key concepts such as governance, actor and institution, health policy and Healthy Cities, will become the knowledge base for this dissertation.

2.1.1 Health in social science

Social conditions have always been concerned with the influence on the health and well-being of a population. In the late nineteenth century, the disciplines of public health and social sciences emerged along with the recognition of the needs of the poor and marginalized groups and the association between living conditions and health. It was not until the mid-twentieth century that professionally trained social scientists became actively involved in public health programmes. The most important challenges for improving health in the twenty-first century involve social, cultural and behavioural change. Political and economic constraints deeply rooted in the social order define what structural change is feasible (Coreil and Dyer, 2017).

In the nineteenth century, social theorists in Europe called attention to the unequal distribution of infectious diseases among the poor and working classes, citing unhealthy living conditions in crowded urban slums, inadequate diet, and physically taxing labour as contributing to the poor health of the disadvantaged. Many important figures contributed to a broad discourse that framed public health issues as socially produced, often referred to as ‘social medicine’. The contributions of this period are significant for establishing the idea that public health is a social science and that social structures and change generate population-level health effects. However, the turn of the century ushered in the bacteriological era, and attention shifted to the discovery and control of biological pathogens in the early decades of the twentieth century (*ibid.*).

The growth of social and behavioural science applications in public health was strengthened by the redefinition of health in 1948 by the newly formed World Health Organization (WHO) as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.” Since that time, WHO and other national and international organisations have affirmed the importance of psychosocial well-being as an integral component of health. This expanded conceptualization of health required the expertise of many disciplines to formulate policies and design programmes to improve health conditions around the globe (*ibid*.).

Throughout the twentieth century, the public health enterprise underwent a significant transformation as a result of a radical shift in focus from infectious diseases to chronic conditions as the major challenges to population health in industrialised societies. As chronic disease and disability became the focus of public health interventions, the role of social and behavioural factors became increasingly important for disease prevention and control. With their focus on broad social processes and macro-level determinants, the social sciences helped to redefine the public health agenda as one integrally concerned with policy, economics, social organisation, and cultural dynamics across diverse institutions. This shift is built upon advances in the professional development of these disciplines, theoretical and methodologic contributions, and political advocacy on the part of diverse communities (*ibid*.).

At the turn of the twenty-first century, important events and publications marked the maturation of the field and recognition of the significance of ‘higher-level’ analysis of the social and cultural aspects of health. A large knowledge base on the upstream social determinants of health has amassed over the past three decades and continues to grow, providing evidence of the link between health outcomes and social factors such as neighbourhood conditions, working conditions, education, income, wealth, race and racism, stress, early childhood experiences, immigration, and the intergenerational transfer of advantage (e.g., Braveman et al., 2011; Castañeda et al., 2015).

Anthropology, sociology, political science, demography, gerontology, and other social sciences made important contributions to this reframing of public health. Because public health by definition is concerned with issues in the arena of social action, political science offers important perspectives on policy analysis, health legislation and regulation, the influence of commercial interests on health care, and the relationship between the political system of a society and its public health agenda. In fact, social scientists from various backgrounds including anthropology and sociology have adopted critical stances on public health issues, applying political-economic analyses to problems such as reproductive health, HIV/AIDS, health disparities, and the plethora of health problems affecting the poor and disenfranchised (*ibid*.).

When the social aspect of health was gaining more attention, research on Healthy Cities also started in some Western countries. Hancock and Duhl (1986) initially shaped the following definition: "a Healthy City is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and developing to their maximum potential". Later, it was extended to the following description: A Healthy City is defined by a process and not just an outcome. A Healthy City is not one that has achieved a particular health status level; it is conscious of health and striving to improve it. Thus, any city can be a Healthy City, regardless of its current health status; what is required is a commitment to health and a structure and process to achieve it (Tsouros 1991).

Evolution was not limited to the Healthy City concept following the WHO stream, but also included different understandings of a Healthy City according to people's interests, disciplinary background, culture, and values. For an economist, a Healthy City might replace imports in a positive frenzy of creativity and innovation (Jacobs, 1984 cited in Hancock and Duhl, 1986), while to a sociologist, it may promote equality and social cohesion; to an urban planner, a Healthy City may be one with good physical characteristics such as housing, infrastructure and open space; while for an epidemiologist, it should be one with high health status; for the WHO it may promote health for all, enabling attainment by all citizens of a level of health that will permit them to lead a socially and economically productive life; and for a person on the streets, being able to make a living, move around safely, meet their friends and feel free to carry out all functions of life, is what a Healthy City can provide (Hancock and Duhl, 1986).

Although research in China started later than in other countries, it has developed rapidly. Studies on the Healthy Cities in China started in the 1990s when the Healthy Cities development in the world and its concept were introduced (Fu, Xuan and Li, 2006; Huang, 2002; Yu and Qian, 1998; Zhou *et al.*, 2000). A popular proverb in Chinese is that among the many needs that people have, health is the most important. Without health, nothing else can be achieved (Wang, 2005). Fu, Xuan and Li (2006) defined a Healthy City as:

> *"...one that put people's health in the centre in every aspect from urban planning, construction to management. It aims to secure healthy life and work of citizens and forms a development entity of organic combination of healthy people, healthy environment and healthy society which is necessary for the development of human society (p. 14)".*

Since the actual construction of Healthy Cities in China began in 2003, more studies are focused on the strategy development (Fu, Xuan and Li, 2006; Huang, 2002; Luo, 2011; Lv and Sun, 2007; Xu and Zhong, 2005; Yang, 2004b) and feasibility analysis (Xu, Cheng and Ma, 2006; Xu *et al.*, 2013) in the Yangtze River Delta, including Shanghai (Gu, 2009; Xuan *et*

al., 2003; Zhao, 2010), Suzhou (Ai, 2004; Gao *et al.*, 2012; Huang, 2006; Xie, 2005), Hangzhou (Liu, Zhang and Zheng, 2009; Zhang, Cao and Li, 2012), and Ningbo (Xu, Cheng and Ma, 2006).

Later, in the 2010s, once Healthy City practices were established in China, opinions on the status quo and challenges started to emerge. Luo (2011) identified problems of insufficient infrastructure construction, the limitation of public health-oriented perceptions, and the low capacity of dealing with rapid changes in the environment, while Yue et al. (2016) studied 15 Healthy Cities in China and concluded that the China Healthy Cities initiative was associated with significant improvement of infrastructure construction, yet had little impact on the urban environment in terms of green space and air quality.

Based on a cite space analysis conducted on 2282 articles on Healthy Cities and healthy urban planning inside and outside of China, in terms of research topics and content, research from outside China first focused on urban sanitation and the physical space environment of a good living environment, then gradually shifted to focus on racial equality, social security, community culture, institutional environment and other social justice and environmental psychology. In contrast, research in China is still focusing on public health and the provision of facilities in physical space. Regarding collaborations among researchers and organisations, Chinese scholars are scattered with a low connection between the individuals and research institutes. In contrast, scholars and organisations outside China collaborate much more frequently and form more clusters than the researchers and organisations in China (Li and Wen, 2019).

Currently, the level of research on Healthy Cities is still low compared to the high demand for development. There are several weaknesses in the current status: Lack of master planning; the feasibility of urban planning needs to be improved; the coordination ability of the Patriotic Health Campaign Committee declined; the connotation and content of Healthy Cities need to be extended; the level of public awareness is low; health literacy needs to be improved; lack of motivation for the Healthy City development; the role of NGOs needs to be enhanced; and there is very little training for talents compared to plenty of programme tasks (Wang, Xie and Sheng, 2016).

2.1.2 Health in political science

> *Health is ultimately a political choice.*
>
> *- Tsouros, 2015, i3*

Politics plays a critical role in health affairs. Politics is essential in determining how citizens and policymakers recognise and define problems with existing social conditions and

policies, in choosing certain kinds of interventions over others, and in putting restraints on policy implementation. If science can identify solutions to public health problems, then only politics can possibly turn these solutions into reality (Oliver, 2006).

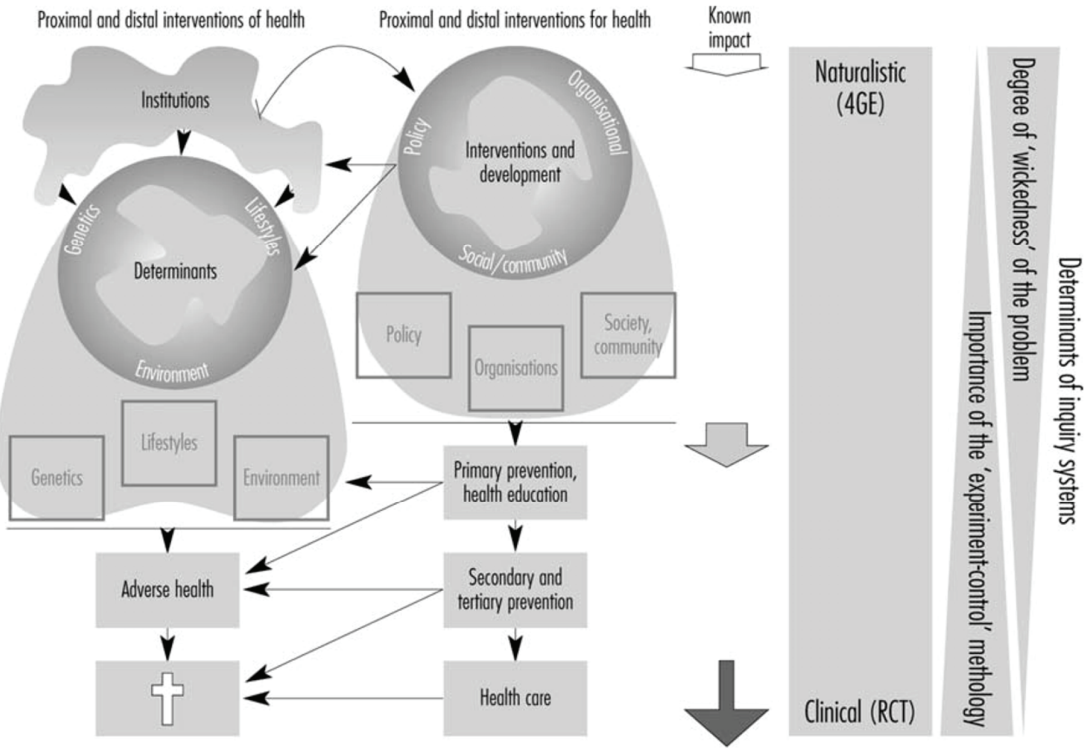
The number of policy-related articles is growing (Breton and De Leeuw, 2010), and an increasing number of studies apply political science concepts and theories, such as policy entrepreneurs (Béland and Katapally, 2018); the Advocacy Coalition Framework [29, 30] that emphasises the importance of coalition formation of camps of proponents and opponents to new policy directions (Brooks, 2018); the policy network theory coming from different perspectives on network governance (Zheng, De Jong and Koppenjan, 2010); and Social Movement Theory, which argues that disenchanted people will join social movements in order to mobilise resources and political opportunity to change public policy to their advantage (Arnold *et al.*, 2018; de Leeuw, Clavier and Breton, 2014).

Generally speaking, public health research tends to focus on generating evidence for policy recommendations or focusing on evaluating the impact of recent policies, rather than understanding the policy-making process (Bernier and Clavier, 2011; de Leeuw, Clavier and Breton, 2014). However, claims have been emerging that the political determinants of health do not receive due consideration (Bernier and Clavier, 2011; Greer *et al.*, 2017). This is because many public health professionals seem to limit themselves to a technical advisory role and consider engaging with the political system to be outside their area of expertise or mandate (Greer *et al.*, 2017).

The Healthy Cities movement employs a wide range of political, social, and behavioural interventions for the development of urban population health, and the ambition to address institutional change for health. After reviewing Healthy Cities methodologies through the first three phases of the WHO European Healthy Cities Network (WHO-EHCN), de Leeuw (2009) summarised a meta-theory for Healthy Cities (see Figure 2.1). The main elements in this conceptual framework are determinants of health, interventions for health, their 'known impact', and determinants of inquiry systems (the research methodology).

Institutions play an important role in Healthy City development. In each Healthy City, different unique contexts determine the variety of (theoretical) conceptualisations identifying different models. To a significant extent, the observed and valued degree of impact of a determinant on the health problem is the result of existing institutions in the given context. In the specific context of each city, institutions may take different shapes, employ different (political) paradigms and guide different operational actions. Institutions are not only the overarching notion of health determinants, but also impact parameters of different interventions for health (de Leeuw, 2009).

Figure 2.1 Health determinants and interventions and associated inquiry systems



Source: de Leeuw (2009)

Governance is an important issue in Healthy City development (de Leeuw, 2015; Mao and Zeng, 2008). The concept of governance originates from different disciplines and is multidimensional (Pyone, Smith and van den Broek, 2017). The concept of governance for political scientists focuses on 'formal institutions, accountability, trust and legitimacy' for governance (Pierre and Peters, 2005). They are interested to see how collective decisions are made among key actors (both government and non-government actors) with different levels of power. Thus, governance from political science and public administration focuses on both input (the processes) and output (results of governing networks) (Chhotray and Stoker, 2009).

The governance processes associated with the functions create incentives that condition the extent to which the various actors involved fulfil their roles and responsibilities, and interact with each other, to achieve public purposes. Good governance results when these incentives encourage and pressure both state and non-state actors to be efficient, effective, open, transparent, accountable, responsive, and inclusive (Li and Ren, 2010).

Governance of the health system is the least well-understood aspect of health systems. Health governance is about developing and putting in place effective rules in the institutional arenas for policies, programmes, and activities related to fulfilling public health functions to achieve health sector objectives. These rules determine which societal

actors play which roles, with what set of responsibilities, related to reaching these objectives (Brinkerhoff and Bossert, 2008). Key issues considered around health governance includ the role of the state vs. the market; the role of the ministries of health vs. other state ministries; the role of actors in governance; static vs. dynamic health systems; and health reform vs. human rights-based approaches to health (Siddiqi *et al.*, 2009).

Health system governance is complex and difficult to assess. A comprehensive assessment of governance could enable policymakers to prioritize solutions for problems identified as well as replicate and scale-up examples of good practice. Studies reviewed the frameworks that were developed to assess governance in the health system and found that the frameworks were developed based on theories from new institutional economics; political science and public management disciplines; as well as development literature and multidisciplinary approaches. Few of the frameworks identified in social science have been applied in empirical studies. These applied frameworks use the principal-agent theory, theory of common-pool resources, North's institutional analysis and cybernetics theory (Pyone, Smith and van den Broek, 2017).

The most commonly used theories which underpin the available frameworks originate from new institutional economics and include the 'principal–agent' theory, Douglas North's theory of institutional analysis and Elinor Ostrom's theory of 'common-pool resources'. Frameworks that originate from development literature tend to pre-define principles of governance and are the only ones attempting to measure governance. The majority of frameworks assess overall governance while some assess specific principles of governance such as accountability, corruption and patron-client relationships (*ibid.*).

The frameworks draw on the 'institutional analysis' theory of North (1990), originally derived from new institutional economics. Douglas North's theory of institutional analysis assumes that markets are created and maintained by institutions. North defined 'institutions' as the rules of the game and 'organisations' as the players. Institutions consist of formal rules and informal constraints while organisations consist of groups of individuals with common objectives (North, 1990). North's principal argument is that individuals within an institution have certain opportunities which are the result of specific formal and informal constraints that constitute the institutions.

Some frameworks appear to be based on principles of more than one discipline. These frameworks highlighted that institutional analysis is key to assessing governance to understand the institutional arrangement and rules set by the organisations. A mapping of the power distribution can be used to identify the key decision-makers who affect the behaviour of health system actors (Pyone, Smith and van den Broek, 2017). Institutional analysis is important for fulfilling the research objective of the dissertation and will be

included in the analytical framework. Further explanation about new institutionalism will be presented in section 2.2.

2.1.3 Health governance in China

To understand the context of Healthy Cities development in China, this section will focus on health governance in China. Research has been done on the stages of health governance, the main challenges in healthcare system reform, and the role of the state and the market. The recent research on health policy will be introduced.

Researchers identified the stages of health governance in China based on socio-economic status, level of health, and healthcare reform development. Fu (2015) divided health governance into three stages. The first stage started when the the People's Republic of China was established, with the focus on universal healthcare. The second stage began with the economic reform in 1978. In this stage, healthcare as a service was emphasized. The third stage began in 2003 when social segregation became an issue and public interests were valued with globalisation and urbanisation. Yang and Huang (2018) divided health governance into three types: the governance of population health, regional health and social system health. The categories follow the development of the health concept.

Summarising the points from previous research and connecting with the urban development stages and local actions mentioned in section 1.1 (summarised in Table 2.1), health governance in China is divided into the following stages. The focus of each stage is shaped by socio-economic status, urban-rural development stages, and the institutional settings in China.

Table 2.1 Urban development stages in China (1949-2016)

Year	Economy Stages	Urban/Rural Planning Stages	Urban Health Stages
1949	Planned Economy	Industry development	Life expectancy
1966	Cultural revolution	Rural development	Epidemic diseases
1979	Market economy	Urban development	Chronic diseases
2001	Global economy	Eco-development	Healthy lifestyle

Source: own compilation

1949-1978: Universal healthcare

China aimed to have universal healthcare for all. Social welfare was reflected in several schemes, such as labour insurance schemes, public health services, and rural healthcare schemes. Rural areas became the focus since 1965. Until 1976, 85% of the rural population was covered by the rural healthcare scheme. The Patriotic Health Campaign had a special position as an innovative way of public health work (Fu, 2015). During this period, the urbanisation rate in China was low, in which only 18% of the population lived in urban areas in 1978 (see section 1.1.1).

1979-2000: Health service

After the 1980s, efficiency replaced equity as the priority in reformation. Public institutions such as government-owned companies and people's communes were reformed and dissolved. The institutional settings that the healthcare schemes were based on were changed by the economic reform (Fu, 2015). Cities in China began to develop rapidly. It also influenced the discourse on health. Healthcare became a service product instead of social welfare.

2003-now: Public interest

Public interest came back to the picture of health policy. After the economic reform, the inequality in society and the gaps between urban and rural areas got bigger and bigger. The outbreak of SARS made the government and scholars reflect on the balance between efficiency and equality. A series of policies were issued on improving public health, paying attention to rural areas, and expanding health expenditure from the government (Fu, 2015).

Identifying the stages of health governance in China helps us to understand the development of Healthy Cities in China. A detailed analysis of the Patriotic Health Campaign to the Healthy City Action Plan in Shanghai will be presented in Chapter 4.

Since healthcare reform began in 2009, it became the main topic of health governance studies in China. Studies show that from 2003 to 2006, the studies focused on healthcare insurance systems, such as health care, health insurance, pharmaceutic health, and health service. From 2007 to 2013, research was related to health policy in China, including the new rural healthcare scheme, China's healthcare reform, basic medical and healthcare services, and public hospitals. During this period, research on medical and health policy in China also reached a peak since the 1950s. In the last five years, research has been focused on primary care and basic public service (Zhu *et al.*, 2019).

Researchers also identified the main challenges in health governance in China. These challenges also influenced the Healthy Cities development. Yang and Huang (2018) identified the challenges in the perception of health and the role of actors and institutions, the perception of health limited to physical health, and the importance of psychological and social health not being fully recognised. Health is emphasized at the individual level but not at the community and national level. The role of actors besides the government is not recognised. Health governance needs the collaboration of the public, private sectors, and society. The importance of institutions in health governance is not recognised, such as culture, economics, and especially politics.

Other researchers identified the challenges in the leading role of the government or the market. Some scholars blame excessive marketisation for the failure of the healthcare system. They believe healthcare should be social welfare instead of a service product. Therefore, the government should take the leading role in health governance. Other scholars believe the problem is from the control of the government causing insufficient health services in the market (Xiong, 2016).

Besides taking a stand against the government or the market, other scholars emphasized the role of institutions in facilitating health governance in China (Gu, 2005 cited in Xiong, 2016). Xiong (2016) studied policy instruments in China's healthcare policy (1978-2015) based on the level of dependence on government control. Results show that 49.1% of the policy instruments used were coercive, such as command and control. 36.2% were treasure-based or information-based policy instruments that did not rely so much on government authority to be effective, including subsidies, taxes, exhortations, and research inquiries. Voluntary policy instruments that entail no or little involvement by the government took up only 14.8%. The large proportion of coercive policy instruments reflected the dominant role of government in health governance. The low occupancy of voluntary instruments showed the low impact of actors in the society (Xiong, 2016).

The challenges were identified from the balance between the government and the market and the battle between control and incentives. The research on health policy reflected the issue of the tension between legitimacy and effectiveness in health governance in China (Xiong, 2016; Yan, 2019). Scholars emphasising the role of the market are concerned about efficiency. Scholars emphasising on social welfare characteristics of health focus on the legitimacy of health governance. Efficiency and legitimacy focus on different subjects and analyses. They also focus on different research questions and have different logic and mechanisms (see Table 2.2). They can complement each other in explaining behaviours at different levels.

Table 2.2 Comparison between efficiency and legitimacy

	Efficiency	**Legitimacy**
Analysis subject	Transactions	Institutions
Logic and mechanism	Motivations and behaviours of pursuing efficiency	Legitimacy mechanism and institution constraints
Focus of analysis	Interest relationships	Institutional settings and relations
Research question	Divergence of organisations	Convergence of organisations

Source: own compilation based on Zhou (2003)

Efficiency is generally focused on the individual level and legitimacy at the macro level. However, it can also be used across levels; for example, the efficiency mechanism can explain not only individual behaviours but also how the institutions come about (Zhou, 2003).

The efficiency perspective is taken in the transaction cost theory. It focuses on transactions to explain the efficiency mechanism. Legitimacy is the concern of institutionalism. Institutionalism focuses on the reason why a certain type of organisation has certain behaviours. The theoretical lens of legitimacy explains the influence of institutional settings on the action and form of organisations (Zhou, 2003).

From a causal relationship view, the theoretical lens of efficiency emphasizes the motivation and behaviour of the agents to pursue efficiency. In contrast, institutionalism considers agents to have limited capacities, while institutions shape the behaviour of people; for example, even on a weak level of legitimacy, people consciously use it to fulfil their self-interest (*ibid.*).

Debates around efficiency and legitimacy were inspired by new institutional economics and organisation theory. In this research, both perspectives will be used to explain behaviours at different levels in the policy process. Regarding the institutional approach discussed in section 2.1.2, the next section will further explain the theoretical lenses guiding the empirical research.

2.2 THEORETICAL LENSES

In this section, the theoretical lenses that guide the empirical research will be presented. More specific references to theory beyond the guiding lenses will be discussed in the course of the presentation of empirical results.

As mentioned in the last section, theories from new institutional economics, political science and public management were used to assess health governance. The debates over health governance in China focused on the tension between efficiency and legitimacy, which are based on new institutional economics and organisation theory. These theoretical lenses belong to the same stream of new institutionalism, which will be further discussed in this section.

2.2.1 Institutionalism

Institutionalism is a general approach to governance and social science. It concentrates on institutions and studies them using inductive, historical, and comparative methods. Institutionalism encompasses a range of methodological approaches in political science that have at their core an emphasis on institutions, understood as the rules, regularities, structures, and the more general context which influences political outcomes and shape political conduct (Bevir, 2009).

There is the old institutionalism, which was born in the United States in the early twentieth century, with Thorstein Veblen, Wesley Mitchell, and John Commons as its founding fathers (*ibid.*). Old institutionalism is concerned with the role of social structures, rules and conventions, organisations, and the habituation of economic actors in shaping how markets operate. Old institutionalists do not, therefore, embrace the methodological individualism or rational choice basis of conventional economics (Dequech, 2015).

Then there is the new institutionalism, developed since the 1970s when John Meyer published two seminal papers, “The Effects of Education as an Institution” and “Institutionalized Organisations: Formal Structures as Myth and Ceremony” (with Brian Rowan, ch.2) which set out many of the central components of neo-institutional thought. Meyer’s preoccupation with macro influences on local phenomena is evident in his early work on contextual effects on organisational research (DiMaggio and Powell, 1991; Meyer and Rowan, 1977).

In some quarters, the development of new institutionalism is a reaction against the behavioural revolution of recent decades, which interpreted collective political and economic behaviour as the aggregate consequence of individual choice. Behaviouralists view institutions as epiphenomenal, merely the sum of individual-level properties. But the cost of neglecting social context and the durability of social institutions became high in a world in which “social, political, and economic institutions have become larger, considerably more complex and resourceful, and prima facie more important to collective life (March and Olsen 1983:734 cited in Powell and DiMaggio, 1991).

Table 2.3 The old and new institutionalism

	Old institutionalism	**New institutionalism**
Conflict of interest	Central	Peripheral
Source of inertia	Vested interests	Legitimacy imperative
Structural emphasis	Informal structure	Symbolic role of formal structure
Organisation embedded in	Local community	Field, sector, or society
Locus of institutionalization	Organisation	Field or society
Organisational dynamics	Change	Persistence
Basis of critique of utilitarianism	Theory of interest aggregation	Theory of action
Evidence for critique of utilitarianism	Unanticipated consequences	Unreflective activity
Key forms of cognition	Values, norms, attitudes	Classifications, routines, scripts, schema
Cognitive basis of order	Commitment	Habit, practical action
Goals	Displaced	Ambiguous
Agenda	Policy relevance	Disciplinary

Source: adapted from (DiMaggio and Powell, 1991)

Both the old and new approaches share a scepticism toward rational-actor models of organisation, and each views institutionalization as a state-dependent process that makes organisations less instrumentally rational by limiting the options they can pursue. Both emphasize the relationship between actors and their environments, and both promise to reveal aspects of reality that are inconsistent with actors' formal accounts. Each approach stresses the role of culture in shaping organisational reality (DiMaggio and Powell, 1991).

However, new institutionalism, tracing its roots to the "old institutionalism", has a rather different flavour. It does not reject the methodological individualism of mainstream economics but rather seeks to derive the existence of institutions from the actions of economic agents. A concern for contracting and incentives is central to much theorising in this field. Rather than rejecting the mainstream emphasis on rationality and utility maximisation, the new institutionalism seeks to encompass explicit consideration of the interaction of individual maximising behaviour with specific institutional structures, on the one hand, and exploration of the boundaries of rationality in the face of complexity

and information asymmetry, on the other hand. The former can be seen in approaches that focus on property rights, the latter is more clearly associated with the transaction cost economics school (Marsh, 2012).

The new institutionalism in organisational analysis has a distinctly sociological flavour. This perspective emphasizes the ways in which action is structured and order made possible by shared systems of rules that both constrain the inclination and capacity of actors to optimize as well as privilege some groups whose interests are secured by prevailing rewards and sanctions (DiMaggio and Powell, 1991; Marsh, 2012).

Both the old and new approaches agree that institutionalization constrains organisational rationality, they identify different sources of constraint, with the older emphasizing the vesting of interests within organisations as a result of political trade-offs and alliances, and the new stressing the relationship between stability and legitimacy and the power of common understandings that are often vague (DiMaggio, 1988).

The two traditions also treat organisational structures in different ways. The old institutionalism illustrates how the informal structures deviated from and constrained aspects of formal structure and demonstrate the subversion of the organisation's intended, rational mission by parochial interests. Selznick (1949:260 cited in Meyer and Rowan, 1977) called it the "shadowland of informal interaction", including influence patterns, coalitions and cliques, and particularistic elements in recruitment or promotion. The new institutionalism, by contrast, locates irrationality in the formal structure itself, attributing the diffusion of certain departments and operating procedures to inter-organisational influences, conformity, and the persuasiveness of cultural accounts, rather than to the functions they are intended to perform (DiMaggio and Powell, 1991; Meyer and Rowan, 1977).

Moreover, one of the biggest differences between the old and new is the heterogeneity or homogeneity of organisations they emphasize. The old institutionalism viewed organisations as organic wholes which would increase inter-organisational diversity, for the character-formation process operated at the organisational level. In the new view, institutionalization tends to reduce variety, operating across organisations to override diversity in local environments. Therefore, neo-institutionalism tends to stress the stability of institutionalised components (Powell and DiMaggio, 1991:14).

Both old and new institutionalism reject a view of organisational behaviour as merely the sum of individual actions. The neo-institutionalist stresses the unreflective, routine, taken-for-granted nature of most human behaviour and views interests and actors as themselves constituted by institutions (Powell and DiMaggio, 1991:14).

2.2.2 Types of new institutionalism

Different types of new institutionalism developed around the common ground that institutions structure the behaviour of actors, and at the same time are structured by interactions. However, there are still some differences among these types of new institutionalism in their interests, the normative approach that they take, and their interpretation of actors, power, political process and institutional mechanisms (Table 2.4). This section will focus on organisation theory and rational choice institutionalism.

Table 2.4 Types of New Institutionalists: Similarities and Differences

	Rational Choice	**Historical Institutionalism**	**Organisation Theory**
Interests	Strategic factors cause rational actors to choose suboptimal equilibria (e.g., prisoner's dilemma, the tragedy of the commons)	Actors' interpretations of their interests shaped by collective organisations and institutions that bear traces of their own history	Actors do not know their interests; limits of time and information cause them to rely on sequencing and other processing rules (bounded rationality)
Normative	Substantively rational ends are useless without formally rational means (Elster); Maximize efficiency through unanimous rule and buying votes (Buchanan and Tullock)	Juridical democracy is based on the strengthening of congress, deliberation on rules, not particular outcomes, need for public philosophy (Lowi)	Implications of bureaucratic power and bounded rationality (Perrow)
Actors	Rational	Self-reflective (social, cultural, and historical norms, but reinvention of tradition)	Cognitively bounded

Power	Ability to act unilaterally	Depends on recognition by the state, access to decision making, political representation, and mental constructs	Depends on the position in the organisational hierarchy
Political process	Without rules for ordering, cannot arrive at public interest; rules for the sequence of congressional votes, jurisdictions, etc., affect outcomes	Political process structured by constitutions and political institutions, state structures, state-interest group relations, policy networks, contingencies of timing	Inter- and intra-organisational processes shape outcomes, as in the garbage can model, efforts to achieve administrative reorganisation and policy implementation
Institutional mechanisms	Structuring of options through rules (reliance on norms controversial)	Structuring of options, calculation of interests, and formation of goals by rules, structures, norms, and ideas	Structuring of options and calculations of interest through procedures, routines, scripts, frames (implies norms)

Source: adapted from Immergut (1998, p. 18)

Organisation theory

New institutionalism first received attention in organisational studies when Meyer and Rowan (1977) published their work concerning the relation between organisations and their institutional environment. There are two types of environments: technical and institutional. These two environments have controversial requirements on the organisations: the technical environment values efficiency; the institutional one focuses on legitimacy.

DiMaggio and Powell (1983) emphasized the interdependency of organisations and concluded three mechanisms on the organisational field level: coercive, mimetic and normative. A coercive mechanism threatens sanctions for failing to comply with a request for action. A mimetic one motivates the organisations to learn from successful practices. A normative one induces compliance through referring to a mutual goal or to the legitimacy of the person requesting action (e.g. a superior in a hierarchy). A remunerative

mechanism includes enough incentives, often additional resources, to make the desired course of action attractive to the actor.

From a sociological perspective, the major concern is isomorphism of organisations. The concept of isomorphism captures the process of homogenization properly; it is a constraining process that forces one unit in a system to resemble other units in the same settings. Among the three types of institutional isomorphic change, coercive isomorphism results from political influence, in which organisations receive formal and informal pressure exerted by other organisations they depend upon. For instance, as rationalized states expand their area of dominance, organisational structures reflect rules institutionalized by and within the state (DiMaggio and Powell, 1983).

The legitimation mechanism can be effective on a multilevel - cultural values, legal system, etc. From a macro level, Meyer and Rowan (1977) used “rationalised myth” to explain isomorphism in organisations. Weber (1978) focused on “authority” and its origin. Mary Douglas (1986) believe behaviours and structures of organisations are strongly determined by institutions, agents have no choice in respect of anthropology and functionalism. Olson (2009) pointed out the challenge of collective action that is the “free rider” problem. Durkheim (2013) argued that “collective consciousness” holds the society together, which is similar to “common knowledge” in game theory.

Rational choice institutionalism

The rational choice perspective can be defined as the analysis of the choices made by rational actors under conditions of interdependence. That is, it is the study of strategic action of rational actors, using tools such as game theory. How then should we understand and interpret political choices? Institutions, as the rules that determine the sequence of congressional votes, or the division of legislatures into jurisdictions, allow political choices to be made because they do not allow every conceivable political choice to be considered. Thus, institutions—in this case, the rules of the game—significantly affect political choices (Immergut, 1998).

Despite the decisive role that institutional rules are accorded in this branch of the new institutionalism, however, the rational choice perspective has not particularly emphasized the relative justness or unjustness of different institutional rules. Not only empirical rational choice studies but also explicitly normatively oriented works return to the focus on individual utilities as a standard for judging political institutions and outcomes (Immergut, 1998). Rational choice institutionalism focuses on rational actors who pursue their preferences following a “logic of calculation” within political institutions, defined as structures of incentives (Schmidt, 2014).

Rational choice institutionalism seeks to establish the most universal of generalizations, by positing rational actors with fixed preferences who calculate strategically to maximize those preferences and who, in the absence of institutions that promote complementary behaviour through coordination, confront collective action problems (Hardin, 1982; Ostrom, 1990). This deductive approach to explanation makes it good at capturing the range of reasons actors might normally have for action, identifying the institutional incentive structures, predicting likely outcomes, and bringing out anomalies. However, its universal claims about rationality along with its deductive approach to explanation mean that it risks overgeneralizing and has difficulty explaining any anomalies that depart radically from interest-motivated action, an individual's reasons for action, or real political events (Green and Shapiro, 1996). Moreover, rational choice institutionalists' emphasis on the self-interested nature of human motivation can appear economically deterministic (Schmidt, 2014).

Finally, rational choice institutionalism also has difficulty explaining the institutional change, given its assumptions about fixed preferences and a focus on equilibrium conditions and a lack of concern with the origins and formation of preferences. Only recently have rational choice institutionalists sought to "endogenize" change, by redefining the goal of institutions – from "self-enforcing" to self-reinforcing or self-undermining institutions – and their effects (Greif and Laitin, 2004). The problem here is that we are still left with the irrationality of the choice of institutions, to begin with; the deterministic trajectory of change over time, now for better or worse; and the limited rationality of these supposedly "rational" actors at any given point in time (Schmidt, 2014)

2.2.3 Actor-centered institutionalism

Following rational-choice institutionalism, German scholar Fritz W. Scharpf proposed the analytical framework of actor-centered institutionalism based on game theory and assumptions from transaction-cost theory, which reveals that policy is influenced by the interaction among policymakers, policy implementers and policy targets concerning the institutional settings. The empirical basis of actor-centered institutionalism and the phenomenon it explains are established in the macro institutional setting that constitutional democracy is restraining power with laws and constitutions (Scharpf, 1997).

Scharpf's approach to social scientific explanation, which combines "actor-centered institutionalism" with a rational choice methodology to uncover causal generalizations about policy and polity, is one of the most methodologically fruitful approaches found in rational choice institutionalism today. This is because, in his efforts to shed light on real-world problems, Scharpf is almost alone in his refusal to over-generalize. Despite a methodology that most political scientists see as an invitation to universal generalization,

Scharpf seeks to move toward “bounded generalizations” through the identification of subsets of cases in which variance in policy outcomes can be explained by variances in the same set of factor constellations. Thus, he seeks to lend insight into the complexity of “real actors’” institutionally-embedded policy choices without giving up his quest for theory-based, parsimonious explanation in social science. Scharpf, unlike many of those whose primary methodology is also rational choice institutionalism, accepts that while his own variant of such institutionalism, however, bounded in its generalizations, cannot explain, other kinds of non-rationalist explanations may do so. As a result, his methodology proves useful not only as an analytic tool showing where actors’ rationally reconstructed, institutionally-constituted strategies are sufficient to explain policy choices but also where they are not (Schmidt, 2003).

However, these bounded generalizations of strategic institutional interactions often cannot account for actual outcomes, because actors do not always know what they want, know what other actors want, pursue what they want, and how to get it within any given institutional context. In fact, actors’ purposes, preferences, and perceptions are not always clear and, in any case, can and often do change in the course of interaction. Schmidt (2003) suggests introducing the factor of discourse to explain. Discursive institutional interactions may change perceptions of problems and legacies, influence preferences, and thereby enhance or undermine actors’ problem-solving capacity even where actor constellations and modes of interaction in given institutional settings seemingly disallow this (Schmidt 2001b).

Vivien A. Schmidt introduced discourse institutionalism to offer explanations based on ideas, values, and deliberation to fully understand policy change where bounded generalizations founded on actors’ strategic institutional interactions are not enough. This framework of the analysis of discourse is a descriptive language or analytical framework that allows one to identify, describe, and analyse important phenomena when they occur, that applies only under certain conditions, and for which theories can be developed and tested. Discourse offers different but also complementary explanations for rational choice, historical, and sociological institutionalism. It seeks to lend insight into the role of ideas and discourse in politics while providing a dynamic approach to institutional change (Schmidt, 2003).

There are few policy studies in China using the perspective of actors. A and Qu (A and Qu, 2014) compared the positions of actors in historical institutionalism and new institutionalism and emphasized the importance of actors in the institutionalism theory. Li (Li, 2020) provided an extensive review of Scharpf’s actor-centered institutionalism and explored its connection with current research on policy process and governance process

in China. However, these studies remain theoretical; there is no application in analysing specific cases or policies.

In the application of frameworks from the actors' perspective, there is sometimes a lack of explanation of the methodology and empirical evidence, such as in the study on rural land policy. Lu and Shen (2012) took bureaucrats on the local and national levels, especially the major officers as the core actors in local governments, since they possess the power to influence the policy process. They categorized the actors' motivations into political, social, and economic aspects based on the bureaucratic economy theory and the interactions between national and local actors into four models based on game theory.

Regarding the discussion and application of actor-centered institutionalism in various public policies in China, the studies mostly focus on domestic actors. Wei (2011) adapted the framework of actor-centered institutionalism to analyse the formulation process of the Gender Equality Act in Taiwan and pointed out that the distribution of power and resources of the policy is an essential factor for passing the Act or not. Su (2013) used the actor-centered institutionalism framework to compare female labour protection policies between mainland China and Taiwan to identify the gaps in gender equality. Since these studies are about national policy, actors at the international level are not considered, which is common in other research on public policy in China.

The actor-centered institutionalism framework has also been adopted to interpret public health policies in China. Kuang, Feng and Ma (2012) applied actor-centered institutionalism framework to analyse the integration process of rural health services between the township and the village levels. They interviewed key actors from 13 counties (cities) and provided strategies on policy, as well as financial and organisational resources. Zhang *et al.* (2021) further explored the same topic with the inclusion of local residents as one of the main actors, but with still no consideration of the influence from the national level. Cao and Yan (2022) analysed the interaction between national and local actors and examined how the actors reacted to the health reform policy. They conducted interviews and focus group discussions with 15 informants from government departments and hospitals. The authors mainly focused on local actors at the city and county level and failed to consider the national level actors.

Actor-centered institutionalism is not widely adopted in developing countries because the theoretical plausibility is limited in non-western political systems, which have a low level of formal institutionalisation, where the respect for independent legislation is low, and the differences between the formal rules of games and widely-accepted informal norms are huge, and the distinctions between the rights and limitations of public agencies are ambiguous (Li, 2007).

There is great potential for actor-centered institutionalism to be applied in the analysis of policy processes and governance processes in China. The application in China will potentially generate new evidence for the effectiveness of actor-centered institutionalism, further enrich the framework and produce knowledge about the scenarios in China, which contributes to the development of the framework (Li, 2020).

There are some studies in China using discourse to analyse policy. For example, Mierzejewski (2009) examined the discourse of the new left in Chinese reforms. Joshi (2012) analysed the discourse of 'harmonious society' to examine human development. Xu (2015a) analysed the change of environmental discourse in the five-year planning of Guangzhou over the decades.

However, there are no studies that combine the conceptual lens of actor-centered institutionalism with discourse, potentially to employ actor-centered institutionalism to identify the main actors, analyse how they interact with each other, and the underlying institutional settings that are crucial to interpret policy making and policy implementation. The study will also find out whether the actor-centered institutionalism approach is fully applicable under the conditions of China, or whether the combination with discourse analysis can improve theoretical plausibility in the context of China.

2.3 CONCEPTUAL FRAMEWORK

The study applies an approach that is influenced by the discussion on actor-centered institutionalism. The interpretive lens of actor-centered institutionalism is taken to identify the main actors, analyse how they interact with each other, and the underlying institutional settings that are crucial to interpreting policy making and policy implementation.

2.3.1 Overview

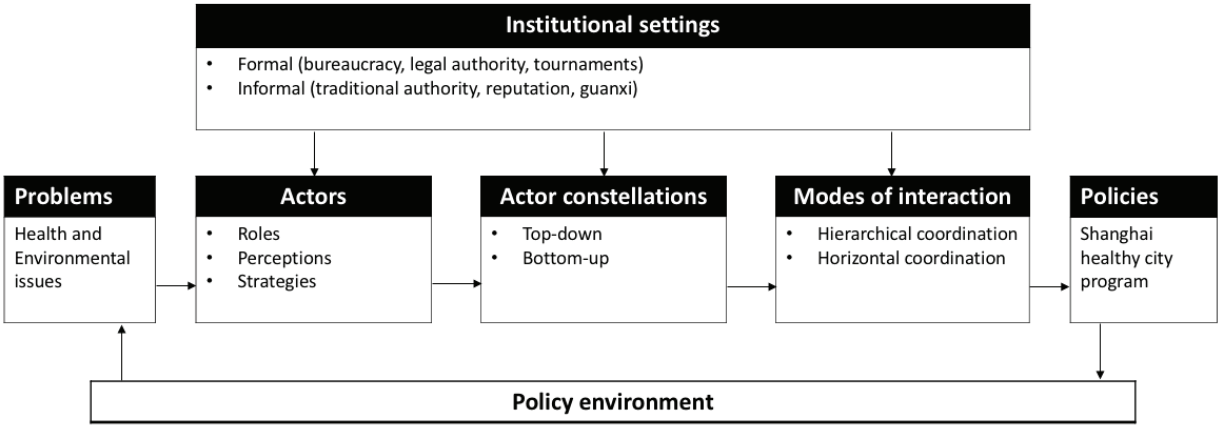
Policy in its definition is a set of the intentional actions of actors, whose ultimate interest is to get beneficial outcomes. In the process of policy interaction, all the actors are pursuing the maximisation of their own interests, which forms a constellation of actors, namely policymakers, interest groups and the public, which redistribute the power or political resources. The formulation of a policy is not necessarily an end, but rather a possible beginning. On the one hand, policy outcome is determined by the institutional settings, and the implementation needs to be monitored; on the other hand, new institutional settings can trigger the discovery of new policy problems and formulation of new policy accordingly. A policy can be defined as the programmatic activities formulated in response to an authoritative decision (Matland, 1995; Wei, 2011).

The Healthy City is a complex topic which requires intersectoral collaboration. In order to understand the multilevel health governance involved in the policy process, an in-depth analysis of the interactions in the policy process is essential. The analysis of 'multi-level' governance in urban societies nowadays needs to focus on informal relationships as well as formal establishments, acknowledging the role of the diversity of actors and their interactions among collaboration and network structures. The institutional theory offers a variety of insights to interpret contemporary urban processes systematically (Manzi and Jacobs, 2008; Stoker, 2017).

Interaction-oriented research is developed around the actors and the institutions in which the interactions and the actors are embedded. Therefore, an analytical framework based on actor-centered institutionalism is taken, not only because of its capability of describing changes but also for setting the boundary of concepts. The model will be adapted for the application in China. For example, the bureaucratic authoritarian state and the authority in the political and cultural context will be taken into consideration. Concepts such as isomorphism of organisations and informal institutions like authority and reputations are also included in the framework to illustrate the characteristics of China. However, the overall logic of the framework remains consistent with actor-centered institutionalism.

Policy events are embedded in three major aspects of the social context: time, space, and culture. The assessment of the outcomes is predominantly a problem of conceptualization and value selection. Standards of evaluation need to be sensitive to time, institutional context, and local cultures. In the case of transnational discussions, the different ways people interpret social and political events should be taken into account. Policy events are embedded in three major aspects of the social context: time, space, and culture (Hart, 2017).

Figure 2.2 Conceptual Framework



Source: own compilation based on Scharpf (1997)

Actor-centered institutionalism is adapted to explain the past policy choices and to produce systematic knowledge that may be useful for developing politically feasible policy recommendations or for designing institutions that will generally improve the formation and implementation of public-interest-oriented policy (Scharpf, 1997).

However, policy analysis cannot be so abstract and brief. Scharpf also pointed out that the framework works as instructions for explaining policy phenomena, not as a general theory. This research intends to provide a narration from the perspective of actor-centered institutionalism (Scharpf, 1997; Wei, 2011). Figure 2.2 illustrates the conceptual framework this research is adapting, which helps to construct the research questions and propositions that will be elaborated in section 2.4.

2.3.2 Sensitising concepts

New institutionalists generally care about why different types of organisations would act in a certain way. It assumes that the capacity of individuals is limited—it is the institutions that shape the actions of people. Institutions are taken as an essential independent variable (Douglas, 1986; Li, 2007).

Therefore, institutionalists often study the influence of institutions on actors, by a broad set of constraints and limitations, e.g., institutional settings, culture, and norms. Institutionalism can be used to explain the phenomena of organisational convergence from the macro perspective, and the strategic choices of the organisations. There are multiple perspectives on institutionalism, of which the major influences come from disciplines including economics, politics and sociology (Manzi and Jacobs, 2008; Li, 2007; Zhou, 2003).

These questions are related to perspectives of actors, interactions, and institutions in governance (see section 1.2). The following section will explain these key concepts related to governance in Healthy Cities.

Actors

Actors, both individual and corporate, are those who are involved in the policy process and whose choices will ultimately determine the outcome. In actor-centered institutionalism, actors are characterized by their orientations (perceptions and preferences) and by their capabilities. An actor is attached to a range of alternative courses of action (history of past choices will influence its decision) and a set of associated payoffs (Scharpf, 1991). There are similar terms like agencies, stakeholders, and sectors. A stakeholder is a person who speaks for or represents a group that is affected or affects a policy. Stakeholders have specific names and titles (Dunn, 2012). Actors' perceptions of directly observable facts will be empirically correct; what cannot be observed and the

causal linkages will be shaped by theories prevailing at the particular time and in the particular institutional setting (Scharpf, 1997).

Capability is meant to describe all the action resources that allow actors to influence the outcome in certain respects and to a certain degree. Capabilities include personal properties such as social capital and physical resources like money and properties; there are also technological capabilities, access to information, etc. In the context of policy research, the most important resources are created by institutional rules granting or limiting rights of participation and autonomous decisions. However, it is important to take the orientations of individuals when leadership positions are less constrained by institutionalised controls, sanctions and routines than other organisational roles. There are contradictions between different reference units. The idiosyncratic orientation of individuals may become so important, most likely in leadership positions that are less constrained by institutions than other organisational roles (*ibid.*).

Actor Constellations

Actor constellation is a role play, which reflects the positions of all actors involved in a project. The distance between an actor and the central question, or the other actors, expresses the relevance of the actor in the project (Scharpf, 1997).

Actor constellations translate what we know of the actors involved in the particular policy interactions into potential "strategies" (their capabilities) and "payoffs" (their perceptions and evaluation of the outcomes obtainable), and represent the degree to which their payoffs aspirations are compatible or incompatible with one another (*ibid.*).

The constellation can be used to discover empirical regularities that might otherwise remain hidden under the surface of differences; it can also characterize the level and types of potential conflict, thus helping us to find out the demands for conflict resolution in a particular policy (*ibid.*).

Modes of interaction

Any given constellation could be played out in various modes of interactions, including "non-cooperative games", "cooperative games" (where strategies are chosen by negotiated agreement), or "hierarchical games" (where the strategies of actors can be determined by the unilateral choice of another actor). On the other hand, any given mode of interaction may be applied to deal with different actor constellations. The actual outcome will be affected by both constellations and modes in each case. Useful knowledge can be generated by treating each dimension separately (Scharpf, 1997, p. 45).

The actual character of interactions is not only defined by the formal steps that must be taken, but also by a larger institutional setting within which the interactions take place. It is assumed that modes of interaction differ in their demands on the institutional capacity for conflict resolution and that institutional structures differ in their capacity to support different modes of interaction. There is the possibility that modes of interaction will change their character—and their capacity for the resolution of policy problems—from one structural setting to another (Scharpf, 1997, p. 47).

Institutions

In this research, institution means "underlying rules of games" (Harper, Jones and Watson, 2012; North, 1990, p. 3), it is a system of rules that structure the courses of actions that a set of actors may choose (Scharpf, 1997). Institutions are devised by human beings to create order and reduce uncertainty in exchange (North, 1991). However, institutions are often confused with terms like "organisations" and "corporate actors" (Scharpf, 1997, p. 38). North (1990) defines it as the formal and informal rules and norms that organise social, political and economic relations.

Institutional settings affect the problem-solving effectiveness of policy processes through rules determining the constitution of actors and their institutional capabilities—which also influence their inclusion, and their strategic options, in the actor constellations related to policy (Scharpf, 1997, p. 46).

It is worth noticing that institutions vary cross-nationally and intertemporally. Once institutions are installed, and actors rely on their coordinating function, institutional change will be costly. Consequently, institutions are difficult to reform or abolish. It implies that empirical regularities will be limited by time and space (Scharpf, 1997, p. 41). Therefore, the aim of this section is not to generalize any standardizing effects of the institutions but to focus on the Chinese context and the Healthy City Action Plan (2003-2017).

Institutional settings are normally differentiated into two categories: formal institutions and informal institutions. Formal institutions include legal rules that are sanctioned by the court, such as constitutions, laws, policies, rights and regulations enforced by official authorities (Berman, 2013; Leftwich and Sen, 2010; Scharpf, 1997). Informal institutions include social norms, customs, traditions, behaviour patterns, and shared values (Berman, 2013; Gailing and Leibenath, 2015; Leftwich and Sen, 2010).

2.4 RESEARCH QUESTIONS AND PROPOSITIONS

Agreement on goals is unnecessary. Agreement on actions is sufficient.

- Matland, 1995, p. 164.

This research is based on the assumption that social phenomena are to be explained as the outcome of interactions among intentional actors; it is by the characteristics of the institutional settings that these interactions are structured, and the outcomes shaped. The Healthy City programme is studied as a public policy, which is likely to result from the strategic interaction among several policy actors, each with its own understanding of the nature of the problem; and the feasibility of particular solutions, each with their own individual and institutional self-interest and its own normative preferences, and each with its own capabilities or action resources which will be used to influence the result (Scharpf, 1997).

Policymakers, policy implementers and policy target groups are the main actors in the policy implementation process; they are rational players who want to maximize their own interests. Different interests and orientations will ultimately determine their choices in policy implementation, thus directly influencing the outcome of policy implementation (Xu, 2015b). When obstacles appear in policy implementation and they are related to all involved sectors, the implementation will be influenced by sectoral interests. The extent is unpredictable; therefore, deep analysis into the influence of sectoral interests on public policy implementation is needed (Zhang, 2014).

Therefore, the focus of explanations should be on the interaction among purposeful actors—which often means highly organised collective and corporate actors (Ahlers and Schubert, 2015). In the political process, the most relevant actors are typically acting in the interest and from the perspective of larger units, rather than for themselves. This allows us to simplify analysis by treating a limited number of large units as composite (i.e., aggregate, collective, or corporate) actors with relatively cohesive action orientations and relatively potent action resources.

Moreover, these larger units are operating within institutional settings in which they are more strained in their actions than autonomous individuals might be. They are likely to be constituted by institutional norms that not only define their competencies and other action resources but that also specify purposes and shape the associated cognitive orientations. Consequently, policy actors are likely to end up in relatively stable “actor constellations” that can be analysed with the help of the game-theoretic concepts. In addition, the institutional setting also defines the modes of interaction—unilateral action, negotiations, voting, or hierarchical direction—through which actors can influence one another and shape the resulting policy choices (Scharpf, 1997). Ahlers and Schubert (2015)

argue that three major factors, i.e., central policy design, institutional constraints, and strategic agency of local implementers, may be observed throughout China in the cases of effective policy implementation.

The overall research question is "***how was the Healthy City programme in Shanghai shaped by the interactions of actors and institutions***" from the perspective of local actors between the forces of globalisation and local institutions; three major research questions are formed. Moreover, propositions are proposed to guide the empirical studies of Healthy City programmes in China. Some propositions are derived from actor-centered institutionalism; others are from studies on Healthy City projects. The objective is not to verify the propositions, but only as a reflection of the perceptions of the researcher.

RQ1 How do the international movement and the national campaign influence the local policy?

The first research question deals with policy change related to the Healthy City programme and beyond. It tries to investigate how much the local actions converge with national and international movements. Empirical evidence is needed to reveal how the globalisation trend, represented by the international movement of Healthy Cities, and local institutions, represented by the National Patriotic Health Campaign since the 1950s, have jointly influenced the formulation of the Healthy City Action Plan in Shanghai.

The main propositions come from the convergence of different organisations. According to the legitimacy mechanism, organisations adopt similar structures and standards to gain recognition. Therefore, assumingly, the municipal organisation would share common characteristics with the national and international organisations. International and national institutions put constraints on the actions at the municipal level, regarding the motivation and the power to sustain the programme.

RQ2 How do the actors interact with each other in the policy process?

The second research question focuses on the internal organisation of the Healthy City programme, where the actors and modes of interaction come under the spotlight. The local actors in the Healthy City programme need to be identified. The administrative tier they belong to (sector, department, position, etc.) and the stages they are involved in within the Healthy City programme are clarified. The actors' roles and capacities, in general, are analysed, which include time, human and financial resources the actors possess, the perceptions of the actors about themselves and other actors, the interests these actors represent, and the conflicts between the interests of actors.

This question focuses on the mode of interactions of the main actors, addressing the motivations and patterns of actors to participate in the Healthy City programme. The

prominence of the actors is examined as well as its change through different stages of the policy process. The characteristics of the actor constellations are analysed. The modes of interaction are analysed in horizontal and hierarchical directions. The strategies and the challenges in the policy interactions are identified.

RQ3 How do the local institutions influence the interaction of actors?

The third question intends to gain deeper insights into the local institutions since they are the most distinctive part of the Chinese organisations, which may also be the challenging part of adapting actor-centered institutionalism. They can be divided into formal and informal institutions.

Regarding formal institutions, there is the vertical or hierarchical setting from central to local government, with a Parallel Chinese Communist Party system; and the horizontal setting defined by different departments, where the competing institutional logics and power imbalances play an important role. The other part is informal institutions, such as social norms defining the social pattern of actors are to be analysed.

It is worth noting that the three questions are interrelated, as illustrated in the conceptual framework. Actors and actor constellations are constantly influenced by the institutional context; at the same time, institutional settings are modified by actors.

3 RESEARCH METHODOLOGY

This chapter focuses on the research methodology. The research design to answer the research questions is presented. The case study area of Shanghai is introduced, including the history, the status of health and urban environments, and the programme in focus. The research methods for data collection and analysis are explained.

3.1 RESEARCH DESIGN

This section focuses on the research design to answer the research questions systematically. After providing the rationale for conducting qualitative research and adopting a case study approach, the overall research design is presented.

The rationale of qualitative research

In order to get a complex, detailed interpretation of the policy process, qualitative research is conducted. The details of the process can only be achieved by talking to people directly, visiting their homes or places of work, and letting them tell the stories behind what is hypothesised or what is written in literature (Creswell and Poth, 2016). Qualitative research methods provide the tools to question and critically reflect on why and how the problems manifested. The qualitative tools can also provide reactions to these problems and responses to policy interventions (Manzi and Jacobs, 2008).

Qualitative methods are needed as a Healthy City is a process more than an outcome. However, most of the evaluations of Healthy City programmes in China are still restrained concerning public health and often use quantitative methods (Luo, 2011). It is important to fill the research gap with qualitative research. A Healthy City cannot be described only by data; unless data are turned into stories that can be understood by all, they are not effective in any process of change, either political or administrative (Hancock and Duhl, 1986).

To understand the policy process, the researcher needs the point of view of the actors. The researcher intends to interpret the meaning the actors have about the world (Creswell and Poth, 2016). Open-ended questions need to be asked. The researcher needs to listen to the participants and in return shape the questions after exploratory talks with a few individuals. The questions change and become more refined during the process of research to reflect an increased understanding of the questions. A variety of sources of data need to be collected including information in the forms of words and images (*ibid.*).

Case study

The overall research is a single case study of Shanghai's Healthy City programm. The qualitative nature of the problem merits semi-structured interviews, content analysis of documentation, and questionnaires based on the theoretical lens of actor-centered institutionalism. The approaches to the research questions are illustrated in the matrix of research objectives and methods (see Table 3.1).

A single case study is conducted when there is a need to develop an in-depth understanding. Case study research involves the study of a case within real life, involving the contemporary context and settings (Yin, 2014). As Stake states, it is also a choice of what is to be studied, i.e. a case within a bounded system, bounded by time and space (Stake, 2005). It is exactly what is needed in this study.

Case study research is a qualitative approach in which the researcher explores a case, in this case the Shanghai Healthy City programme, over time (from policy making to policy implementation), through detailed, in-depth data collection involving multiple sources of information (documents, surveys, interviews, audio-visual material), and reports a case description, which is briefly presented in the following part, and case themes (Creswell and Poth, 2016).

Empirical studies on how the policy process works and how partnerships work are needed. To capture local governance arrangements, the following tasks arise for the empirical analysis (Elander, 2002; Meyer, 2011). These tasks are closely related to the main research question and the sub-questions:

1) Identification of main actors, i.e. those who were involved in policy making and implementation of the Healthy City programme in Shanghai. For further details please see 3.4.1 stakeholder analysis.
2) Analysis of actors' perceptions of the issue, interests, and capabilities. This is an important part of answering sub-question 2.
3) Analysis of actor constellations and modes of interaction, e.g. coalitions or partnerships formed, and conflicts between actors and interests, which are analysed to answer sub-question 2.
4) Consideration of the institutional context, e.g. existing and traditional structures of authority, methods and instruments. It is the main task for sub-question 3.
5) Analysis of influences across different levels (international/national/local), which is considered mostly in identifying the modes of interaction and also in answering the main research question.

6) Analysis of the development of all aspects from policy making to policy implementation, e.g. the change of the prominence and the centrality of actors and partnerships (Lipp, Winters and de Leeuw, 2013).

Research design

The research methodology is designed to answer the research questions systematically. As mentioned in section 2.4, the main research question is to understand "***how was the Healthy City programme in Shanghai shaped by the interactions of actors and institutions***" in the policy process. It involves studying a group (i.e. actors in the Healthy City Action Plan in Shanghai), and identifying variables (e.g. perceptions and preferences of actors, modes of interaction, institutional settings) that cannot be easily measured quantitatively.

Table 3.1 A matrix of research objectives and methods

Research Objectives	Method	Necessary Information	Sources of Information
Policy content	Document analysis, discourse analysis	The official announcements, the indicator system, the evaluation process of the international Healthy City programme, National Hygienic City, National Civilised City, and Healthy City Action Plan	Policy documents, news articles, and interviews
Actor constellations	Stakeholder analysis	Stakeholders, their interests and influence, range of other issues on checklists	Policy documents, news reports, and interviews with stakeholders
Institutions	Multi-attribute assessment	Formal institutions like laws and regulations, informal institutions like traditions, customs, and shared values	Policy documents, literature, news articles, interviews for problem structuring

Source: adapted from Hermans, 2009

Research question 1 is focused on the convergence of organisations. The characteristics of the studied programmes such as the goal, the indicator system and the organisational structure are compared between Shanghai's Healthy Cities Action Plan, the international Healthy Cities movement, and the local campaigns (National Hygienic City and National Civilised City), to see how similar or different they are, thus explaining the main motivation

of formulating Shanghai's Healthy City Action Plan. Content analysis and discourse analysis are adopted.

Research question 2 investigates further the different modes of interactions in the policy process of the Healthy City Action Plan from the perspective of actor-centered institutionalism. The objective was to identify the actors involved, the constellations and modes of interactions exercised during the policy process. In-depth interviews with local actors were conducted to acquire primary empirical data, and various types of documents were also used for content analysis and stakeholder analysis.

Research question 3 examined local institutions related to the interpretation of policy outcomes, which was connected to the first two research questions as well. A Multi-attribute assessment was taken to have an overview of both formal and informal contexts. Literature reviews and document analysis were conducted parallel to research questions 1 and 2 to give reflections simultaneously, literature reviews and interviews were combined with questions from the other two sessions.

All questions needed to deal with policy outcomes, from a qualitative perspective. Policy documents, news articles and information from social media were collected to reflect the public opinion, the enforcement and the effect of Healthy City programmes.

3.2 STUDY AREA

> *Changes in cities parallel with that in traditional social structures. Cities as stages of life reflect the growing tensions among their population.*
>
> *- Ashton, 1986, p. 320*

Shanghai was chosen as the study area for several reasons. First, for the theoretical purpose to include as many main actors in the policy process as possible, the municipality, where the Healthy City programme was formulated and implemented, should be the major study area. Plus, Shanghai was a 'central-administered municipality' that follows the 'state-municipality-district' structure instead of a 'state-province-municipal' one, more scales were available from the local level (see Table 3.2).

Second, to make the empirical work in China, access and time should be considered carefully. In order to get the most out of the field trip, the city of Shanghai was more compact to travel around and reach actors at different levels. Besides, the access was easier since there were already local informants, which provided more opportunities to get further contacts.

Table 3.2 The administrative divisions of Shanghai and its districts in China

Level	Administrative divisions of China	Shanghai
1	Provincial level	Municipality
2	Prefectural level	-
3	County level	15 Districts, 1 new area
4	Township level	105 Subdistricts, 107 Towns, 2 townships
5	Basic level autonomy	4253 Communities, 1590 Administrative Villages

Source: Shanghai Municipal People's Government (2019)

Health profile

In 1949, there were 358 health institutions, with 10033 beds, which was less than 2 beds for every 1000 beneficiaries. There were 12983 health technicians, which was 2.6 per 1000 beneficiaries. The average life expectancy was 35 (Office of Shanghai Chronicles, 2013).

The health sector in Shanghai was a mixed system. The public health services system consisted of Shanghai Municipal Health Bureau（SMHB）and its sub-agencies. There were 24 departments within the SMHB, 8 for administrative functions and 16 line departments with specific programmes or functional authority. At the end of 2001, the sub-agency of SMHB included the 432 hospitals; the 3210 out-patient departments; the 5 nursing homes; the 57 institutions for disease prevention and health care; the 14 medical research institutions; the other 75 health organisations. And there were 723 private health sub-sectors in Shanghai too. All the health systems had 36.5 (37.1 in the urban area and 26.3 in the rural area) physicians and 27.9 (28.5 in the urban area and 15.5 in the rural area) nurses for every 10,000 beneficiaries (WHO, 2005).

In 2002, before the Healthy Cities action plan started, Shanghai's population had reached 13.2864 million. The natural population growth rate was -0.26%, with a fertility rate of 17.91‰, the birth rate reaching 0.47% and the mortality rate of 0.73%. The elderly population aged 60 years and over was 2471.02 thousand, accounting for 18.6%. The child dependency ratio was 13.83%, the elderly dependency ratio 26.37%, and the dependency ratio was 40.20% in 2002. The life expectancy was 79.52 years (77.36 for males and 81.63 for females) (*ibid.*).

By the end of 2017, Shanghai's population had reached 24.1833 million. The natural population growth rate was 0.28%, with the birth rate reaching 0.81% and the mortality rate 0.53%. The elderly population aged 60 years and over was 5.3912 million, accounting

for 22.3%. The elderly dependency ratio was 58.8% in 2017. The life expectancy was 83.37 years (80.98 for males and 85.85 for females) (*ibid.*).

At the end of 2017, the health care institutions included the 363 hospitals; the 3210 basic medical and health institutions; the 112 professional medical and health institutions for disease prevention and public health; the other 95 health care organisations. All the health systems have 28 physicians and 48 beds for every 10,000 beneficiaries (*ibid.*).

Urban environment

Located on the Western coast of the Pacific, the eastern side of the Asian continent, on the south edge of the Yangtze River Delta in East China, Shanghai sits on the middle of the eastern Chinese coast, roughly equidistant from Beijing and Guangzhou. The previous old town and the modern city centre of Shanghai spread along Huangpu River, on a peninsula formed by natural deposition and by artificial land reclamations, where the Yangtze River enters the East China Sea.

Table 3.3 Urban environment in Shanghai 1951-2015

Year	**1951**	**1961**	**1981**	**2000**	**2015**
Urban population (million)	5.5	10.5	11.6	13.2	14.4
Population density per km²	-	-	1888	2537	3809
Housing per capita(sqm)	3.4	4	4.3	12.5	24
Green space per capita(sqm)	0.10	0.57	0.46	4.6	13.38

Source: own compilation based on statistics from Shanghai Municipal Government

Since the population almost tripled in the last 60 years, the infrastructure in the city also improved a lot compared to before. However, it is challenging to deal with the pressure that the huge and dense population put on the urban environment, but In 2015, the mean annual PM2.5 concentration registered at 52 μg/m^3 in Shanghai (Shanghai Municipal Statistics Bureau, 2015), and the total polluted days were 84 days, almost ¼ of the year (Shanghai Municipal Bureau of Statistics, 2016). Outdoor air pollution was associated with mortality from all causes and cardiorespiratory diseases in Shanghai (Kan et al., 2008).

The economic and human costs of environmental risks are high and rising: It was estimated that the total economic cost of health impacts due to particulate air pollution in urban areas of Shanghai in 2001 was approximately 625.40 million US dollars, accounting for 1.03% of the gross domestic product of the city (Kan and Chen, 2004).

Master Plan is the major legal plan at the municipal level (Xu, 2015a). Since June 1927, the establishment of the new Shanghai Special City Government, drafts of city construction plans were submitted several times (Sun, 1999). Until November 1931, the Greater Shanghai Plan was approved based on the ideas from Garden Cities of Tomorrow.

During the first Five-Year Plan, emphasis was put on “Industrial construction” in the inner land of China. After consultation with experts from the Soviet Union, the conclusion for the function of Shanghai was to shift consumption to production. In 1957, Shanghai Municipal Committee proposed to build satellite towns to disperse industrial companies and population to the suburbs.

During the Open-up era in the 1980s, economic development has definitely become the priority. With the Pudong New Area being established within a national strategy, and the modernisation of the infrastructures, the municipality has aimed at becoming an international city.

As China joined the WTO and the trend of globalisation, Shanghai continued on the path toward a 21st-century international city. The municipality also tries to expand beyond the metropolis by establishing closer links in the Yangtze River Delta region to become a metropolitan area. It was also the first time that sustainable development was taken into consideration in the master plan in Shanghai.

Table 3.4 Strategies in Master plan of Shanghai since the 1950s

Period	Focus	Spatial	Strategies
1959	Industry	Suburbs	- Reform the old city centre - Control suburban industrial areas - Develop satellite towns
1986	Economy	Pudong New Area	- Open up Pudong Area - Modernize infrastructure - International City
2001	Globalization	Yangtze River Delta	- 21st century international City - Sustainable development - Human centre
2017	Localization	Community	- Innovative development - Regional development - Sustainable development - International development - Community development

Source: own compilation

In the most recent version of the Shanghai Master Plan, the community environment for promoting activities of citizens has been one of the key innovations. Guidelines were developed for the planning process, including the Shanghai Planning Guidance for 15-Minute Community-Life Circle, and the Shanghai Street Design Guidance.

Healthy City Action Plan

The first round of the Healthy City Action Plan started in 2003. To cope with the 10th Five Year Plan (2001-2005), the project length was set to three years to finish at the same time. It aims to change people's behaviours to empower them with the ability to achieve better health.

4 key actions remained since Phase I: "Clean Environment", "Food safety", "Fitness", and "Smoke control". Minor changes were made within the themes, see indicators. Other key actions change through phases: e.g. from Phase IV to Phase V, "Pleasant Body and Mind", "Alcohol Control" was eliminated, and "Appropriate Medical Treatment" was added.

After the life span, maternal mortality rate and infant mortality rate had steadily reached the level of developed countries for years. The citizens' quality had been improved greatly; There was a substantial rise in the following indicators like environment control in water and air, the per capitol green-land ownership rate, and the community exercise setting area. However, there was still a gap between urban environment quality and people's expectations about it (Tang *et al.*, 2016).

In the process of making the Shanghai Healthy City Action Plan, the government, citizens and other participants had three different levels of influence. Government departments were the most decisive part, especially the officers who were in charge of the health promotion committee; the second one was the demand of citizens; the influence of other participants including NGOs and expert consultant group was less important.

Surveys on the city capital, citizens, and public sectors were conducted during the plan-making process, however, the intensity and contents had significant differences. After the first round of action, the participants of the Shanghai Healthy City Action Plan had a deeper understanding of the Healthy City, especially the main participants had more comprehensive knowledge of the Healthy City, thus making the action more rational and coordinating with the concept of Healthy City construction in China (Gu, 2009)。

The institution of inter-sectoral collaboration was well established. Surveys were conducted in different public sectors in the demand survey process, which distinguished Shanghai from other cities in China. Through survey and analysis, the duties of relevant sectors were clarified. After negotiation, departments which participate in the Healthy City construction action and supportive departments which are not included in the action plan

were determined. This negotiation process represents the inter-sectoral collaboration institution (Gu, 2009).

The content and indicators of the Shanghai Healthy City Action Plan were determined based on the following rules: closely related to the routine of individual departments, which is feasible and would not make many extra workloads; generally recognized by participants, neither radical nor against the human-centred concept of improving people's health and environment; from less to more, step by step, and gradual improvement, mainly advocating Healthy City concept; accessible, all the work can be achieved through efforts which is encouraging (Gu, 2009)

3.3 DATA COLLECTION

Qualitative data has various forms, which mainly include text (i.e. interview transcriptions or policy documents), and non-textual data such as tables, pictures, and audio and video recordings (Patton, 2002; Strauss and Corbin, 1998). Direct content analysis and discourse analysis were used to analyse the qualitative data.

The qualitative data include in-depth descriptions of circumstances, people, interactions, observed behaviours, events, attitudes, thoughts and beliefs and direct quotes from people who have experienced or were experiencing the phenomenon (Patton, 2002), including experts who worked for the policy and action plans regarding Healthy City initiative. It also includes excerpts or entire passages from personal or organisational documents such as transcripts of meetings, historical records, budget plans etc.

3.3.1 Documents

A variety of documents that are related to the issue of Healthy City development and its actors constitute the pillar of information. Both current documents and those covering the period since the 1950s are taken into account. The older programmes like Patriotic Health Campaign and National Hygienic Cities are mainly analysed based on historical records. Documents required at the local level are listed in Table 3.5.

Different types of documents have different kinds of accessibility based on the source of information. The news reports on Healthy City programmes and related policies are easily accessible, recent reports are available online, and older ones related to Patriotic Health Campaign can be accessed in the city archive. Similar conditions can be applied to the literature on local traditions; since the digitalisation of governmental services, a lot of notices, reports and policy papers are accessible online, in the case of Shanghai, most of them are open to the public, and part of them are not complete on the website, which needs authorisation. The most difficult part of document collection is the internal files

from the government, including minutes of meetings, budget plans, the original version of policy papers, detailed city health profiles and evaluation reports for the former periods of the Healthy City Action Plan. To acquire these internal files, the trust of the officers is very important. Therefore, document collection was done after the interviews were finished.

Table 3.5 List of documents required at the municipal level

Source of documents	Documents required	Accessibility
Hardcopies	Historical records, transcripts of meetings, budget plan, the original version of policy papers (regulations, laws, guidelines), detailed city health profile and evaluation reports on Healthy City programmes;	Internal informants
Softcopies	Notices of appointment & removal, announcements of Healthy City programmes and related policy papers (regulations, laws, guidelines), reports on the work of the government, and general city health status;	Government websites
	Literature on traditions, news reports on Healthy City programmes and related policies	Internet

Source: own compilation

Besides the documents from the local level, national-level policies also have a huge influence on the Healthy City programmes. The nature of health problems can be changed to manifestations of an urban lifestyle (McKeown, 2014), underlying these lifestyle diseases are usually issues of local and national policy (Ashton, Grey and Barnard, 1986). Since 1984, the national government have issued policies and regulations related to the environment, urban development and health. For example, in 2016 the State Council issued the “Healthy China 2030” blueprint which means the Healthy City programme has officially become a national strategy. These types of national policies are available on the national government website and municipal policy documents were reviewed to find out the influence on Healthy City programmes from different scales. Some major policy papers to be analysed are listed in Table 3.6. A more detailed timeline of international/national/municipal policies influencing the Healthy City programme development is affiliated in the Appendix.

Table 3.6 Major policy papers required from the national and municipal level

Policy	Institution	Year
The "Healthy China 2030" blueprint	The Communist Party of China Central Committee and the State Council	2016
Guidance on the construction of healthy urban health villages and towns	Office of Patriotic Health Campaign Committee (PHCCO)	2016
National Health City Assessment and Management Measures	Office of Patriotic Health Campaign Committee (PHCCO)	2015
National health literacy promotion action plan 2014-2020	National Health and Family Planning Commission of the PRC	2013
China chronic disease prevention and treatment work plan (2012-2015)	National Health and Family Planning Commission of the PRC	2011
Action Plan on Environment and Health (2007-2015)	Ministry of Public Health	2007
Shanghai Healthy City Action Plan 2015-2017	Shanghai Municipal People's Government	2014
Shanghai Health Promotion Plan 2011-2020	Shanghai Municipal Commission of Health and Family Planning	2010
Shanghai Health Community Guidance Indicators (Trial)	Shanghai Municipal People's Government	2003

Source: own compilation

3.3.2 Interview

Primary data as empirical evidence was essential for the research on the policy process per se. Therefore, in-depth interviews with local actors were necessary.

Based on the setting of the Shanghai Health Promotion Committee, four groups of actors (municipal government; district government; academia; the non-profit organisations) and over ten organisations in Shanghai were approached. It follows the approach to start from the academia to the government, and then from the district level to the municipal level. Eventually, thirteen in-depth interviews were conducted in the field between 4th of October and 24th of November 2017, and a follow-up session from the 1st to 10th of January, 2018.

The process of interviewing, sampling and target groups all had to be adjusted on site since gaining trust and setting appointments with interviewees in a short time was

difficult. So the interviews are not conducted fully according to the plan, but rather depend on the schedule of the interviewees and the actual information provided during the interviews. The actual number of interviews conducted was below expectation (13 compared to 30), however, it covered the four groups of actors targeted, including municipal government; district government; academia; the non-profit organisations. The community was not included in this study due to their absence in the decision-making process of formulating a Healthy City programme.

Sampling

A sociometrist or "snowball" sample was deployed, which is an effective way to estimate the "population" of stakeholders (Dunn, 2012). Snowball sampling is a non-probability sampling technique to identify key informants since access to the sample was dependent on local knowledge. Snowball sampling generated an average of ten key informants, reflecting different categories of organisations: the statutory (health and local authority); the non-profit organisations; academia; and the community.

One of the key principles determining sample sizes in qualitative research is saturation. The concept of saturation originated from the grounded theory developed by Glaser and Strauss (1967). Conceptual categories are "saturated" when no additional issues or insights emerge from data and all relevant conceptual categories have been identified, explored, and exhausted in data collection (Hennink, Kaiser and Marconi, 2017). In this research, the sensitising concepts are bounded by actor-centered institutionalism. Therefore, saturation in this study means that all the conceptual categories are covered by the data collected from qualitative research.

Considering the difficulty in approaching government officials, who are often reluctant to be interviewed or questioned—especially when it comes to how they operate behind the scenes—the snowballing process started with the key informants from academia who have been involved in the Healthy City programme from the beginning and actively participated ever since. With the connection and the reputation of the leading academics, getting access to and building trust with officials became easier. The challenge lies in extending our knowledge and finding the balance between obtaining the trust of officials and dealing with the information objectively (Zheng, De Jong and Koppenjan, 2010).

Time plan

Planning for the appointments was also difficult, due to the busy schedule of people working at the decision-making level. The author had to be on-site and meet the informants to get in contact and make appointments. People don't take email or phone calls that easily before meeting in person. After building up connections with the initial

informants, more interviewees can therefore be accessed, which caused certain delays in the plan.

Another challenge that occurred during the fieldwork was the ongoing 19th National Congress of the Communist Party of China, which is a party congress that is held every five years. It is a time of a general personnel reshuffle, as well as review and changes to policy direction at the national level. Therefore, it is considered a crucial and sensitive period in the Chinese political context. For this whole week, censorship intensified, and the chance of meeting government officials was limited.

Semi-structured interviews with open-ended questions were used and the transcripts were subject to content analysis (Goumans and Springett, 1997). As mentioned in the research design, interviews were used to understand the actors' perspectives on the Healthy City programmes; for example, their perception of the policy content, their motivation to participate in the policy process, their influence on the policy content and process, their perception of other actors and how they interact with each other. Their subjective opinions could only be obtained by in-depth interviews and open-ended questions. The result from the interviews also guided the mapping of stakeholders and provided clues to the hidden rules in the policy process, which are essential for portraiting the institutional settings. The topics related to each research question are illustrated in Table 3.7.

Table 3.7 Interview guidelines

Themes	Topics
Resources of actors	Time, human and financial resources available and invested into the HCP
Orientations of actors	Motivation to participate in HCP; Perception of the HCP and own influence on it
Interactions	Perception of other actors and the relations
Institutional settings	Preferences for various attributes and alternatives

Source: own compilation

As an example of how questions could be asked in the interviews, the following structure is presented as a draft for interviewing officials in government departments, which is adapted from the WHO European Healthy Cities evaluation (de Leeuw *et al.*, 2015):

- What has the department done to promote Healthy City programmes?

- Has the department been successful in developing and implementing a city health development plan? Do you have evidence for this?
- To what degree have Healthy City programmes developed working links and synergy with other projects and initiatives such as central government programmes?
- How did the Healthy Cities programmes influence the way and the procedure of working in the department?
- Have Healthy City programmes been successful in forging effective partnerships with other city departments and sectors?
- Do you have personal contacts with other actors besides Healthy City programmes?

3.4 DATA ANALYSIS

Table 3.8 Data analysis and representation in the case study

Steps	**Data analysis and representation**
Data organisation	Create and organise files for data
Reading, memoing	Read through text, make margin notes, form initial codes
Describing the data into codes and themes	Describe the case and its context
Classifying the data into codes and themes	Use categorical aggregation to establish themes or patterns
Interpreting the data	Use direct interpretation; Develop naturalistic generalisations of what was learned
Representing, and visualising the data	Present an in-depth picture of the case using narrative, tables, and figures

Source: adapted from Dunn (2012)

In general, a qualitative approach of analysis is taken. After multiple sources of information are collected, the data needs to be organised and stored carefully, e.g. masking the names of respondents. The analysis process includes the perplexing exercise of trying to make sense of the data inductively, from generalized perspectives, like codes, categories, themes or dimensions, followed by the deductive work to gather evidence to support the interpretations and themes. This process is worked through multiple levels of abstraction, starting with the raw data and forming broader and broader categories.

While writing, different forms of narratives were experimented with to represent the data from different perspectives. In the end, the findings were discussed by comparing them with extant literature, emerging models and the researcher's personal views. The work of data collection, data analysis, and writing reports are all interconnected processes, which need to be repeated continuously. In the approach of the case study, general organising steps to follow are presented below.

The following section will present the main methods adopted in this research, including stakeholder analysis, document analysis and discourse analysis.

3.4.1 Stakeholder analysis

To identify the main actors in the Healthy City programme, first, a stakeholder analysis is needed. Similar stakeholder analyses were conducted in the evaluation of Healthy City programmes in Bangladesh and California (Burton, 1999; Kegler, Twiss and Look, 2000), The first focuses on the value of evaluation and how such evaluation can involve the stakeholders in identifying evaluation needs and tools. The second provides the framework to measure intermediate community changes. The potential of this kind of analysis lies within the evaluation of ongoing projects, especially for primary stakeholders.

The stakeholder analysis is based on the assumption that stakeholders have an influence on the success of the policy and are interested in its outcomes. It collects and structures information on stakeholders, resulting in specific participation strategies for each group. It finally forms the tables and matrices for stakeholder classification and participation strategies.

The following steps of the stakeholder analysis were taken for the Healthy City Action Plan in Shanghai. First, the policy papers and literature on Shanghai's Healthy City Action Plan were collected and analysed and key government officials and scholars identified. It was difficult to find specific names in the policy papers, therefore we found the responsible government officials listed on the government website or mentioned in the newspaper articles. It was not common for participants of the policy making process to be directly mentioned in the policy papers. However, the information could be obtained from the articles or publications that the responsible government officials publish together with the scholars. The roles of the scholars could be identified preliminarily from the topics of the publications. Since it was easier to approach scholars than government officials, we started with one of the scholars who published frequently on Shanghai's Healthy City Action Plan. After interviewing the first scholar, the list of the stakeholders got longer and the contacts of the government officials in charge of the Healthy City programme were accessible.

Table 3.9 Steps of a stakeholder analysis

STEPS	CONTENT
STEP 1	Using policy papers and literature on Shanghai's Healthy City Action Plan, identify and list about 10 stakeholders who have taken a public position on the policy. Make the list as heterogeneous as possible by sampling opponents and supporters.
STEP 2	For each stakeholder, obtain a policy document or literature that describes the position of each stakeholder.
STEP 3	Beginning with the first statement of the first stakeholder, list other stakeholders mentioned as opponents or proponents of the policy.
STEP 4	For each remaining statement, list the new stakeholders mentioned. Do not repeat.
STEP 5	Draw a graph that displays statements 1, 2, 3..., n on the horizontal axis. One the vertical axis, display the cumulative frequency of new stakeholders mentioned in the statements. The graph will gradually flatten out, with no new stakeholders mentioned.
STEP 6	Add to the estimate stakeholders who should be included because of their formal positions (organisation charts show such positions) or because they are involved in one or more policy-making activities: agenda setting, policy formulation, policy evaluation & policy adaptation, succession or termination.

Source: adapted from Dunn (2012)

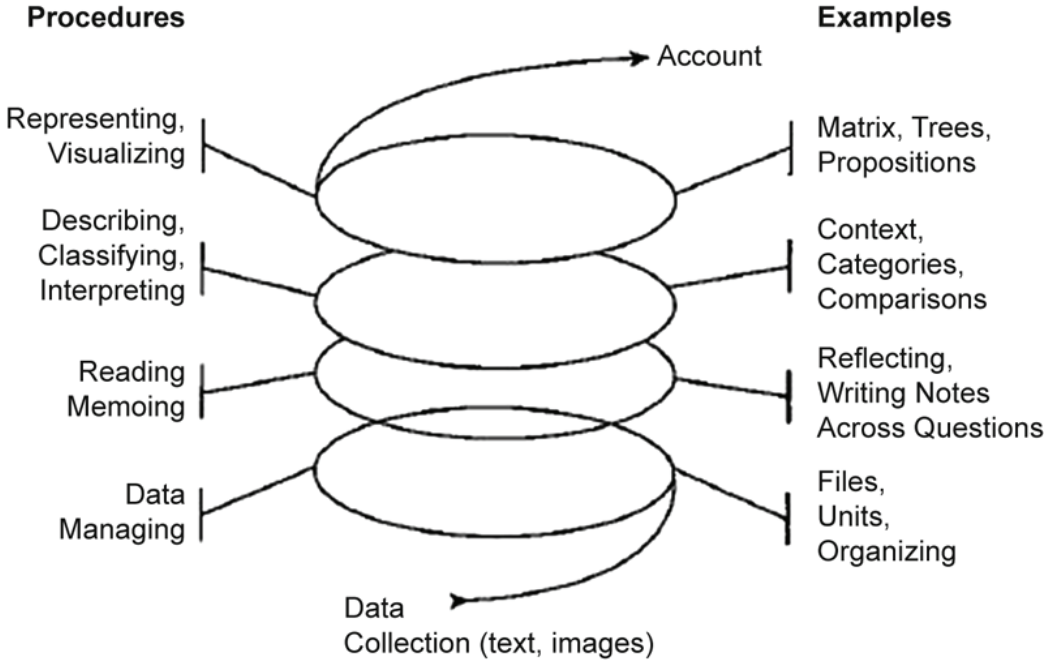
In the process of making Shanghai's Healthy City Action Plan, the government, citizens and other participants have different levels of influence. Government departments are the most decisive part, especially the officers who oversee the health promotion committee; the influence of other participants including NGOs, and the expert consultant group is less significant. Although the policy papers stated that the demand of citizens is important, the citizens do not participate in the decision-making process of the policy; they are only consulted and have no veto power. Since the focus of the study is on policy interactions, citizens are not directly included in the policy process analysis but are considered as the group influenced by the policy.

3.4.2 Content analysis

Qualitative content analysis is a careful, detailed, systematic examination and interpretation of a particular body of material to identify patterns, themes, biases, and meanings (Berg and Lune, 2009). The content itself might be texts of various formats, pictures, audio or video. Social scientists use content analysis to examine patterns in communication in a replicable and systematic manner. One of the key advantages of using content analysis to analyse social phenomena is its non-invasive nature, in contrast to simulating social experiences or collecting survey answers (Bryman and Bell, 2011).

The process of analysing the document data followed the general data analysis steps developed by Creswell. It starts at the bottom of the spiral and proceeds upwards through various stages, including 'Reading, Memoing', 'Describing, Classifying, Interpreting', and 'Representing, Visualising', until a written account is developed. Also, some specialised steps for the case study: 1) organisation of details (logical/chronological order); 2) categorisation of data; 3) interpretation of a single instance; 4) identification of patterns; 5) synthesis and generalisation (Creswell and Poth, 2016).

Figure 3.1 The Data Analysis Spiral



Source: Creswell and Poth (2016)

The particular content in the study of Healthy City programme (HCP) in Shanghai includes government plans, reports, literature, and news articles were analysed in order to answer different themes in the research questions, which are stated in Table 3.10.

Table 3.10 Research questions and related documents

	Themes	Documents to be analysed
RQ1	Discourse of Healthy City	International guidelines, national standards, local action plans
RQ2	Actor's resources	Budget plan of the HCP and involving departments; notices of appointment & removal for the HCP and relating committees;
	Perceptions	Transcripts of meetings of the HCP committee; policy papers related to the HCP, reports on the work of the government; news articles
	Interactions	Historical records, transcripts of meetings
RQ3	Formal institution	Policy papers (regulations, laws, guidelines), reports on the work of the government
	Informal institution	Literature on traditions, news articles

Source: own compilation

Research question 1 focuses on the resources and perceptions of different actors in the HCP, therefore, budget plans, and changes in the administration organisation were analysed to figure out the financial and human resources that the actors possess and invest in the HCP; the priority of the HCP in the political agenda was reflected upon what was discussed during the meetings, reports on government work and the amount and frequency of news reports concerning it. The comparison of two major and recent programmes, the National Hygiene City and Healthy City, was done before the fieldwork was conducted to lay the foundation for the interview guideline since the research aims to investigate the reasons for the policy changes.

Research question 2 focuses on communications among the actors that are central to research question 2. The minutes of meetings and other records of communications among the actors are examined to find out the relations, whether closer or farther between certain pairs of actors.

The last part deals with the institutional settings, both formal and informal. The formal institutions are represented by regulations, laws, and guidelines that determine the rules for the HCP. Other aspects like traditions and social norms are taken as informal

institutions that can be acquired by literature and everyday reports like newspaper articles.

The content has to be "decoded" so it can be summarised and understood by others. Content analysis provides a way to do this. Although this is not the only technique for textual analysis, it is a major one. It is in this type of analysis that the most striking differences between quantitative and qualitative approaches can be seen (Goodman, 2011). Qualitative content analysis goes beyond merely counting words or extracting objective content from text to examine meanings, themes, and patterns that may be manifest or latent in a particular text (Zhang and Wildemuth, 2009).

Hsieh and Shannon (2005) define three clear and succinct categories for the application of content analysis: conventional content analysis, directed content analysis, and summative content analysis (see Table 3.11). Conventional content analysis is a way to describe a phenomenon when the existing information or theory on its occurrence is limited. Researchers examine the text and allow names for categories to emerge from the text, as opposed to assigning pre-determined categories. Directed content analysis is less flexible in terms of identifying key themes and categories. This approach begins with the assumption that existing theory is helpful, and can be used to explain a phenomenon, but it is incomplete. Researchers use this approach to "validate or extend" current theory. Thus, categories are predetermined from the existing literature, as opposed to surfacing from the textual examination. Summative analysis connects the frequency of a given word with its contextual meaning and aims to deepen the understanding of the phenomenon by the researcher. Meanings associated with different words, related symbolism, and euphemistic versus explicit meaning are all areas where the researcher may discover rich connections and meaning associated with the text (Hsieh and Shannon, 2005).

Table 3.11 Three types of content analysis

Type of content analysis	**Approach**	**Purpose**
Conventional content analysis	Categories are surfacing from the textual examination	When the existing information or theory on its occurrence is limited
Direct content analysis	Pre-determined categories	To "validate or extend" current theory
Summative content analysis	Connects the frequency of a given word with its contextual meaning	Deepen the understanding of the phenomenon by the researcher

Source: own compilation based on Hsieh and Shannon (2005)

3.4.3 Discourse analysis

> *Whatever does exist we can only know by way of our constituting it through discourse.*
>
> *- Grint, 1995, p. 8*

Discourse analysis has been deployed as a methodology to understand the urban policy implementation process (Jacobs, 2006). Schmidt also pointed out that bounded generalizations founded on actors' strategic institutional interactions are not enough. Interpretations based on ideas, values, and deliberation, which are under the umbrella of discourse, are necessary to a complete understanding of policy change (Schmidt, 2003). This approach is used here to interpret the political and scalar construction of the Healthy City programmes in China.

Table 3.12 Analytical structure for discourse analysis

Dimension	Content
Text analysis	The study of the structure of text, vocabulary and grammar cohesion
Discursive practice	The analysis of the processes in which texts are framed, that is, the context in which statements are made and fed into other debates
Social practice	A study of discourse concerning wider power structures and ideology

Source: adapted from Fairclough (1989, 1992, 1995) cited in Jacobs (2006)

The substantive content of discourse is ideas. They exist at three levels—polities, programmes, and philosophies—and can be categorized into two types, cognitive and normative. Discourse is the interactive process of conveying ideas. It comes in two forms: the coordinative discourse among policy actors and the communicative discourse between political actors and the public. These forms differ in two formal institutional contexts; simple polities have a stronger communicative discourse and compound polities have a stronger coordinative discourse (Schmidt, 2008).

Discourse analysis is based on three main propositions: first, subjects are primarily shaped by discourses, not vice versa. A preoccupation with language, with systems of meaning: something can only become a part of social reality when codified in language or in other signifying relations. Second, it is an 'empty' ontology; meaning is always relational and related to differences. Third, discourses are wider cultural or social systems, and political distributions are clashes of competing discourses (Grint, 1995).

Discourses rely on certain elements that function as nodal points or centres of a discourse. The key elements include the centre of discourse; what is excluded from the discourse; what is opposed to the centre (Xu, 2015a). Fairclough (1989, 1992, 1995)

provides a clear analytical structure for adapting discourse analysis within a three-dimensional framework (cited in Jacobs, 2006):

Discourse analysis applies an adapted version of formal logic to structure reasoning used in policy debates, which here means competing institutional logics among different actors in the Healthy City programme in Shanghai. Chains of arguments are presented as an outcome, consisting of ground, claim, warrant, backing, rebuttal, and modality.

The discourse on health and Healthy City can be studied based on the international guidelines, national standards and local plans. Historical versions can be used to compare the changes in discourse, thus reflecting the evolution of perceptions and awareness.

3.5 VALIDATION PROCESS

Triangulation methods were used in this study to validate data and ensure the accuracy of the results. Denzin (1970/1978) introduced the idea of triangulation as "the combination of methodologies in the study of the same phenomenon (Denzin, 1978: 291 cited in Flick, 2017)." It means the researchers take different perspectives in answering research questions. These perspectives can be illustrated by combining different types of data, using several methods or in several theoretical approaches (Flick, 2017) (see Table 3.13). This convergent methodology has been used in social science research as a validation process to ensure the accuracy of the judgements (Jick, 1979).

Table 3.13 Triangulation methods

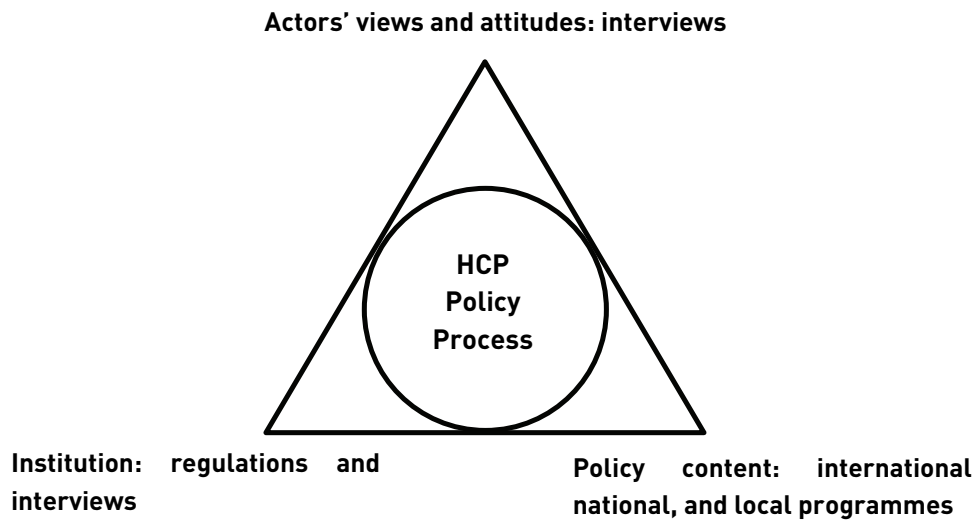
Methods	Content
Data source triangulation	Collecting relevant data from different times, spaces, and people to the same phenomenon to gain multiple perspectives and validation of data (Jick, 1979).
Method triangulation	Using multiple methods to approach the same dimension of a research problem, such as interviews, observations, questionnaires, and documents, to test the degree of external validity (Denzin,1978: 302).
Theory triangulation	Using varying theoretical perspectives to analyze and interpret data. Different theories or hypotheses can assist the researcher in supporting or refuting findings (Carter *et al.*, 2014).

Source: own compilation based on literature

In this research, various types of data collected through documents and interviews (see section 3.3) were analysed with different qualitative methods including stakeholder

analysis, content analysis and discourse analysis (see previous sections in 3.4). Varying theoretical perspectives were applied in this research, such as several theoretical lenses presented in section 2.2. The triangulation of perspectives in the policy process is presented in Figure 3.2.

Figure 3.2 Triangulation of perspectives in the policy process



Source: own compilation

The policy content of the Healthy City programme needs to be reviewed to understand how the local programme was influenced by both international and national programmes. Interviews need to be done with actors to understand their perspectives and expectations in the programme. Regulations and documents need to be reviewed and compare with the experts' view on existing support or barriers in institutions. With a systematic triangulation of perspectives, the policy process of HCP can be understood.

This research examines the policy process of the Healthy City programme in Shanghai. It covers the period from the 1950s until late 2010s, programmes from Patriotic Health Campaign to Healthy City Action Plan, and scales from local to international levels. Extensive literature and policies were collected from various resources, covering different times, spaces and people. For example, to understand the policy process of the Shanghai Healthy City Action Plan, I collected and analysed data from Shanghai. I not only compared the results with previous studies in Shanghai but also compared with similar studies on the Hygienic City in China and Healthy City Programmes around the globe.

Different methods were used to approach the same research question as shown in Table 3.1. For example, to understand the actor constellation, I first reviewed the policy documents to identify the actors' position in the policy process, and then I conducted in-

depth interviews with the actors to verify not only their own positions but also other actors' positions. After all the interviews were finished, I cross-checked the mapping of stakeholders to make sure they fit into the same picture, and if not, to find out the reason behind those differences.

Actor-centered institutionalism is a framework that integrates several theories from political science and economics, including ‘principal-agent theory’ and ‘common pool theory’. Other concepts and theories from policy studies in China were also integrated into the framework, such as ‘rank-order tournament’, ‘the shadow of hierarchy’ and ‘guanxi’ (personal connections in China). These frameworks allowed me to see the same problem with different perspectives and examine their compatibility or conflicts with each other.

Therefore, the triangulation process not only improved the validity of the various data collected, but also provided new perspectives on the same data and results, thus improving the validity of the framework and generalising the results from this study to a broader context.

This chapter focused on the methodology of the research in order to answer the research questions. The rationale for choosing qualitative research and methods were explained. The overview of the study area was presented. The next chapters will be dedicated to answering three research questions.

4 HEALTHY CITY DEVELOPMENT IN CHINA

This chapter examines the Healthy City development as both an international movement and a local campaign based on the policy outcome presented in documents. Health and Healthy City discourses are examined by exploring the divergence and convergence of local action plans with international guidelines and national standards. It is possible to identify major sources of influence across the various stages of the policy process.

4.1 INTERNATIONAL AND NATIONAL PROGRAMMES

Various actions around the world have tried to make cities healthier places to live in. In this section, three international and national programmes that influenced the Healthy Cities development in China are introduced. The background and the timeline of each programme are presented before starting the comparisons of the three programmes in the next section.

The action of connecting public health and urban planning can be traced back to the 19th century, to practices in countries like Britain, Spain and Canada (Awofeso, 2003). It was not until the World Health Organization in the European Region started the Healthy Cities Programme in 1986 that this act became an international movement, supported by systematic indicators and guidelines. Since 1987, WHO Europe has issued Healthy Cities planning every five years for more than thirty years now (Tsouros, 1991b; Tsouros, 2015).

In contrast to the international Healthy Cities movement, the story from the non-western world has rarely been told. This is especially true in China, where several local campaigns were developed in order to improve the rural and the urban environment for public health. One of them is the Patriotic Health Campaign which began in the 1950s and has been carried out on a national scale in China since its start.

In 1989, the National Patriotic Health Campaign Committee began the National Hygienic City (NHC) programme as a national inspection. This gradually evolved into a city award issued every three years based upon applications from municipalities or towns (Wang, 2012a). In 1999, the Central Civilisation Commission started another city award under the name of National Civilised City. These awards were especially influential due to the strict evaluation and huge competition among the cities across China (Hou, 2017).

These national health campaigns paved the way for Healthy City development in China. Following the WHO officers' suggestion to the Ministry of Health in China in the 1990s, Beijing and Shanghai were chosen as the first pilot projects in 1994. These studies served to justify the feasibility of introducing the Healthy Cities Programme in China. In 2007, 10 pilot projects were chosen, and many more cities joined the Healthy Cities development

in China. Each city made plans according to its own conditions, established specific institutes in charge of the implementation and coordination of the Healthy City plan, and carried out various health promotion strategies to improve the health level and life expectancy of citizens (Fu, Xuan and Li, 2006).

Table 4.1 The development of Healthy City in Shanghai 1952-2016

Year	China	Shanghai
1952	Patriotic Health Campaign	Patriotic Health Campaign
1955	Control Vector Species	Control Vector Species “Four Pests”
1966	2 managements and 5 reforms	
1981	5 Stresses, 4 Beauties	5 Stresses, 4 Beauties
1983	5 Stresses, 4 Beauties, 3 loves	
1989	National Hygiene City	
1994		WHO Healthy City Pilot Project: Jiading
1999	National Civilised City	
2002		Shanghai Healthy City Action Plan Phase I
2007	National Healthy Cities pilot projects	
2011	“Clean-up Campaign”	Shanghai Health Promotion Plan 2011-2020
2016	Healthy China 2030	Healthy Shanghai 2030

Source: own compilation

In 2003, Shanghai Municipal Government issued the Healthy City Action Plan 2003-2005. It is the first Healthy Cities planning from the municipal level in a mega-city in China (Wang, 2005). The plan was adapted from the principles and indicators of the WHO Healthy Cities guidelines to fit the local needs. In 2005, the health promotion committee was established as the steering committee of the action plan. New plans were issued every three years under the coordination of the Municipal Office of the Patriotic Health Campaign Committee (Tang *et al.*, 2016).

Under the guidance and support of the Commission of National Patriotic Campaign and the WHO, Healthy Cities constructions have achieved great success over the past twenty years. Several cities received recognition and accolades after visits from the WHO (Wang, Xie and Sheng, 2016). In August 2016, the National Patriotic Health Campaign Committee issued the guidelines for initiating the construction of Healthy City and Healthy Village.

This was the first national guideline for Healthy Cities promotion in China (NPHCCO, 2016b). In November 2016, the Communist Party of China's Central Committee and the State Council issued the "Healthy China 2030" blueprint, which put health into the centre of national strategies again.

4.1.1 International Healthy Cities Movement

In order to bring the WHO strategy Health for All to the local level, Healthy Cities in Europe was formally launched in 1987-1988. In January 1986, the planning of the Healthy Cities project was started by a small group of health promoters gathered at the WHO Regional Office for Europe in Copenhagen. Eleven cities were selected for the WHO project in 1986, growing to 35 cities and 25 national networks in the first phase (1987-1992) of the WHO European Healthy Cities Project (Tsouros, 2015).

Since the 1980s, the concept, principles, and approaches of Healthy City have been discussed by the scholars and practitioners working around the Healthy City movement from WHO. Planning, implementation and evaluation are conducted in a collaborative way and shared in the Healthy Cities Network. Throughout the years, WHO has also gradually developed Healthy City guidelines on a regional basis.

Among the pioneers of the Healthy City movement, Hancock and Duhl (1986, p. 33) developed the parameters of a Healthy City based on several influential urban planners and theorists, i.e. Kevin Lynch, Constantino Doxiadis, and Hans Blumenfeld, suggesting that 11 parameters are worthy of consideration:

1) A clean, safe, high quality physical environment (including housing quality)
2) An ecosystem which is stable now and sustainable in the long term
3) A strong, mutually supportive and non-exploitative community.
4) A high degree of public participation in and control over the decisions affecting one's life, health and well-being.
5) The meeting of basic needs (food, water, shelter, income, safety, work) for all the city's people.
6) Access to a wide variety of experiences and resources with the possibility of multiple contacts, interaction and communication.
7) A diverse, vital and innovative city economy.
8) Encouragement of connectedness with the past, with the cultural and biological heritage and with other groups and individuals.
9) A city form that is compatible with and enhances the above parameters and behaviours.
10) An optimum level of appropriate public health and sick care services accessible to all.
11) High health status (both high positive health status and low disease status).

To achieve these goals of the Healthy Cities, the WHO established a number of principles, strategies and approaches. In the first statement about the Healthy City strategy, developing a Healthy City requires commitment, involvement and participation at three levels that combines both top-down and bottom-up approaches (Hancock and Duhl, 1986, p. 39).

a. Commitment of municipal (and where appropriate, regional or national) governments.
b. Involvement of a broad-based coalition/network of community agencies, organisations and groups.
c. Participation by citizens.

Later on, more authors suggested the principles of Healthy Cities, which are presented in Appendix 1. These principles range from three to eleven elements in different publications, and from infrastructure to networking. However, aspects such as a) political commitment, b) changes in process, and c) inter-sectoral collaboration are always highly valued in the Healthy City development, therefore, these important elements were taken into the conceptual framework.

More recently, with the renewed 2030 agenda and the Shanghai Declaration on the 9th Global Conference of Health Promotion, Healthy City Programmes also build a closer connection with sustainable development worldwide, especially Sustainable Development Goal 11 (WHO and UNDP, 2016).

The focus of the 2030 Agenda for Sustainable Development shifts the view on how interconnected our social, economic and environmental ambitions are. A Healthy Cities approach generating health promotion efforts will contribute to achieving the Sustainable Development Goals (SDGs), for example, SDG 11: Make cities and human settlements inclusive, safe, resilient and sustainable. A powerful value-based commitment to innovations at the cutting edge of social determinants of health and Health in All Policies is also enclosed in the distinctive contributions of the successful WHO Healthy Cities programmes/movement. Healthy Cities Networks in all WHO regions have become an important platform for achieving health and sustainable development in many parts of the world, as cities are often at the forefront of innovation with mayors and municipalities spearheading efforts to enhance the daily conditions of urban life. Political leadership and participatory governance can be transformational for health and health equity, as well as help mitigate the impacts of environmental degradation, climate change, ageing, migration, growing inequalities and social isolation can be catalysed by a Healthy City approach as well (see Appendix 3) (WHO and UNDP, 2016).

The WHO European Healthy Cities Network has been developing based on 5-year cycles, with specific goals, objectives, values and principles. The theme has been evolving with cutting edge concepts, including city health profiles in phase I, intersectoral action in phase II, addressing social determinants of health in phase III, healthy urban planning and health impact assessment in phase IV, health equity in phase V, and Sustainable Development Goals in phase VI (Tsouros, 2015).

Since the late 1980s, the WHO Western Pacific Region (WHO/WPRO) has been promoting the Healthy Cities initiative as an integrated and multisectoral approach to address urban health issues. By World Health Day in 1996, which adapted the theme "Healthy Cities for a Better Life," hundreds of cities worldwide had in some way or another linked with the international Healthy Cities network (World Health Organization. Regional Office for the Western Pacific, 2000).

In 1994 WHO/WPRO decided to initiate Healthy Cities pilot projects in developing countries in the region like China to cope with rapid urbanization and the health issues it brings about. WHO collaborated with the Ministry of Health and conducted pilot projects in Beijing Dongcheng and Shanghai Jiading, as examples of downtown and suburban areas respectively. By 1998, there were six WHO-supported Healthy Cities projects in China (World Health Organization. Regional Office for the Western Pacific, 2000).

In 1993, the WHO Regional Office for Western Pacific developed a broad project proposal designed to involve selected cities as model cases and the Ministry of Health as a national focal point to coordinate and facilitate various Healthy City-type activities. WHO discussed this generic proposal with the government of China and developed more country-specific proposals which were endorsed by the government in early 1994, choosing Jiading District in Shanghai as one of the pilot projects, the other one being Dongcheng District in Beijing (World Health Organization. Regional Office for the Western Pacific, 2000).

In May 1994 the WHO advisor of WPRO visited the Jiading district and met senior government officials of the Shanghai People's Government. They concluded that the "Healthy City Programme" should be launched to promote health in the Jiading District. The Healthy Urban China project commenced in the third quarter of 1994, which focused on the integration of health and environment considerations into planning for sustainable development. (World Health Organization. Regional Office for the Western Pacific, 2000).

In October 1996, the WHO held the Regional Consultation on Healthy Cities in Beijing, China to conclude the projects (World Health Organization. Regional Office for the Western Pacific, 2000). In the following decade, WPRO continued to publish guidelines on Healthy Cities, for example, the "Healthy Urbanization" in 2011, "Toolkit for local governments to support healthy urban development" in 2015, and "Regional Framework for Urban Health" in 2016 (World Health Organization. Regional Office for the Western

Pacific, 2000; World Health Organization. Regional Office for the Western Pacific, 2011; World Health Organization. Regional Office for the Western Pacific, 2015; World Health Organization. Regional Office for the Western Pacific, 2016).

The objective of the "Healthy Urban China – Jiading District" project was to evaluate the present capacity of urban facilities to provide environmental management, and social and health services; predict future development that would cause new problems; and find methods to solve them (World Health Organization. Regional Office for the Western Pacific, 1996). The case study report served as a baseline and feasibility study of the Healthy Cities initiative in China. After the project finished in 1996, there were no further actions by WHO or the Ministry of Healthy on the Healthy Cities movement in Shanghai.

In 1997, the Government of China decided to establish a national coordination role for both the Healthy Cities and Hygiene Cities projects with the National Patriotic Health Campaign Committee. Hygienic Cities projects that have adopted the Healthy Cities concept are considered to be equivalent to the Healthy Cities projects (World Health Organization. Regional Office for the Western Pacific, 2000).

4.1.2 Patriotic Health Campaign

Long before the Healthy City concept was introduced to China, China's Communist Party started promoting the health of the people. In 1933, Mao wrote in the *Changgangxiang Report*: "disease is a big enemy in Soviet Area since it weakens our power. To initiate people's health campaign to decrease or even eliminate diseases is the Soviet responsibility of every township". In 1941, the Committee of Disease Prevention was established in Shaanxi - Gansu - Ningxia Border Region later (Yang, 2004a).

The Patriotic Health Campaign first started in the 1950s, is a social movement aimed to improve sanitation, and hygiene, as well as to attack diseases in China. This was the first major national programme that put health into consideration since the establishment of the People's Republic of China. By 1953, a complete institution of disease prevention had been established, which was later renamed the National Patriotic Health Campaign Committee Office (NPHCCO) (*ibid.*).

The Patriotic Health Campaign can be traced back to the Korean War in the 1950s, as a reaction to germ warfare, which turned out to be a rumour. In 1959, the Office of National Patriotic Health Campaign Committee initiated the "Control Vector Species" programme. This was initially targeted at controlling rats, sparrows, flies, and mosquitoes, and was modified to rats, cockroaches, flies and mosquitoes in 1960 after opposition from zoologists. The programme not only dealt with the vector species mentioned but also impacted the hygiene conditions more generally. In just six months, more than 15 million

tons of rubbish were cleared across the country, 280,000 kilometres of channels had been dredged, 4.9 million toilets were built and reconstructed, and 1.3 million wells had been reconstructed (NHCPRC, 2014).

In the 1960s, as the strategy of the national development shifted to the countryside, the focus of health work also shifted to the rural sanitation infrastructure. For example, the “Two managements and five reforms” programme was introduced, which was based on the experience of grassroots staff referring to managing water and manure, transforming water wells, toilets, livestock pens, stoves, and the environment. "Two managements and five reforms" have generated the specific requirements and action targets for organising and guiding the rural patriotic health campaign (NHCPRC, 2014).

After the economic reform in 1978, known as the “Open-up policy”, the focus of development shifted to cities, and so did public health work. Programmes like “Five Stresses and Four Points of Beauty” started to improve the sanitation infrastructure in urban areas (NHCPRC, 2014).

Since 1989, the National Hygienic Cities programme has been implemented under the guidance of the Office of National Patriotic Health Campaign Committee (NPHCCO) with its own criteria, awarding cities for improving physical infrastructure and environment. Since the National Congress approved the hygiene examination of 455 cities in 1990, national hygiene examinations were conducted in central-administered municipalities (municipalities under direct administration of the central government), provincial capitals and other major cities in China in 1992, 1995, and 1997 (Wang, 2012a).

The National Hygienic City Inspection and Assessment Standards Implementation Rules were issued in 1991. The National Patriotic Health Campaign Committee organised training programmes for inspectors of the programme, held seminars for mayors to develop National Hygienic Cities, conducted field investigations in several cities and commended the awards for seven cities in 1992 (*ibid.*). Since 1999, instead of conducting inspections for all the cities around the country, the Office of the National Patriotic Health Campaign Committee changed the process to being application based. Since 1999, the results from former examinations (in 1992, 1995, and 1997) have become a basis for applications (Li, 2005).

In 2000, the National Patriotic Health Campaign Committee (NPHCC) issued the standards for National Hygienic Districts (NHD) to encourage the districts of central-administered municipalities to participate in the National Hygienic City programme (NPHCC, 2000). By April 2012, the NPHCC had named 153 National Hygienic Cities, and 32 National Hygienic Districts. By December 2018, there were 93 National Hygienic City (Districts) which were reconfirmed, accounting for one-sixth of all the cities in China. As of February 2019, there were in total 342 National Hygienic Cities and National Hygienic Districts (NHCPRC, 2019).

Table 4.2 The development of National Hygienic City Standards

Year	Policy document	Issuing Institute
1989	*Notice on the development of National Hygienic city activities*	National Congress
1991	*National Health City Inspection and Assessment Standards Implementation Rules*	NPHCC
1994	*National Health City Inspection and Assessment Standards Implementation Rules (Revised)*	NPHCC
1999	*National Health City Standards and Assessment Nomenclature*	NPHCC
2005	*National Health City Standards and Assessment, Supervision and Management Measures*	NPHCC
2010	*National Health City, District Standards, Appraisal Nomenclature and Supervision and Management Measures*	NPHCC
2014	*National Health City Standards and Assessment Methods*	NPHCC

Source: own compilation

A survey conducted by Peking University China Centre for Health Development Studies (CCHDS) shows that through the creation of National Hygienic Cities, the reported incidence of statutory infectious diseases has been reduced by 19.4% on average, and the proportion of standardized bazaars has increased from 35.2% to 60.6%, and residents' satisfaction with the city's appearance and environment has increased from 30% to 98%. The satisfaction rate of the sanitation effect reached 98%, achieving good economic and social benefits (CCHDS, 2014). In 2019, according to the evaluation organised by the Office of National Patriotic Health Campaign Committee (NPHCCO) of all National Hygienic Cities across the country, 33 indicators among the 37 indicators in the evaluation had improved compared with the previous year, and 29 indicators were higher than the national average, and 24 indicators were higher than the national target of the year 2020. The median life expectancy per capita in participating cities (districts) reached 79.15 years, and the overall health level of the urban population was better than the national average (NPHCCO, 2019).

Over the past 65 years, the Patriotic Health Movement has successively carried out actions such as eliminating the "four vector species", "Two managements and Five reforms", "Five stresses and four beauties", the creation of National Hygienic Cities, the Health Education Campaign for 900 million farmers, and the urban and rural environmental sanitation

actions in response to prominent health problems in different periods. This has allowed effective control over the epidemic of severe infectious diseases such as plague and cholera, eliminate infectious diseases such as smallpox and filariasis, greatly reduced the incidence of intestinal infectious diseases, parasitic diseases and vector infectious diseases, and basically eliminated Keshan disease, and key endemic diseases such as Kashin-Beck disease. The average life expectancy increased from 35 in the early days of the founding of the People's Republic of China to 76.3 in 2015. The infant mortality rate dropped substantially to 7.5‰ in 2016, and the maternal mortality rate to 19.9/100,000 in 2016, reaching the level of a moderately developed country and achieving the United Nations Millennium Development Goals (Wang and Deng, 2017).

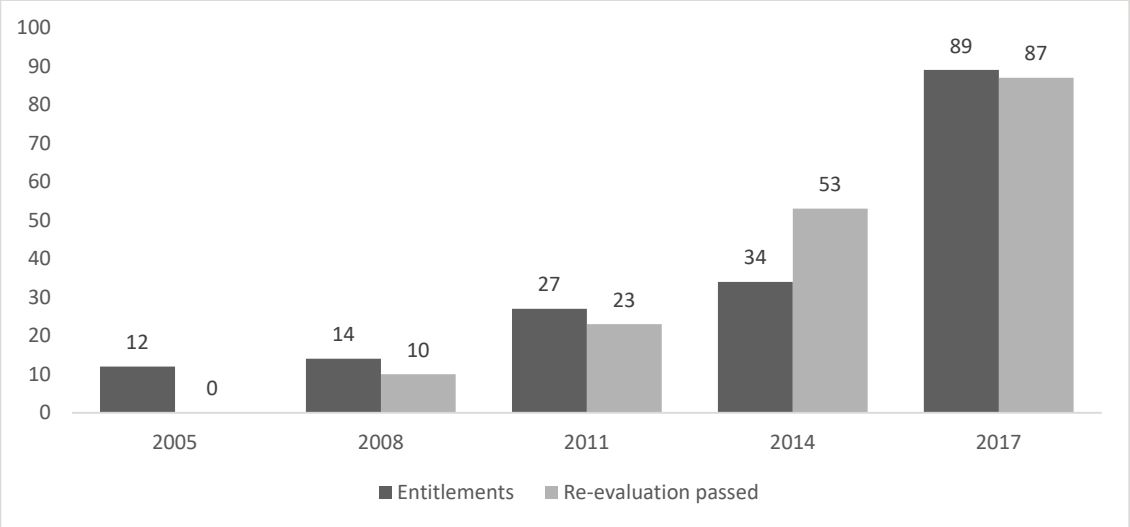
4.1.3 National Civilised City

The National Civilised City is an initiative of the General Office of the Central Commission for Guiding Cultural and Ethical Progress (CCGCEP, *Zhongyang Jingshen Wenming Jianshe Zhidao Weiyuanhui*) which was established in May 1997 (Hou, 2017). The National Civilised City programme is a hybrid form of social control and urban governance that seeks to address the development of Chinese cities not just as economic engines but also as 'environmentally sustainable', 'culturally civilised' settings for their inhabitants (Cartier, 2013).

Instead of targeting one particular goal, the National Civilised City programme sets out standard urban development benchmarks covering government accountability, air quality monitoring and improved public infrastructure including cultural facilities, plus programmes promoting volunteerism and ideals for urban youth. The National Civilised City model is a broad-based approach involving a set of goals, criteria and indices of measurement designed to regularise urban governance and promote its standards nationwide (Barmé, 2013; Cartier, 2013).

The title of National Civilised City is a comprehensive honorary title which has been awarded every three years since 2005, reflecting the overall level of civilisation of the city. It is considered the highest level of award for urban governance in China. Till 2018, 176 cities and districts of municipalities have received the title of National Hygienic City in 5 rounds (see Figure 4.1) (CCGCEP, 2005a; CCGCEP, 2009; CCGCEP, 2012; CCGCEP, 2015; CCGCEP, 2017).

Figure 4.1 National Civilized City awards and re-evaluations



Source: own compilation based on data from CCGCEP

The government has been using the term 'civilisation' (*wenming*) to promote improved civic standards and limit dissent (perceived as harmful to society). One of the paramount leaders in China, Deng Xiaoping, described 'spiritual civilisation' (*jingshen wenming*) as encompassing education, science, culture, communist ideology, morality, a revolutionary attitude and other abstract ideas (Barmé, 2013). Since 1980s, several movements aiming to build spiritual civilisation have taken place in China, such as "5 Stresses, 4 Beauties, 3 love", of which NPHC was also one of the 9 national institutions that initiated the programme. In 1983, the Central Committee of 5 Stresses, 4 Beauties, 3 loves was established. Later in the 1980s, the movement shifted to creating civilised units in urban and rural areas, which is related to the National Civilised City (NCC) movement later (Hou, 2017).

On the Sixth Plenary Session of the 14th Central Committee of the Communist Party of China in 1996, issues related to ideological, moral and cultural construction were discussed, and the "Resolution of the Central Committee of the Communist Party of China on Strengthening Several Important Issues in the Construction of Socialist Spiritual Civilisation" was reviewed and adapted. It pointed out the necessity to create more civilised cities to improve the quality of the citizens and the degree of urban civilisation. By 2010, a number of pilot cities and urban areas were expected to be built, especially municipalities, capital cities, and major cities along the coastal area that should take the lead in creating activities (CCPCC, 1996).

In 1999 and 2002, the Central Civilisation Committee approved 121 cities (districts) for being advanced in building civilised cities. Municipalities directly under the Central Government would participate in the selection of national civilised cities by the districts

of municipalities. In August 2003, the Central Civilisation Commission issued Document No. 20039, clarifying the selection criteria, the selection scope of national civilised cities, civilised villages and towns, and civilised units. In September 2004, the Central Civilisation Commission promulgated the "National Civilised City Evaluation System" (Trial). In 2005, the first batch of National Civilised Cities (districts) was entitled, which was based on previous commendations in 1999 and 2002. Since then, whenever there is a new batch of National Civilised Cities, there are also candidates of the National Civilised Cities selected as a basis for the next award in three years, which means only the districts or municipalities commended in the previous batch can participate in the next National Civilised City selection (CCGCEP, 2005b).

Table 4.3 Major policy papers issued for National Civilised Cities

Time	Policy issued	Issuing Institute
10/10/1996	*Resolution of the Central Committee of the Communist Party of China on Strengthening Several Important Issues in the Construction of Socialist Spiritual Civilisation*	The 14th Central Committee of the Communist Party
21/04/1997	*Notice on the establishment of the Central Guidance Commission on Building Spiritual Civilisation*	The Central Committee of the Communist Party of China
09/1999	*1st batch of National advanced cities in building civilised cities (58)*	The Central Civilisation Commission
10/2002	*2nd batch of National advanced cities in building civilised cities (63)*	The Central Civilisation Commission
25/08/2003	*The Interim Measures of the Central Spiritual Civilisation Construction Steering Committee on the Selection and Recognition of National Civilised Cities, Civilised Villages and Civilised Units*	The Central Civilisation Commission
14/09/2004	*National Civilised City Evaluation System (Trial)*	The Central Civilisation Commission
23/03/2005	*Notice on Recommending National Civilised Cities, Civilised Villages and Towns, Civilised Units, and Advanced Units for the Creation of Spiritual Civilisation in the Country*	The Central Civilisation Commission
09/2015	*National Civilised City Evaluation System (New)*	The Central Civilisation Commission

Source: own compilation

4.2 COMPARISON OF THE PROGRAMMES

After the introduction of the three international and national programmes, in order to understand the convergence and divergence of the three international and national programmes that influenced the Healthy Cities development in China, the three programmes were compared in different aspects such as the scale and time, the standards, and the evaluation process.

Table 4.4 Comparisons of the international and national programmes

	International Healthy Cities Programme	**National Hygienic City**	**National Civilised City**
Scale	International (WHO)	National (NPHCC)	National (CCGCEP)
Type	International network, voluntary participation	National award, application	National award, recommendation & application
Starting year	1986	1989	2005
Time	5 years	2 or 3 years	3 years
Objectives	The improvement of social and physical environment for health	The improvement of the physical environment for health	The improvement of the quality of the citizens and the degree of urban civilisation
Criteria	Both qualitative and quantitative measurements, including commitment of the government, inter-sectoral collaboration, public awareness	Mostly quantitative indicators, focused on public health, urban infrastructure and environmental protection	Quantitative and qualitative indicators and focus on the spiritual civilisation and urban environment. Standards for five levels of administrative divisions separately.
Evaluation method	Self-evaluation and third-party evaluation	Investigation and unannounced visits by national and provincial PHCCO	Household survey and field trips conducted by the National Statistics Bureau

WHO=World Health Organization; NPHCC=National Patriotic Health Campaign Committee; CCGCEP=Central Commission for Guiding Cultural and Ethical Progress.

The Healthy Cities programmes started at the international and national levels at different times and on different scales of application. Research had previously been conducted comparing the National Hygienic City and the international Healthy Cities programme across various dimensions such as background, executive process and evaluation indicators (Xia, 1999; Zhou *et al.*, 2000; Zhu, Cao and Li, 2014). In the research, the National Civilised City programme was included to gain a comprehensive perspective of the divergence and convergence of the three programmes. This enabled deeper investigation into the resulting impacts on the Healthy City programme in Shanghai.

The three programmes share common objectives such as improvement of the environment and vary in other aspects. The main distinctions lie in the criteria for evaluation, the methods of evaluation, and the implementation methods (Wang, 2012b). The criteria for Healthy Cities at the international and national levels are different in terms of qualitative and quantitative measurements. The evaluations of the programmes are also conducted in distinctive manners. The summary of the comparisons is presented in Table 4.4, and the details will be discussed in the following section.

4.2.1 Scale and Time

Scale

As discussed in section 4.1, the international Healthy Cities programme began in Europe but soon became an international movement with national networks of Healthy Cities across the world. There is no official award for being involved in the international movement. However, due to its international status, there is a global recognition of participating nations.

Concerning the scale, the National Hygienic City started as a national inspection in 1989. By 1999 it had developed into a national award from the Chinese government for cities and districts, involving evaluation at the national and provincial levels of Office of Patriotic Health Campaign Committee (PHCCO). Today, municipalities, districts, towns, communities, and units in China can apply and receive this award from the National, Provincial or Municipal level PHCCO.

Similarly, the National Civilised City began as a government inspection scheme in 1999 and became a national award in 2005. Here, the evaluating bodies also include the Commissions of Building Spiritual Civilisation at the national and provincial levels. The evaluation system applies to various municipalities such as central-administered municipalities, provincial-level cities, prefecture-level cities, and county-level cities (CCGCEP, 2004).

Time

As discussed in section 4.1, the starting points of the programmes vary. Although many consider the WHO Healthy Cities programme in the 1980s to be the pioneer of urban health programmes, the Patriotic Health Campaign started in China as early as the 1950s and evolved into the programme of National Hygienic City in 1989. Similarly, the National Civilised City is closely related to the movement of improving the urban environment since the 1980s in China, and finally formed a national governing body in 1997.

Each programme has different application processes and different duration in the time of each cycle. At the international level, the Healthy Cities Action Plan in WHO Europe is renewed every five years, and is the same in the regional guidance on Healthy Cities in WPRO; they are based on five-year planning. However, the national programmes in China run in a 3-year cycle.

National Civilised City, National Hygienic City, and Healthy City programmes started at different points historically. However, they share the same evaluation cycle of three years, and they have synchronised with each other since 2003. The cycle often begins with the application in the first year, the evaluation and the award in the third year. Certain distinctions in the evaluation process of the three programmes still apply.

Table 4.5 Process of National Hygienic City Award

Phase	Steps	Time
I. Application	1. Application	Before June in the 2nd year
	2. Recommendation	
	3. Data review	
II. Evaluation	4. Unannounced inspection	
	5. Technical evaluation	
	6. Comprehensive evaluation	
	7. Public notice	
III. Award	8. Award from NPHCCO	The end of the 3rd year
IV. Re-evaluation	9. Inspection	Every 3rd year after the award

Source: own translation based on NPHCC (2005)

The National Hygienic City award rotates every three years. The applications are voluntarily submitted by cities or districts of central-administered municipalities. The

recommendation is organised by the provincial (central-administered municipal) committee, for cities with over 70% public support. The review and evaluation are conducted by the national office, including unannounced inspection, technical evaluation and comprehensive evaluation. Re-evaluation is conducted by the provincial level office every three years after the award. In case the city does not pass the spot check by the national office, it will be circulated in a notice of criticism, or the award will be denied in more serious cases (NPHCC, 2015).

Similarly, the selection of the National Civilised City is conducted following the procedures of voluntary declaration, step-by-step recommendation, early publicity, and selection of the best. Cities that have the qualifications to declare can voluntarily apply to the higher-level Spiritual construction committee. Spiritual Construction Committees at all levels review the declared cities, villages, and units according to the standards and qualifications of the National Civilised City. After the review by the province (region, city) and the relevant central and national authorities, the committee will propose a list of recommendations for the province or region, which should be published in major media for 15 days. The Office of the Central Civilisation Committee of the Communist Party of China review the recommendation reports of various localities and relevant departments and solicit the opinions of relevant parties and the people in an appropriate manner. After the review and approval of the Central Civilisation Committee, the award will be commended with medals and certificates and certain rewards.

4.2.2 Standard setting

Application Preconditions

The requirements or standards of the programmes vary as well. The Healthy Cities in its definition is open to every city that aims to promote health, so the cities can join voluntarily. Take the example of the European Healthy Cities Network: there are 10 preconditions for cities participating in phase III (1998-2003), which are general commitments to the principles of developing Healthy Cities (see Box 1).

Box 1. Ten requirements for cities participating in the WHO European Healthy Cities Network

1. Cities must demonstrate that they have sustainable municipal political support, and support from other key decision-makers, to implementation of the principles and goals of the Healthy Cities project within the city and pledge a commitment to the values, principles and objectives of the health for all strategy.

2. Cities must demonstrate that they have produced a city health plan (or equivalent) which is based on an assessment of local health needs and concerns (health profile), and the

Healthy Cities policy framework. The plan or its equivalent may be one or several documents. Whichever form it takes, it should provide evidence of health for all based on coordinated planning (policy, strategic, operational) for health in a city. If a health plan (or equivalent) is not yet produced, an indication should be given of its expected date of completion. The designation will be withheld from a city unless the final product is received before the closing date of that round.

3. Cities must demonstrate that they have the basic structures in place to deliver the programme of activity required for Phase III. These structures include having an identified full-time project coordinator or equivalent, who is fluent in English, adequate administrative and technical support for the project, and an intersectoral steering group involving executive-level decision-makers.

4. Cities must be committed to collaboration and networking with other Healthy Cities. This ensures information sharing, joint problem solving, and the provision of support both to cities at similar levels of development and to cities at earlier stages.

While the requirements of National Hygienic City are formulated in a very different manner, take the version in 1999 as an example (see Box 2); the conditions for application are very specific in a quantitative way. First of all, the city needs to be qualified as a provincial-level Hygienic City. Moreover, there are quantified standards for solid waste treatment, sewage treatment, green area, air quality, and pest control (NPHCC, 1999).

Box 2. Preconditions for applying for a National Hygienic City

1. The declared city must be a provincial-level Hygienic city

2. The harmless treatment rate of municipal solid waste is ≥80%;

2. Urban domestic sewage treatment rate ≥30%;

3. The green coverage rate in the built-up area is ≥30%, and the per capita green area is ≥5 square meters;

4. Annual and daily average of total suspended particulates in the atmosphere (TSP): Northern cities ≤O. 350 mg/m3; southern cities ≤ 0.25 mg/m3;

5. At least three of the four pest control items in the urban area meet the standards set by the National Patriotic Health Committee.

The requirements of the National Civilised City are more qualitative compared with National Hygienic City, plus there are indicators with veto power. It is similar to National Hygienic City in the way that it requires the applying city to be qualified for the National advanced cities in building civilised cities in 1999 and 2002. Besides, the municipalities have to maintain the GDP per capita above the national average for two consecutive years. Two other indicators with veto power include no violation of laws and regulations of the

major municipal leaders, and no severe safety accidents and criminal cases. (CCGCEP, 2004).

This kind of "veto" process strongly restricted the possibility of acquiring the award. For example, Wuhan municipality had been eliminated three times during the evaluations of the National Civilised City. In the first round of National Civilised City (2003-2005), the standing member of the municipal committee was accused of corruption; in 2007, there was a major car accident in Wuhan, killing 23 people and multiple injuries; in the third round, a fire accident killed 14 people and injured 4. The city got disqualified from the veto process (Jiang and Zhang, 2017).

Box 3. Preconditions for applying for a National Civilised City

1. Obtain and maintain the honorary title of an advanced city (urban area) in the work of building a civilized city in the country;

2. The per capita GDP is higher than the national average for two consecutive years before the application (this condition does not apply to civilized urban areas);

3. The main leaders of the municipal party committee (district committee) and municipal government (district government) have not committed serious violations of discipline, law or crime in the 12 months before the declaration;

4. No major safety accidents or major criminal cases with national impact occurred in the 12 months before the declaration.

Evaluation criteria

The evaluation criteria are distinct in each programme. The WHO Healthy Cities programme provided the cities with guidelines and toolkits at the Regional level; for example, "Regional guidelines for developing a Healthy Cities project" issued by WHO WPRO in 2000, which also included the monograph "Indicators for Healthy Cities" developed by WHO CC HCUPR for reference (World Health Organization. Regional Office for the Western Pacific, 2000). When Shanghai municipality developed the Healthy City Action Plan in 2002, the National Hygienic City and National Civilised City only developed the first versions of standards but had no guidelines for implementation. It was not until 2006 that National Hygienic City published the guide manual (CCGCEP, 2004; NPHCC, 1999; NPHCCO, 2006).

The evaluation criteria of the Healthy City programme, National Hygienic City and National Civilised City are different in terms of the balance between quantitative and qualitative criteria. Healthy City Programme was evaluated in both quantitative and qualitative aspects, which included the level of public participation, inter-sectoral collaboration, and citizen awareness. In contrast, the standard of National Hygienic City, consisting of 10

areas and almost 100 indicators, portrayed the city in a very quantitative way in terms of health condition indicators of the citizens, which included indicators of environmental protection, mortality and morbidity, etc. The basic criteria of National Civilised City are composed of 7 areas and 37 indicators mixed with qualitative and quantitative indicators including governance environment, legal environment, market environment, human-culture environment, living environment, ecological environment, and implementation activities, which reflected the comprehensive civilisation level (*Wenming shuiping*) of the city (CCGCEP, 2004).

The areas of focus are different in each programme. WHO's visions of Healthy Cities included the commitment of the government, inter-sectoral collaboration, and public awareness, while National Hygienic City was focusing on public health, urban infrastructure and environmental protection, and National Civilised City not only focused on the urban environment but also the spiritual civilisation (*Jingshen wenming*).

The Healthy City concept emphasizes the inclusive collaboration between the public health system and other sectors. The WHO version includes all kinds of activities in society, environment, and public health that cover almost all the areas related to health, i.e. economy, society, ecological environment, community and personal behaviour. A Healthy City values not only the improvement of the physical environment, government service, people, process and outcome, but also the social environment and public awareness to improve health literacy and conditions. It requires a learning process in a city to promote health. As long as the government is committed to improving the health of the people, even villages without many resources can be entitled to be a Healthy City (Luo, 2011; Xu *et al.*, 2013; Zhu, Cao and Li, 2014).

In comparison, National Hygienic City is based on the public health system, and the standard is also focused on public health, urban infrastructure and environmental protection. National Hygienic City places more emphasis on the improvement of the physical environment, and the outcome, and less emphasis on the social environment, people and concepts. Therefore, the measures used by many cities are to enhance the number of street cleaners, the amount of green space, and put more punishment of environmental pollution activities to improve the indicators in a rather short period (Zhou *et al.*, 2000; Zhu, Cao and Li, 2014).

The criteria of each programme have been updated over the years. The Healthy City Programme has been updated every five years both in the regional guidelines and action plans. The standard of the National Hygienic City has been updated almost every five years since 1999. The National Civilised City evaluation system has been updated every three years since 2005, before which it has been tested for eight years for the first version.

Table 4.6 WHO European Healthy Cities Project—six phases (WHO, 1998, 2003, 2009, 2014)

Phase	Key focus
I (1987-92)	Creating new structures for and introducing new ways of working for health in cities. City health profiles—an essential tool.
II (1993-97)	Emphasis on intersectoral action, community participation and comprehensive city health planning.
III (1998-2002)	Action on health and sustainable development and healthy urban planning. Action on key NCD risk factors. Addressing the social determinants of health. City health development plans—an essential tool. Partnership with other city networks in Europe
IV (2003-07)	Increasing emphasis on partnership-based health development plans. Core themes include healthy urban planning, health impact assessment and healthy ageing
V (2008-13)	Health and health equity in all local policies. Core thematic strands: caring and supportive environments, healthy living, healthy urban environment and design
VI (2014-18)	Leadership for health City, health diplomacy. Applying Health 2020 lens with an emphasis on life-course approaches, community resilience and health literacy

Source: Tsouros (2015)

The Healthy Cities Network in Europe has been developing action plans since 1986. The approach is based on 5-year cycles or phases with specific goals and objectives as well as a set of constants—values and principles—underpinning the Healthy Cities approach from the start. The themes are constantly changing, representing the concepts of public health and sustainable development (Tsouros, 2015). For example, Phase I includes five action areas: Inequities in health, Strengthening community action and developing personal skills, Supportive environments for health, Reorienting health services and public health, and Healthy policies for Healthy Cities (WHO Healthy Cities Project Office, 1988). Then in Phase II (1993-1997) and Phase III (1998-2002), Healthy City Indicators (HCI) were introduced, and an original set of 53 indicators covering the areas of health, health services, physical environment, social environment and economic conditions were developed, and a more concise set in 1998 of 32 indicators consisting of four groups: health, health services, environmental indicators, and socioeconomic indicators (Webster and Sanderson, 2013).

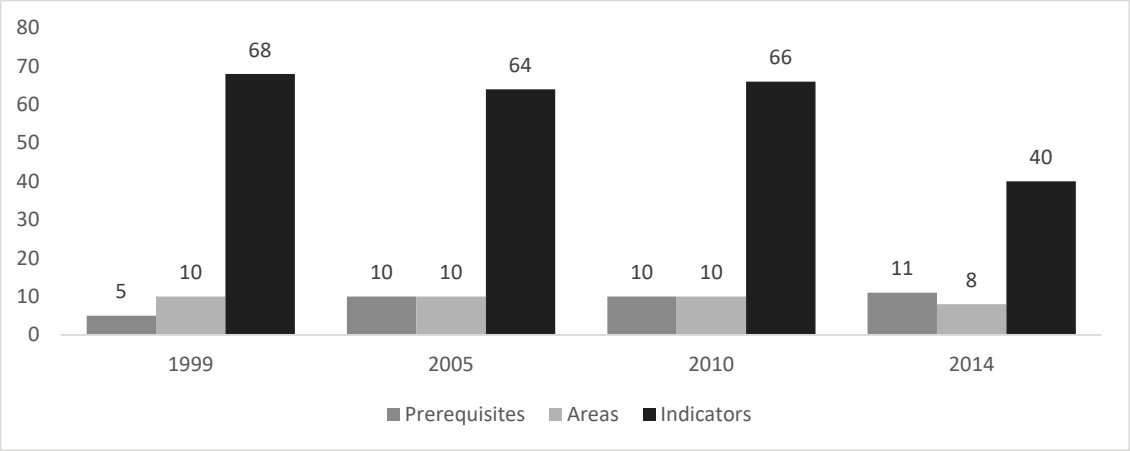
Table 4.7 National Hygienic City standard—four versions (NPHCC, 1999, 2003, 2009, 2014)

Version	Key sections and number of indicators
1999	Organisation and management (6), Health education (7), City environment sanitation (10), Environmental protection (9), Public place and drink water sanitation (7), Food hygiene (8), Infectious disease control (8), Vector species control (4), *Institution and Residential Area Sanitation (8), Polls (1)*.
2005	Organisation and management (6), Health education (8), City environment sanitation (10), Environmental protection (6), Public place and drink water sanitation (4), Food hygiene (8), Infectious disease control (7), Vector species control (4), *Community and institution sanitation (5), Urban village and suburbs sanitation (7)*.
2010	Organisation and management (6), Health education (8), City environment sanitation (10), Environmental protection (6), Public place and drink water sanitation (5), *Food safety* (9), Infectious disease control (8), Vector species control (1), *Community and institution sanitation (5), Urban village and suburbs sanitation (8)*.
2014	Organisation and management (4), Health education (4), City environment sanitation (8), Environmental protection (4), Key places sanitation (4), Food and drinking water safety (5), Public health and healthcare service (8), Vector species control (3).

Source: own compilation

The main structure of the National Hygienic City standard has not changed much from the first version in 1999 until 2014, which focuses on four dimensions: health literacy of citizens; (2) infrastructure and city appearance management; (3) environmental protection; (4) laws and regulations to protect citizen's health. Eight major sections remain the same: Organisation and management, Health education, City environment sanitation, Environmental protection, Public place sanitation, Food and drinking water safety, Public health service, and Vector species control. While these sections have been extended or reorganised, certain requirements and indicators are preserved. For example, the "Health education" section in 2014 includes the "Health promotion" part. Sections like "Urban village and suburbs sanitation" are eliminated and merged into other sections, and no longer exist in the 2014 version, but the same requirements are combined into "City environment sanitation". Some sections are reorganised: "Public Place and Drink Water Sanitation" and "Food Safety" are rearranged into "Key Places Sanitation" and "Food and Drink Water Safety"; "Infectious Disease Control" and "Community and Institution Sanitation" are merged into "Public Health and Healthcare Service" (NPHCCO, 2016a).

Figure 4.2 Number of prerequisites and indicators of National Hygienic City



Source: own compilation

In general, the indicators of the standards have become more concise over the years (see Figure 4.2). Until 2010, the standard has been constantly consisting of more than 60 indicators. From the latest version in 2014, the number of indicators has been drastically reduced by 40% compared to the former one. More criteria are included in prerequisites, from five in 1999 to eleven in 2014. The major change was in 2005, when the obliged terms increased from 5 to 10, concerning management regulations, tobacco, food, epidemic disease, and the satisfaction rate of citizens.

Standards have been raised for indicators related to people's life, e.g. fitness activities and facilities are added to "Health Education and Health Promotion", waste categorisation is considered in environmental sanitation in the urban area; health settings like school clinics and occupational health check-ups are added; chronic diseases and mental diseases are controlled in public health and service; standards for urban green areas and parks are raised; air quality index should fulfil higher criteria (NPHCCO, 2016a).

Unlike the National Hygienic City standard, which is applied to all municipalities and the districts of the central-administered municipalities, the evaluation system of National Civilised City has specified criteria for cities at five different administration levels, including direct-administrated municipalities, capital cities/sub-provincial level cities, prefecture-level cities, county-level cities, and districts of municipalities. There is a strict hierarchy in the award standard. In this section, the criteria for central-administered municipalities are taken as an example.

Table 4.8 National Civilised City evaluation system—five versions

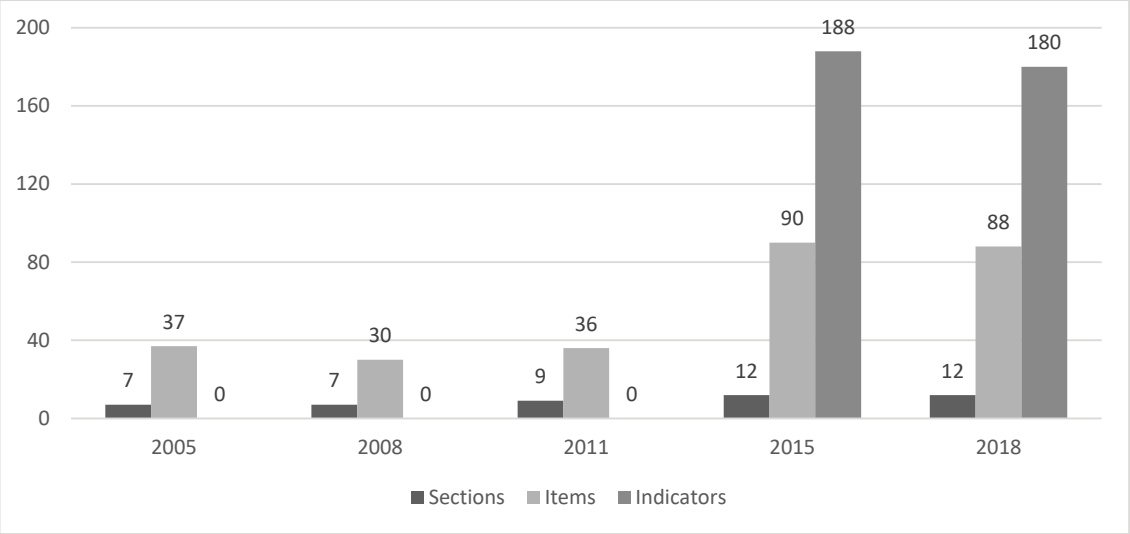
Version	Key sections and number of indicators
2005	A clean and efficient government environment, a fair and just legal environment, a standardized and trustworthy market environment, a healthy and progressive humane environment, a comfortable living environment, a sustainable ecological environment, and solid and effective creation activities
2008	A clean and efficient government environment, a fair and fair legal environment, a standardized and trustworthy market environment, a healthy and progressive humane environment, a comfortable living environment, a sustainable ecological environment, and solid and effective creation activities
2011	A clean and efficient government environment, a democratic and fair legal environment, a fair and honest market environment, a healthy and progressive humanistic environment, a social and cultural environment conducive to the healthy growth of young people, a comfortable and convenient living environment, a safe and stable social environment, and sustainable development Ecological environment, solid and effective creation activities.
2015	I. A solid ideological and moral foundation: ideal and belief education, the construction of socialist core values, and the cultivation of civilized morality; II. A good economic and social development environment: a clean and efficient government environment, a fair and just legal environment, an honest and law-abiding market environment, a healthy and progressive humanistic environment, a social and cultural environment conducive to the healthy growth of young people, a comfortable and convenient living environment, safe and stable social environment and sustainable ecological environment; III. Long-term normal creation mechanism

Source: own compilation based on CCGCEP (2005, 2008, 2011, 2015)

The evaluation system of the National Civilised City consists of two parts: the basic indicators (100 points) and the characteristic indicators (12-20 points). In the 2005 version, the basic indicators include 7 sections: a clean and efficient government environment, a fair and fair legal environment, a standardized and trustworthy market environment, a healthy and progressive humane environment, a comfortable living environment, a sustainable ecological environment, and solid and effective creation activities; in total 37 items. In 2008, the sections remain the same but the items were reduced to 30. In 2011,

there are 9 sections and 36 items. In 2015, the number increased to 3 large sections, 12 sub-sections, 90 items and 188 indicators (see Figure 4.3).

Figure 4.3 Items and indicators in National Civilised City Evaluation System



Source: own compilation

The characteristic indicators are specific to the National Civilised City, which reflect the characteristics of the construction of spiritual civilization of the city (urban area) and the overall image of the city (urban area), including propaganda, honours, and overall image of the city. In 2011, innovation of work is added. In the 2014 version, all versions of evaluation systems are combined into one, and only one characteristic indicator remains.

The fixed score system of the National Civilised City enables comparison among the candidate cities or districts, while the National Hygienic City is established on a baseline that does not involve competition, neither does HCP which does not encourage competition among the cities but rather improvement of the city itself. Another major difference is the National Civilised City has a limited number of awards, similarly, Healthy Cities Network has a certain number of cities assigned to each country, while the National Hygienic City does not restrict the number of awards for each administration level.

There is also a certain number of adjusted indicators that when it comes to cities from underdeveloped areas (first it referred to Western China, then Central China and Northeast China were also included), the standard from the lower-level administration is applied. This adjustment makes the evaluation balance the inequality related to geographical locations.

4.2.3 Evaluation process

There is guidance on WHO Healthy City evaluation on the global and regional level, but the planning and implementation are different in each city. The evaluation is based on self-report and is suggested to be conducted by a third-party evaluator, not by the WHO office. On the contrary, the evaluation of National Hygienic City is conducted by the national level offices. Similarly, the evaluation of the National Civilised City is conducted by the provincial and national level offices.

The evaluation criteria are carried out differently in terms of mandates. The evaluation of the WHO European Healthy City network is conducted on a voluntary basis, which is mainly based on the city's health profile. The European Healthy Cities Action Plan provided sets of indicators and formats for cities to report on their status related to health, health service, environment, and socioeconomic conditions. The cities can report according to the data availability and it is not mandatory. On the other hand, the evaluation standards of National Hygienic City are mandatory for evaluation once the cities applied for the award. Similarly, the National Civilised City also has a mandatory set of indicators, which are calculated based on a scoring system.

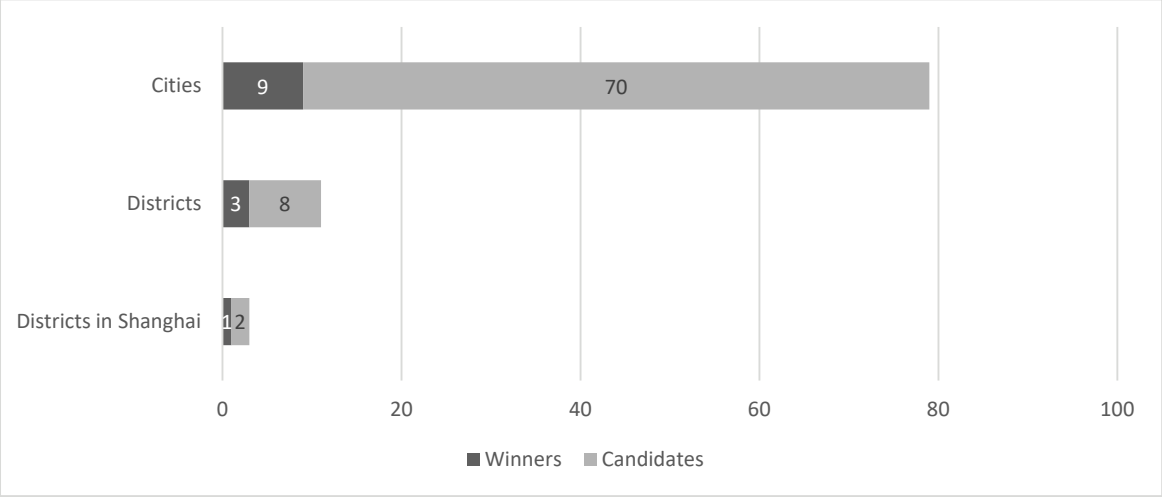
The evaluation of National Hygienic City is conducted by the evaluation committee of National Hygienic City, which is composed of the members of the Patriotic Health Campaign Committee, the General Offices of all provinces, autonomous areas and central-administered municipalities, and relevant experts. The committee is divided into six groups: North-east China, North China, East China, Central South China, Southwest China and Northwest China, each consists of the directors of General Offices in the provinces, autonomous areas and central-administered municipalities in the area. The directors take turns every year to be the person in charge of the groups. The National Hygienic City Evaluation Committee Office is set in the Office of the National Patriotic Health Campaign, which is in charge of the organisation and coordination of evaluations.

The evaluation methods of National Hygienic City include surveys and assessments. The Office of the National Patriotic Health Campaign Committee (NPHCCO) organizes relevant experts to review the application materials and conduct surveys and unannounced visits based on the review results. The first survey is a feasibility survey, aiming to understand how well the basic conditions of the declared city, and the daily hygiene management level. Assessment and appraisal include data assessment and on-site assessment. The data assessment includes listening to reports from the city, and examining relevant files, technical materials, etc.; on-site assessment will be conducted within all urban areas, and the number of places, units, and residential areas inspected should reflect the overall situation (NPHCC, 1999).

The evaluation methods adapted in the National Civilised City are also more sophisticated, which include listening to reports, material review, questionnaire survey, online survey, field survey and overall observation. The assessment data of civilised cities is urban data (except for the evaluation contents described in the note), and the field visits are mainly conducted in the built-up area of the civilized city. Each type of data is measured and evaluated in the first two years of the application cycle; the material review as well (CCGCEP, 2004).

In the field survey alone, there are three methods involved: one is real-scenario simulation verification, such as: calling the legal service and the rights report hotline; the second is the field investigation, that is, entering the scene to verify whether the object under inspection meets the evaluation criteria, such as: examine the relevant work records in communities; the third is on-site observation, that is, according to the requirements of field observation, on-site inspections, in a certain period of time, observe the objects under investigation on-site. Data sources for material review include national or provincial (regional, municipal) statistical yearbooks and information provided by relevant departments of the provinces (autonomous regions, municipalities) (CCGCEP, 2004).

Figure 4.4 National Civilised Cities/Districts Candidates and Winners in 2005



Source: own compilation

The distribution of recommendations among provinces and municipalities is also a unique step in the evaluation of the National Civilised City. At the beginning of each round, the Central Commission will provide a number of recommendations to the provincial or municipal level office before the application process starts. The applying cities or the districts in the case of directly-administrated municipalities have to evaluate themselves based on the evaluation system; if the criteria are met applications can be voluntarily submitted to the civilisation commission on the superior level (e.g. the districts level should apply to the municipal level), then the Municipal Civilisation Commission will select

qualified applicants according to the recommendation quota to the Central Commission at the National level. (CCGCEP, 2004).

Take the example of the application of the first round in 2005, Shanghai has four districts (Huangpu, Luwan, Pudong and Jing'an) commended as advanced civilised districts in 1999 and 2002. But according to the recommendation quota divided by administrative areas announced by the Central Civilised Commission, only two districts can be recommended by the municipal commission. By this recommendation process, 50% of the candidates are eliminated. After the districts become candidates at the national level list, they also need to compete with other 6 districts of central-administered municipalities and 64 cities from all over the country. Eventually, three districts and nine cities were successfully commended, which account for less than one-fifth of the total candidates.

4.3 THE HEALTHY CITY PROGRAMMES IN SHANGHAI

In order to see the policy change of the Healthy City programme and how it converges or diverges with the international movement and national programmes, this section will focus on comparing the agenda, policy content and the evaluation system of the Shanghai Healthy City programme with the international and national programme. The policy documents including the action plans, strategies and evaluation systems are compared between the municipal Healthy City programme in Shanghai, the National Hygienic City programme, the National Civilised and the WHO Healthy City programme. Thus, concluding the convergence and divergence of the local, national, and international programmes.

4.3.1 Scale and Time

Scale

The organisation of the Healthy City Action Plan in Shanghai involves the municipal level, district level, community level and various units like schools, and companies, which is similar to the organisation of the National Hygienic City and National Civilised City, except it does not involve the national level government directly. This hierarchical structure varies significantly with the international HCP, which mainly involves the national and municipal levels. The Healthy City Action Plan in Shanghai takes up the national requirements and implements them in detail.

The national award system was an essential influence on the municipal Healthy City Action Plan. National Hygienic City is a baseline award that cities want to achieve. However, huge disparities between the districts made fulfilling the national standard difficult at the municipality level. In 2001 the National Hygienic District standard was issued by the Office

of National Patriotic Health Campaign Committee to motivate the four central-administered municipalities in China since then the districts of these municipalities could apply for the award of National Hygienic District.

Table 4.9 Number of National Civilised Districts and National Hygienic Districts in Shanghai

Year	Total number of districts	National Civilised Districts	National Hygienic Districts
2002	18	4 (advanced districts)	2
2003	18	8 (advanced districts)	7
2005	18	9	9
2008	18	10	11
2011	16	11	12
2014	16	12	15
2017	15	14	15

In 2005, there were 18 districts in total. Afterwards, Nanhui district was merged into Pudong New Area in 2009.04.24, Luwan District merged into Huangpu District in 2011.05.20, Zhabei merged into Jing'an in 2015.10.13, and Chongming county was upgraded into Chongming District in 2016.06.08. Therefore, until the end of 2018, Shanghai is divided into 15 districts and 1 Sub-provincial new area.

Source: own compilation

80% of the districts in Shanghai were expected to reach the standard of NHD by the end of the first three-year action plan. By that time two districts (Huangpu and Jing'an) were also entitled to NHD. Up until the end of 2003, the year Shanghai Healthy City Action Plan was issued, five more districts were entitled (Pudong New Area, Xuhui, Luwan, Changning, Minhang). In the award of 2005, two more districts (Jiading and Songjiang) were included in the list.

Eventually, half of the districts in Shanghai were entitled to the NHD by the end of the first round. Although compared to the goal of 80%, there was a gap of 5 more districts to fulfil the standard, the action plan served the purpose to motivate the districts in pursuing the award, and it is especially efficient during the first two rounds, which align with the time that the Healthy City Action Plan was implemented as the interviewees stated (G2S9, personal communication, 27 October 2017).

A similar process happened with the National Civilised City. Again, taking the example of the application of the first round in 2005, Shanghai had four districts (Huangpu, Luwan, Pudong and Jing'an) awarded as advanced civilised districts in 1999 and 2002. But

according to the recommendation quota divided by administrative areas announced by the Central Civilised Commission, only two districts can be recommended by the municipal commission. By this recommendation process, 50% of the candidates were eliminated. After the districts became candidates at the national level list, they also needed to compete with other 6 districts of central-administered municipalities and 64 cities from all over the country. Eventually, three districts and nine cities were successfully awarded, which accounted for less than one-fifth of the total candidates.

Time

At the 10th executive meeting of the Shanghai Municipal Government in 2003, the Healthy City Three-year Action Plan was discussed and accepted in principle. In August 2003, the Municipal People's government issued the plan to all the district level governments, and all the municipal bureaus/commissions (Information Office of Shanghai Municipality, 2003).

Table 4.10 Major events in formulating Shanghai Healthy City Action Plan

Timeline	Event	Significance
28/06/2002	50th Anniversary of the Patriotic Health Campaign in Shanghai	Vice Mayor mentioned promoting "Health for all" and building a "Healthy City" for the first time.
12/08/2002	Shanghai Municipal Government Work Conference	Vice Mayor pointed out the necessity to focus on building a "Healthy City" goal, conduct in-depth research, and formulate an action plan for Shanghai's patriotic health work in the new era.
02/06/2003	The 10th executive meeting of the Shanghai Municipal Government	Discussed and adopted the "Shanghai Healthy City Three-year Action Plan" in principle
28/08/2003	Shanghai Healthy City Three-year Action Plan	Shanghai Municipal People's government issued the plan to all the municipal bureaus/commissions, and district governments.

Source: own compilation

Since then, Shanghai became the first mega-city in China to initiate an action plan for Healthy City. As the spokesperson said in the first press conference of the Shanghai Municipal Government:

> *"Building a Healthy City is very important for creating a clean, beautiful and civilised urban environment, enhancing the competence of the city, shaping the spirit of the city in the new century, and promoting the social and economic development (ibid.)."*

Although it was emphasized that the research on the content and feasibility of Healthy City programme had been performed by the experts and the Office of Patriotic Health Campaign Committee for almost a year, the incident of SARS could not be ignored as an essential trigger for initiating the action plan. The Healthy City action plan was an important manifestation of the municipal government to improve the public health system and emergency management. Furthermore, the government and the society already had a consensus on promoting a healthy lifestyle and raising the public health level after the outbreak of such a public health crisis.

While the Healthy City Action Plan was based on the idea of autonomy and self-evaluation, which makes a big difference for the government to enforce it, the National Hygienic City is entitled by the National Patriotic Health Campaign Committee, while there is no process of evaluation and award process for Healthy City in China (Xia, 1999; Zhou *et al.*, 2000). In terms of the length and the starting point of the evaluation cycle, the Healthy City Action Plan is closely related to the schedule of National Hygienic City and National Civilised City, particularly as both follow three-year cycles. The local experts indicated that one of the motivations to begin the Healthy City Action Plan was to encourage districts to pursue NHC awards (G2S9, personal communication, 27 October 2017).

4.3.2 Standard setting

According to the Patriotic Health Campaign Committee of Shanghai, the design of the indicator system of the Healthy City Action Plan was based on the recommended indicators of WHO Healthy Cities in 2000 which includes twelve categories and 338 items: Population health (48), urban infrastructure (19), environmental quality (24), housing, living environment sanitation (30), community action and activities (49), lifestyle and preventive activities (20), healthcare, welfare and environmental health services (30), education and empowerment (26), employment and industry (32), income and family living expenses (17), local economy (17), and demographics (22) (Sun, 2003).

The Healthy City Action Plan was also closely connected with National Hygienic City and National Civilised City. In Phase I (2003-2005), there were specific indicators to achieve National Hygienic District and National Civilised District:

> *"Continue to promote the creation of National Hygienic Districts and National Hygienic Towns, and strive to build 80% of National Hygienic Districts and 20% of National Hygienic Towns"; "continue to develop civilised communities, civilised villages and towns, civilised communities, and civilised urban areas. Two-thirds of the city's communities will be built into civilised communities, one-quarter of villages will be built into municipal civilized villages, and one-third of towns will be built into municipal civilization. Towns and communities are basically built into civilised communities, and 100 municipal and district-level civilised demonstration areas have been built (Shanghai Municipal People's Government, 2002)".*

In terms of the targets and key areas, the first phase of the Healthy City Action Plan (2003-2005) was aimed at promoting the urban environment, community health service and health promotion, leveraging the civilisation and administration of the city, and the quality of citizens. There were eight categories: healthy environment (43), healthy food (10), healthy life (9), healthy family planning (10), healthy exercise (6), healthy schools (11), healthy communities (6), and spiritual civilisation (9). In addition, there were eleven parallel projects (Shanghai Municipal People's Government, 2002). During Phase II to Phase V, healthy environment, healthy population and healthy society were still the key areas and focused on building and improving supportive systems for Healthy City and health promotion and increasing health literacy, building healthy lifestyles and the capacity for self-management.

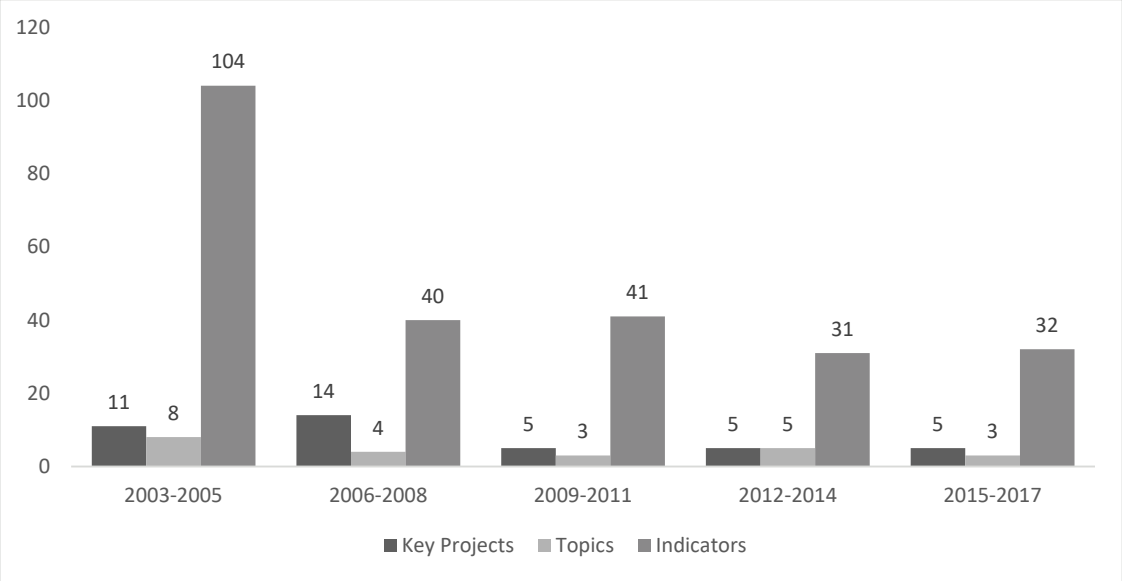
Table 4.11 Three-year action plan for building a Healthy City in Shanghai —four phases

Phase	Key focus
I (2003-05)	Healthy environment, healthy food, healthy life, healthy family planning, healthy exercise, healthy schools, healthy communities, and spiritual civilisation
II (2006-08)	Health service, healthy environment, healthy food, healthy behaviour, healthy exercise, healthy places
III (2009-11)	Healthy environment: environment, food; health service: service, behaviour, marriage and procreation; health management: management, places
IV (2012-14)	Health system; healthy lifestyle; healthy environment; sustainable development
V (2015-17)	Health communication; health support system; health management

Source: own compilation based on Shanghai Municipal People's Government (2002, 2005, 2008, 2011, 2014)

In terms of indicators, the action plan has become more concise over the years. The Shanghai Healthy City Action Plan for Phase I contains 8 categories and 104 items. The plan for Phase II had decreased to four categories and 40 items, which was less than half of the amount in the first round, but six more key projects. The number remained stable in 2009 when three dimensions and 41 items were included in the third round Action Plan, but the number of key projects reduced to five. In 2012 and 2015, the number of indicators decreased to 31 and 32, the key projects remain at five (see Figure 4.5).

Figure 4.5 Topics, indicators and key projects of the Shanghai Healthy City Action Plan



Source: own compilation

Comparing the content of the Healthy City programme, the National Hygienic City and the National Civilised City in the early 2000s, all covered major topics like physical and social environment, health service, behaviour and lifestyle. They all cover environmental indicators, like the physical environment including air quality, water management, and waste management. However, the international Healthy City programme contains the most extended indicators, and National Hygienic City covers the least. In terms of behavioural indicators, Healthy City programme and National Civilised City cover more areas such as sports and exercise, smoking, and drinking. In terms of health literacy, and health service, Healthy City programme covers the most topics. National Civilised City was the first to cover social welfare issues like poverty, unemployment and the elderly.

In general, Healthy City programme and National Civilised City are more comprehensive in terms of the overall topics addressed. Healthy City programme is more comprehensive in aspects related to public health and the environment. If the guidelines and indicators from WHO are implemented, Healthy City programme would also be the most comprehensive in terms of the topics as well. In summary, Healthy City programme covers

all aspects of National Hygienic City, and it also combines the national environmental protection exemplary city, national landscape garden city and eco city (Xu *et al.*, 2013; Zhu, Cao and Li, 2014).

4.3.3 Evaluation process

In 2005, the municipality established the Shanghai Municipal Health Promotion Committee (SMHPC) to oversee the Healthy City Action Plan, which in effect added a position to the Shanghai Patriotic Health Campaign Committee (SPHCC). The committee was responsible for the planning, implementing, and evaluation of the Healthy City Action Plan (Yang and Tang, 2005).

The implementation and evaluation process was announced in the Healthy City Action Plan Phase I (2003-2005). These were divided into three steps (Shanghai Municipal People's Government, 2002):

1. First year: distributing and advocating the plan, establishing the Healthy City Joint-Meeting, starting pilot projects;

2. Second year: implementing the plan according to the indicators of the Healthy City Action Plan, identifying the weaknesses, researching and solving the prominent problems;

3. Third year: fulfil the requirements of the indicators, conduct evaluation, and explore the Healthy City Indicators for the next phase of the Healthy City Action Plan.

It was suggested to establish the Shanghai Healthy City Technical Steering Group *(Shanghai jiankang chengshi jishu zhidao zu)*, which would be overseeing the technical guidance about setting standards and regulations during implementation, establishing the evaluation system based on strategies and effects, and conducting the annual evaluation and the final evaluation of the Action Plan (*ibid.*).

The evaluation process of the local action plan and national awards are very different. As discussed before, the national awards have a long, hierarchical and sophisticated process of recommendation, application, selection and award. While the Shanghai Healthy City Action Plan is based on self-evaluation, as suggested by the WHO guidelines. In the process of localization, the indicators of the Shanghai Healthy City Action Plan are more detailed and explicit in the department in charge. Although most of the implementations are multi-sectoral, there is a leading department in charge of the implementation and evaluation.

Table 4.12 Mission accomplishment of members of first round Healthy City Action Plan

Governmental department	Number of indicators	Accomplished	Unaccomplished
Municipal Office of the Patriotic Health Campaign Committee	6	5	1
Municipal Health Bureau	10	9	1
Municipal Population and Family Planning Commission	5	5	
Municipal Education Commission	13	13	
Municipal Administration of Sports	6	6	
Municipal Environmental Bureau	5	5	
Municipal Administration of City Appearance	11	11	
Municipal Agriculture Commission	4	4	
Municipal Water Authority	5	5	
Municipal Administration of Landscaping	12	11	1
Municipal Commission of Economy	8	8	
Municipal State-owned Assets Supervision and Administration Commission	1	0	1
Municipal Housing Administration	9	7	2
Municipal Commission for Guiding Cultural and Ethical Progress	7	7	
Municipal Administration of Culture, Radio, Film and Television	2	2	
Total	104	98	6

Source: translated from Gu (2009)

However, as the officer from the Shanghai Municipal Administration of Sport explained, the evaluation is completely based on the self-report of each department, and the Office of Patriotic Health Campaign Committee has no power to monitor or supervise. This practice is similar to the international Healthy City programme in City Health Profile. The data are gathered from different parties, and the review process and methods are much less sophisticated compared to National Hygienic City and National Civilised City (C4H3, personal communication, 1 November 2017).

As a result, the goals were not completely met after three years of implementation in Phase I. Six indicators out of 104 were not accomplished as shown in Table 4.12. One of the departments which did not accomplish the goals, the Municipal State-owned Assets Supervision and Administration Commission, did not fulfil the task assigned at all (Gu, 2009).

4.4 SUMMARY

This chapter investigated the degree to which the local actions converge with national and international movements. Evidence shows that the globalisation trend, represented by the international movement of Healthy Cities, and local institutions, represented by the National Patriotic Health Campaign since the 1950s, have jointly influenced the formulation of the Healthy City Action Plan in Shanghai.

After comparing the overall structure and the evaluation system of the international Healthy Cities programme (HCP), National Hygienic Cities (NHC), and National Civilised Cities (NCC), the convergence of the programmes can observe regarding the objectives to improve the urban environment for populations health. The divergence of the programmes lies in the approach these programmes have taken to achieve the same objectives. While the international Healthy Cities Programme is flexible in its themes over the years, the national awards of National Hygienic City and National Civilised City have fixed sets of themes despite standards undergoing multiple revisions. The international Healthy Cities Programme is well-known for its process-oriented principles, voluntary-based and rather qualitative evaluation. The national awards are outcome-oriented and competitive. As a result, the evaluation standards and methods of the national programmes are largely quantitative, and the evaluations are conducted by national and local authorities.

Regarding the Healthy City Action Plan (HCAP) in Shanghai, the municipality was influenced by both international and national programmes. From the experience of collaborative activities with the WHO in the Healthy City pilot project in Jiading District, the municipality had an overview of the feasibility of implementing Healthy City programme

in the local settings. Meanwhile, the national awards including National Hygienic City and National Civilised City provided mandates from the central government.

The Healthy City Action Plan was a programme based on a three-year cycle, the same as National Hygienic City and National Civilised City. The international Healthy City programme action plans and guidelines were a five-year cycle. The organisational structure of the Healthy City Action Plan in Shanghai was *de jure* following the international guidelines on setting the local committee of HCP, and *de facto* using the structure of the existing National Patriotic Health Campaign Committee.

In the standard-setting process, the municipalities tried to follow the guidelines of international Healthy City programme, such as including a wide range of topics related to the discourse of health promotion and conducting an evaluation on a voluntary basis. The municipality successfully expanded the discourses of health and environment beyond the baseline set by the national standards, including eight topics and 104 indicators in the Healthy City Action Plan Phase I (2003-2005), but had to make the activities and standards more concise since Phase II due to the difficulties in collaboration.

As per the evaluation standards and methods, the Healthy City Action Plan followed a more qualitative and less strict model than the national programmes. However, the differences between self-report evaluation and unannounced investigation from a higher authority cannot be ignored. These limitations of the Healthy City Action Plan evaluation influenced the implementation outcome. According to the evaluation reports, more than 5% of the indicators were not fulfilled in Phase I of the Healthy City Action Plan (see Table 4.12).

To conclude, the Healthy City Action Plan in Shanghai has been influenced by the international movement in terms of standard-setting in the agenda setting and policy formulation stage. A mega-city like Shanghai, which aims towards being an international metropolis has a strong motivation to take up the international initiative. However, the national standards are essential in the implementation and evaluation process of the programme. Further discussions on the actors and interactions will be presented in the next chapter.

5 POLICY INTERACTION IN THE HEALTHY CITY PROGRAMME

Following the analysis of policy content in Chapter 4, this chapter focuses on the actors involved in the policy process and the interactions among the major actors that shaped the Healthy City Action Plan (HCAP) in Shanghai. The actors, from the international to the local levels, are identified in section 5.1. The constellations of actors are presented in section 5.2. Section 5.3 examines the modes of interaction between the actors at various stages of the Healthy City programme to determine the level of impact they have within the process.

5.1 ACTORS IN THE HEALTHY CITY PROGRAMME

In this section, the actors who became involved in the Healthy City Action Plan are identified. The actors are first divided according to the level of institution (international, national, municipal, district) in 5,1,1. Then the actors are further identified with their roles in the Healthy City Action Plan in 5.1.2. In section 5.1.3, the actors are divided into the major fields of Healthy City, including public health and urban planning.

5.1.1 Actors at different levels

Table 5.1 Different types of actors in the Shanghai Healthy City programme

Levels	Institutes	Sections	Legislature
International	WHO	Health	
National	Ministries	Health, Environment, Sport, Urban development etc.	National People's Committee
Municipal	Bureaus and Commissions	Health (NPHCCO), Environment, Sport, Urban development etc.	Municipal People's Committee
District	Offices	In accordance with the municipal level	

Source: own compilation

In Chapter 4, actors in the Healthy City Action Plan were largely presented in the policy documents. A list of actors is compiled in Table 5.1. These actors are first divided into different levels; including international, national, municipality and district organisations; then within the local levels, they are further categorized into different sectors covering

governmental departments, academia, NGOs and private sectors. The parallel legislatures are also identified at the national and municipal levels. The chief officers in charge of the institutes are recognised as the key informants for in-depth interviews (see Appendix 6) to verify the list of actors.

As discussed in Chapter 4, The WHO has taken an active role in initiating the Healthy Cities Programme worldwide. The regional office of WPRO is also the initiator of the Healthy City Jiading in Shanghai in 1994. At the national level, National Patriotic Health Campaign Committee is coordinating both Healthy Cities projects in China (World Health Organization. Regional Office for the Western Pacific, 2000). At the local level, the Healthy City Action Plan in Shanghai was initiated by the municipal government in 2002. The implementation process involves other local actors at the municipal, district and community level organisations in Shanghai.

International level

World Health Organization Regional Office for the Western Pacific (WHO/WPRO)

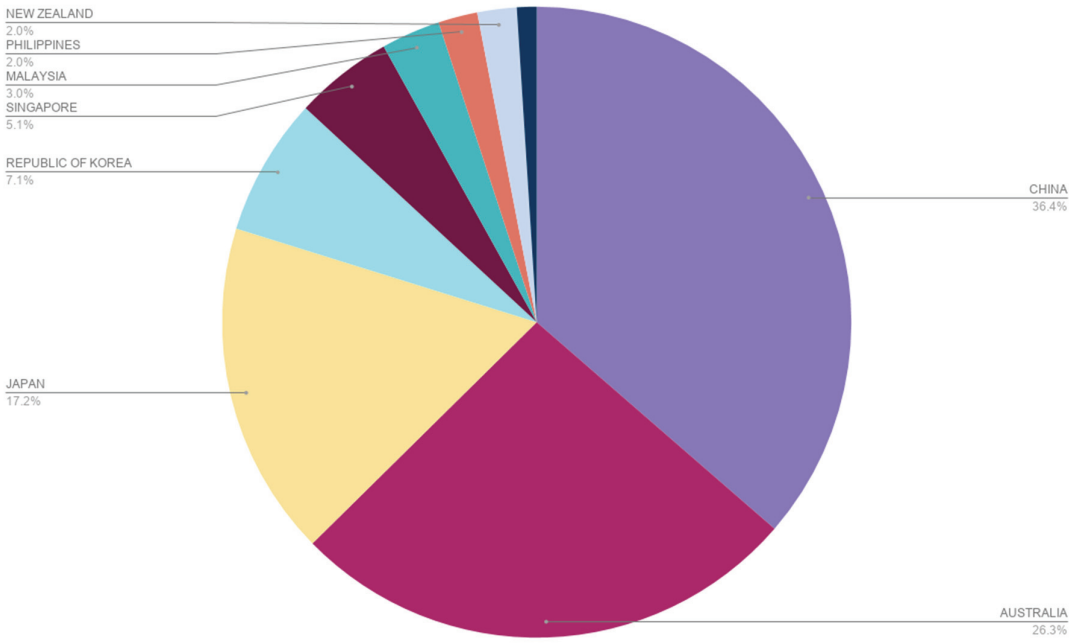
At an international level, the WHO has taken an active role in promoting the Healthy City concept and the Healthy Cities Projects to its member states since the 1980s (as shown in Chapter 4). The World Health Organization (WHO) was established as the directing and coordinating authority in global public health within the United Nations system. The WHO mainly works at the global, regional and country levels. The WHO collaborates with the governments of 194 Member States and other partners to achieve the highest possible level of health for all people (WHO, 2020).

The Western Pacific Region is one among the six regions of the World Health Organization, working with health authorities and other partners in 37 countries and areas with over one quarter of the world's population. China joined the WHO on 22 July 1946 as one of the founders of WHO, which also belongs to the Western Pacific Region. In 1981, the WHO Representative Office in Beijing, People's Republic of China was established (WHO, 2020).

WHO Collaborating Centres

WHO Collaborating Centres are institutions designated by the Director-General of WHO that form a part of an international collaborative network carrying out activities in support of the Organization's programmes in countries, regions and at headquarters. Today, there are more than 175 WHO collaborating centres in the Western Pacific, that provide wide-ranging expertise on issues ranging from traditional medicine to health systems development to serving as global or regional reference laboratories for specific diseases. As the following graph shows, China has the highest number of Collaborating Centres in the Western Pacific Region (WHO Regional Office for the Western Pacific, 2020).

Figure 5.1 WHO Collaborating Centres in Western Pacific Region



Source: WHO Regional Office for the Western Pacific (2020)

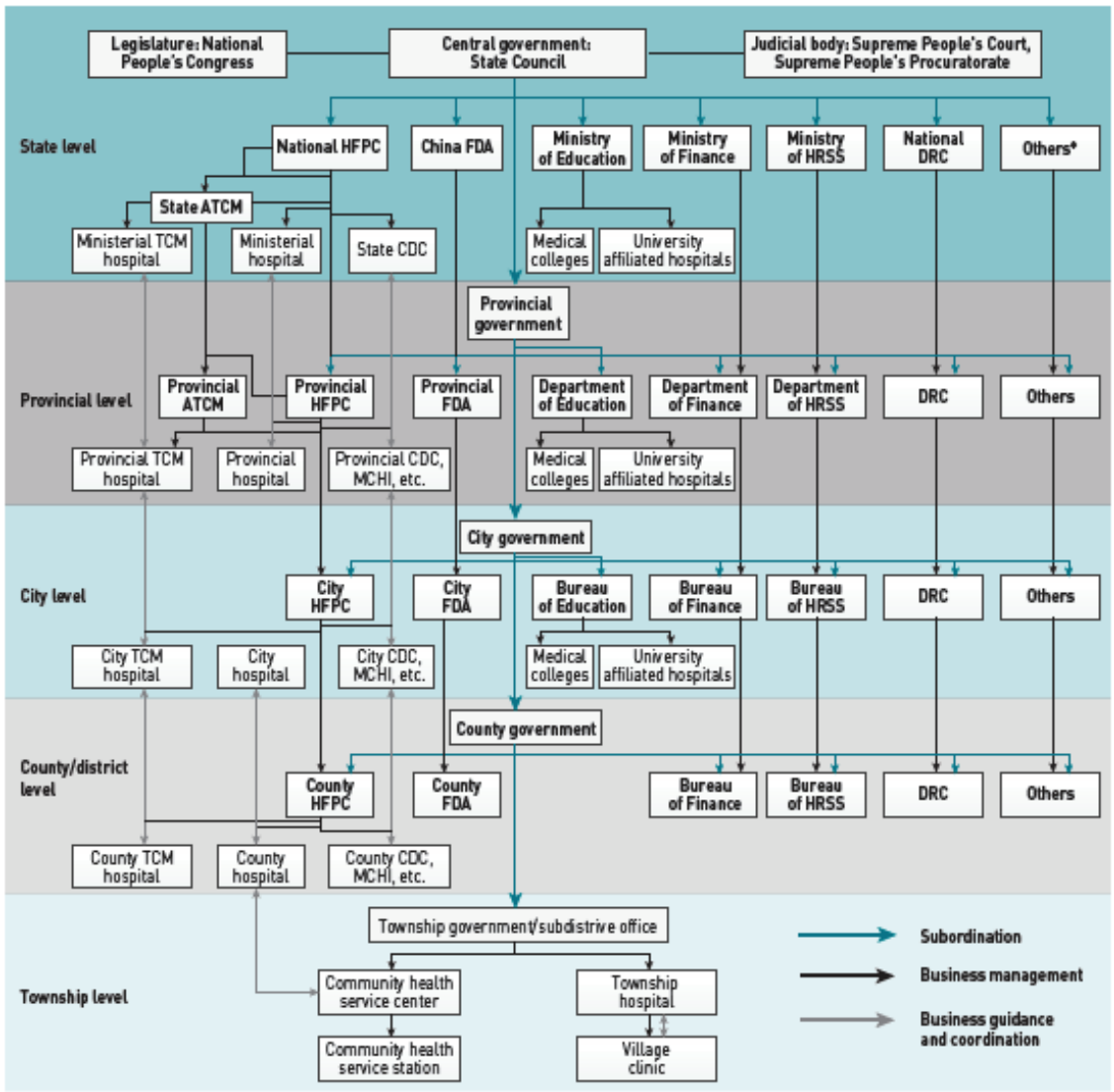
The Office of the Shanghai Municipal Health Promotion Committee became the WHO Collaborating centre for healthy urbanization in 2010. The centre aims to contribute to the WHO Healthy Cities work programme by strengthening links between city networks at different levels: national, regional and global. It also supports WHO to sustain momentum and commitments built during the Shanghai Conference, through documenting and sharing lessons learnt on urban health governance across countries in the region (WHO, n.d.).

The WHO Collaborating Centre for Primary Health Care in Jiading has had more than 10 collaborations between Jiading and WHO since 1980. The cooperation centre has conducted over 20 research programmes with WHO, China's Ministry of Health (currently the National Health Commission) and universities, and played an important role in the development of public health and Healthy City construction in China (Jiading Gov., 2014).

In March 1994, the WHO Collaborating Centre for Primary Health Care, Jiading District, Shanghai organized a task force, under which there are five teams to deal: general city programme, environmental protection, basic infrastructure, health care and prevention of diseases, and health management. The teams began to collect and analyse data and the technical report on urban health was completed in December. It was discussed and revised in January 1995 and the preliminary urban health plan was completed in February 1995 (World Health Organization. Regional Office for the Western Pacific, 1996).

National level

Figure 5.2 The organisation of the Chinese Health System



* Others include Ministry of Civil Affaires, Insurance Regulatory Commission, etc.
HFPC: Health and Family Planning Commission;
FDA: Food and Drug Administration;
HRSS: Human Resource and Social Security;
DRC: Development and Reform Commission;
ATCM: Administration of Traditional Chinese Medicine;
CDC: Center of Disease Control;
MCHI: Maternal and Children Health Institution.

Source: Fang (2020, p21)

China's central government has overall responsibility for national health legislation, policy, and administration. It is guided by the principle that every citizen is entitled to receive basic health care services. Local governments — provinces, prefectures, cities, counties, and towns — are responsible for organizing and providing these services (Fang, 2020).

Both national and local health agencies and authorities have comprehensive responsibilities for health quality and safety, cost control, provider fee schedules, health information technology, clinical guidelines, and health equity. In March 2018, the State Council reorganized the central government's health care structure (see Figure 5.2). The responsibilities of various agencies include the following (*ibid.*):

- The National Health Commission is the main national health agency. The commission formulates national health policies; coordinates and advances medical and health care reform; and supervises and administers public health, medical care, health emergency response, and family planning services. The State Administration of Traditional Chinese Medicine is affiliated with the agency.
- The State Medical Insurance Administration oversees the basic medical insurance programmes, catastrophic medical insurance, a maternity insurance programme, the pricing of pharmaceutical products and health services, and a medical financial assistance programme.
- The National People's Congress is responsible for health legislation. However, major health policies and reforms may be initiated by the State Council and the Central Committee of the Communist Party, and these are also regarded as law.
- The National Development and Reform Commission oversees health infrastructure plans and competition among health care providers.
- The Ministry of Finance provides funding for government health subsidies, health insurance contributions, and health system infrastructure.
- The newly created State Market Regulatory Administration includes the China Drug Administration, which is responsible for drug approvals and licenses.
- The China Centre for Disease Control and Prevention, although not a government agency, is administrated by the National Health Commission.
- The Chinese Academy of Medical Science, under the National Health Commission, is the national centre for health research.

National Patriotic Health Campaign Committee (NPHCC)

In 1997, the Government of China decided to establish a national coordination role for both the Healthy Cities and Hygiene Cities projects with the National Patriotic Health Campaign Committee (NPHCC). Hygienic Cities projects that have adopted the Healthy Cities concept are considered to be equivalent to the Healthy Cities projects (World Health Organization. Regional Office for the Western Pacific, 2000).

The National Patriotic Health Campaign Committee (NPHCC) is a consultant and coordinating body under the state council. In the National Patriotic Health Committee, the formal director is the Vice Premier, and the members of the committee are composed of ministers or deputy ministers of related ministries. The head of the office is doubled by

the Deputy Minister of Health (see Appendix 7). The national office is set in the Ministry of Health (currently the National Health Commission) (General Office of the State Council, 2018).

First, the Director of the Committee is one of the four Vice Premier in the State Council with different ranks, representing the priorities of the national initiatives. The current Director is ranked the second, mainly in charge of "Healthy China 2030" and "Double First-Class Universities", managing education, technology, culture, sports and health. While the first rank Vice Premier is in charge of "Pollution Control", one of the "Three Tough Battles" declared by the President, the overall "Belt and Road" initiative, regional development projects like "Greater Bay Area", managing national development and reform, finance, ecology and environment (Wang and Evans, 2018).

Second, the Deputy Directors take different ranks at the Ministerial level or Sub-Ministerial level in the Ministries or Commissions they are representing, which can also influence the priority of the Patriotic Health Campaign. For example, the Deputy Minister representing the Publicity Department is ranked at the Sub-Ministerial level, while six of the other seven Deputy Ministers of the department are ranked at the Ministerial level. A similar situation takes place with the representatives from the National Development and Reform Commission. Subsequently, the Patriotic health Campaign is more important for Ministries or Commissions represented by the Ministers than the ones represented by the Deputy Ministers; and for the Ministerial-level than the Sub-Ministerial-level Deputy Ministers according to the hierarchical bureaucracy.

Third, according to the Working Rules of the Patriotic Health the Ministries or Commissions, the General Office of the Committee which is set in the National Health Commission is in charge of the routine work, including organising and coordinating the members to carry out the responsibilities, supervising all the plans, decisions and commendations of the Committee, inspecting the implementations. The Director of General Office is doubled by the Deputy Minister of the National Health Commission, who is also a member of the Committee. In terms of the rank in the bureaucratic system, the Director of the Office has no legal authority over the members.

The Ministry of Health P.R. China (MOH)

Before 2013, the Ministry of Health (MOH) was an executive agency of the State Council in charge of providing information, raising health awareness and education, ensuring the accessibility of health services, and monitoring the quality of health services in the mainland of P. R. China. MOH was dissolved in the reforms of 2013 and integrated its functions into the National Health and Family Planning Commission (NHFPC). In 2018, a new agency called the National Health Commission was established in another reform of

the State Council, in which the functions of the NHFPC were integrated (Ma, 2013; MOHPRC, 2006; Wang, 2018).

When the Healthy Cities Programmes were introduced to China in the 1990s, the MOH (nowadays National Health Commission) was the focal point at the national level to cooperate and facilitate various health-related activities with WHO as well as other international organisations. The Ministry of Health was also in charge of the activities of the National Patriotic Health Campaign Committee (NPHCC). The General Office of the NPHCC was also set in the Ministry of Health. Plus, the Deputy Minister of Health to the position of the head of the General Office of NPHCC. This setting between the NPHCC and the National Health Commission was kept in the latest reforms of the State Council (General Office of the State Council, 2018; Wang, 2018).

Municipal level

As discussed in Chapter 4, the Shanghai Municipal Government was responsible for issuing the Healthy City Action Plan in 2002. The Deputy Mayor who was the Director of the municipal Patriotic Health Campaign Committee (PHCC) and oversaw health, education and sports departments was directly involved in the decision and the announcement. The Office of Patriotic Health Campaign Committee at the municipal level coordinated the Healthy City Action Plan. The members of the municipal PHCC, such as health, education and sports departments at the municipal and district level were responsible for the implementation.

At the district level, the district governments issued Healthy District Action Plans (HDAP). Similar to the national and the municipal level Patriotic Health Campaign Committee, the Deputy Mayor of the District who was the Director of the PHCC was overseeing the HDAP. The members of the District PHCC were responsible for implementing the HDAP.

Shanghai Municipal People's Government (SMPG)

Since Shanghai is a direct-administered municipality in China, the Shanghai Municipal People's Government (SMPG) is at the same level as the provinces. The mayor of SMPG is the highest executive ranking official in Shanghai. However, in the dual party-government system in China, the Party Secretary of Shanghai CPCC possesses more power than the Mayor. Various agencies of the SMPG including the Municipal Health Commission, Municipal Education Commission, Municipal Commission of Housing and Urban-rural Development that are related to the health system were listed in Figure 5.2.

Shanghai Municipal Health Promotion Committee (SMHPC, also known as SPHCC)

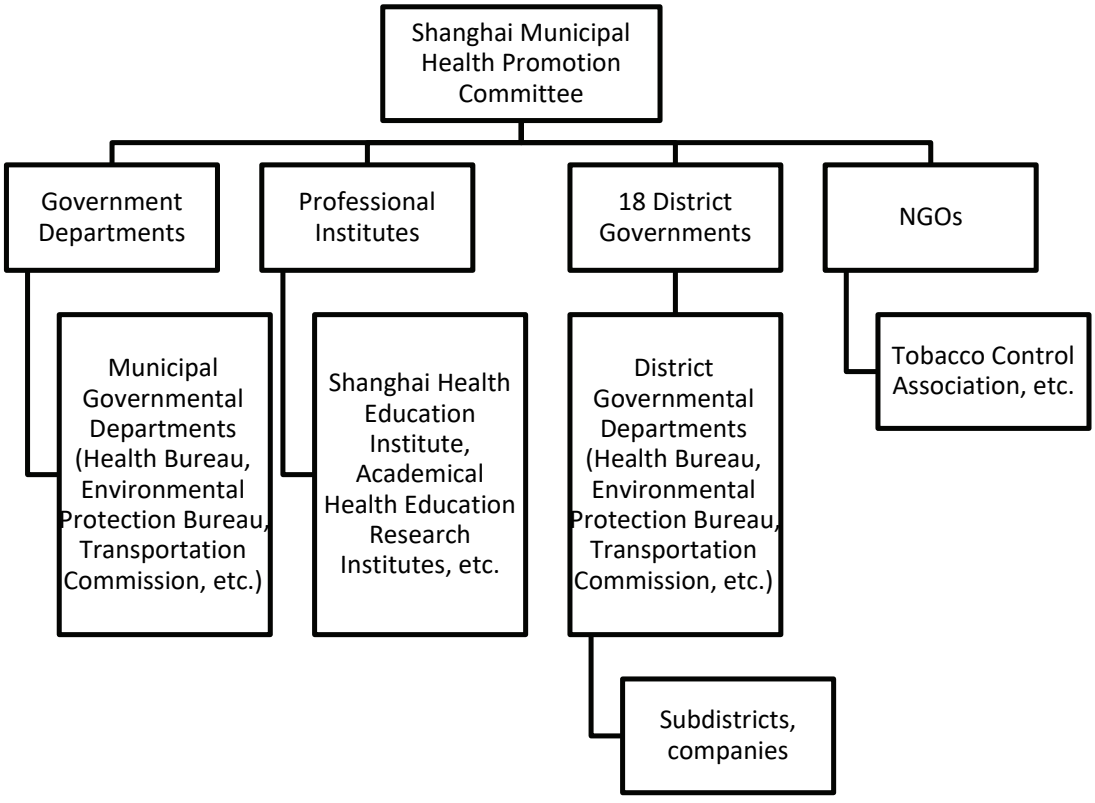
At the local level, the major institutional body of the Healthy City programme in Shanghai is the Shanghai Municipal Health Promotion Committee (SMHPC), which was formed in

2005. The Minister of Health Gao Qiang and the Deputy Mayor of Shanghai Yang Xiaodu added the brand "Shanghai Health Promotion Committee" to the Shanghai Patriotic Health Campaign Committee (SPHCC). The structure and members of the Municipal Patriotic Health Campaign Committee remain the same (see Appendix 9) (Yang and Tang, 2005).

According to the Deputy Director of the Shanghai Patriotic Health Campaign Committee Li Zhongyang:

> *"It is a common practice in other countries that the coordinating body of health promotion oversees Healthy Cities projects. The new brand Health Promotion Committee of Shanghai PHCC would help to promote Healthy City development in Shanghai, further expand the international communication, strengthen the collaboration between the government and social organisations and their members, and correspond to the changes in the activities and missions of Patriotic Health Campaign (*ibid.*)".*

Figure 5.3 The Structure of the Shanghai Municipal Health Promotion Committee



Source: Translated from (Zhao, 2010)

The governmental departments were the main part of the Shanghai Municipal Health Promotion Committee, which included two levels of administrative divisions: 14 municipal departments and 18 districts. The districts followed the same structure as the SMHPC and

formed the District Health Promotion Committees (DHPC). The DHPC covered 45 government sectors, 17 districts and counties, 210 sub-districts and more than 5500 residents' (village) commissions (Tang *et al.*, 2016).

According to the Healthy City Action Plan in Shanghai, the governmental body took the leading role in the organisation of the Healthy City programme. It was institutionalised by the Shanghai Healthy City Construction Joint Meeting Mechanism, in which the meetings were organised every three months and participated by municipal government departments and the district mayor in charge (Shanghai Municipal People's Government, 2002).

Another supplementary institution is the Healthy City Construction Technical Steering Group, composed of university professors and implementing staff in relevant government departments. Professional institutes and NGOs are involved in consultation and evaluation of the programme, but their roles are still minor compared to the government (Shanghai Municipal People's Government, 2002).

The community or the public are consulted in the policy formulation of a new action plan. According to the action plan, the opinions of the public determine the selection of the goals and actions, and the options are still ultimately determined by the government. It is important to recognise the conceptual difference between community consultation and engagement and the purpose of community participation in order to make optimum use of resources (Hall, Davies and Sherriff, 2010). The communities or the public are uncoordinated and lack the power to influence the process of Healthy City development. Therefore, they were not taken as an actor in this study.

The personnel arrangement of the Health Promotion Committee is illustrated in Appendix 8 . Each department has a representative on the committee. The level of civil servants, the party position and the government position of each representative is presented in the table. In the hierarchical system of the government, the position of the person in charge is influencing the agenda setting and implementation process.

As we can see, only the representatives of the health bureau and the Office of Patriotic Health Campaign Committee are the actual directors of that department, the remaining ones are represented by the vice director. The position of the person in charge makes a huge difference in the priority of the Healthy City programme in that department.

The District People's Government (DPG)

The District People's Government (DPG) is responsible for the district level as the Shanghai Municipal People's Government for the municipal level. For example, the Jiading District Government was involved in the implementation of the Healthy City programme and other relevant programmes. In 1995, the district implemented the "Ninth Five-Year Plan

and Healthy City Programme 2010". With the support of WHO, the officials of Jiading District Health Bureau of Shanghai prepared a case-study report on Healthy City-Jiading in August 1996 and the local Congress endorsed the implementation of the "Healthy City Programme" for the entire district. In April 1996, the "Meeting on Mobilizing Manpower to Build Up a Healthy City in Jiading District" was held with the presence of senior officials from both central and local governments. The head of the Jiading District demonstrating his commitment to this issue had signed the contracts for establishing a Healthy City with directors of all the town-level governments (Chen, 2002; World Health Organization. Regional Office for the Western Pacific, 1996).

The District Health Promotion Committee (DHPC)

In Shanghai, the District Health Promotion Committee (DHPC) is also the District Patriotic Health Campaign Committee (PHCC). Since the organisation of the PHCC is parallel to government administrative divisions, the district level PHCC has a similar structure to the national and municipal PHCC. For example, the district committee is led by the Vice-Mayor of the district. The members of the committee are directors or deputy directors of related district bureaus or commissions, aligning with the ministries at the national level and the commissions at the municipal level. The offices of PHCC at the district level are also set in the Health Commission at the district level (see Appendix 9 for the example of the Pudong New District Health Promotion Committee). The DHPC is responsible for making, implementing and evaluating the HDAP (General Office of Shanghai Municipal People's Government, 2017).

Subdistrict Office (jiedao)

In a larger urban area, typically in a central-administered municipality, a district (*qu*) is divided into subdistricts (*jiedao*). The Subdistrict Office (*jiedao banshichu*) is the township level administrative agency. The office of subdistrict PHCC is also set in the Subdistrict Office.

Neighbourhood committee (juweihui)

A subdistrict is divided into several residential conglomerates or neighbourhoods (*xiaoqu*). Neighbourhood committees (*juweihui*) are grassroot divisions in charge of community management[1]. These grassroot divisions do not belong to government agencies, but the neighbourhood committees are one of the strongest assets of Patriotic Health Campaign

[1] 'Xiaoqu' is a spatial concept which refers to residential areas which are often gated. 'Juweihui' is an administrative concept which refers to organized committees promoting community cohesion and a sense of belonging.

Committee. Communities are essential in implementing programmes such as the Healthy City Action Plan, National Hygienic City, and nowadays the control of COVID-19 (see 1.1.3).

5.1.2 Role of actors

Having identified the main actors of the Healthy City Action Plan in Shanghai, the current section divides actors according to their roles in the Healthy City Action Plan. These include consideration of the coordinator, the members and the consultant of the programme.

Coordinator: The Office of Patriotic Health Campaign Committee (PHCCO)

The Patriotic Health Campaign Committee is the initiator, coordinator and evaluator of the Healthy City Action Plan in Shanghai and the National Hygienic City. As an Advisory and Coordinating Agency (ACA) directly led by the Communist Party of China, the National Patriotic Health Campaign Committee has some characteristics. First, it is predominantly political and its administrative body is composed of national and local bodies; its leading bodies follow those of government bodies, and the quota of its staff is officially assigned by the government; and it performs certain administrative functions (Deng, 2010).

The Advisory and Coordinating Agency is a form of coordination through establishing an organisational entity to deal with specific tasks. It is featured by resource-concentrated, low ambiguity, high formality and high restrictions on members' actions. The Advisory and Coordinating Agencies under the State Council are established to accomplish a special or temporary mission, including leading groups, coordinating groups and working groups, sometimes committees, offices, headquarters, etc. The main function of the agencies is to coordinate different departments in the government and solve urgent problems efficiently (Liu and Zhao, 2011; Zhu and Mao, 2015).

The Advisory and Coordinating Agency has a significant hierarchical feature, despite that the departments and the coordinating issues are horizontal. Because normally the Advisory and Coordinating Agency is led by the Premier, Vice-Premier, and State Councillors, joined by leaders of the State Administration departments. An office is often set in the principal department to carry out the specific work. It forms a structure that the leaders and the principal department as the axis, and the other departments follow (Zhu and Mao, 2015).

The Advisory and Coordinating Agency involves interventions of the authority to exercise the administrative power which can be applied to clarify the responsibilities of the members, minimize the uncertainty and risks of avoidance, maximizing the effectiveness of intersectoral coordination. It has an important role in its temporary function, contributing to communication, negotiation and coordination.

However, an Advisory and Coordinating Agency like Patriotic Health Campaign Committee also faces certain challenges. First, a salient problem of the Advisory and Coordinating Agency is "path-dependency". The number of temporary agencies is constantly growing and the cost of administration is increasing. (Zhu and Mao, 2015). Second, the hierarchical feature of the Advisory and Coordinating Agency can be a blessing but an obstacle as well. The authority of leaders is powerful in coordination. But most leaders are occupied in several Advisory and Coordinating Agencies, in some cases as many as nine agencies. As a result, these coordinating groups might not be as effective as they are designed to be (Liu, 2013). Third, the general office set in the principal department does not have authority over other member departments.

Moreover, the lack of resources, skills and knowledge are identified as the major problem in different types of projects within the Patriotic Health Campaign system in the Healthy City programme. Among all the elements, the improvement of resources (time, money, and human resources) is the most wanted by health promotion workers (Peng *et al.*, 2012).

The Patriotic Health Campaign Committee is not an institution with a strong presence in the government, neither for other departments, nor for the people working in the Office of Patriotic Health Campaign Committee, since the image of the Patriotic Health Campaign that remain in people's perception is just a cleaning movement. Therefore, it is difficult for the general office to negotiate with other departments in daily work (Z5J8, personal communication, 27 October 2017; Z5B6, personal communication, 3 November 2017). Regarding the Healthy City Action Plan, the Patriotic Healthy Campaign Committee in Shanghai did not have a separate budget or an award like the National Hygienic City to mobilise the members. The coordination is especially difficult when the incentives are not in place (G2S9, personal communication, 27 October 2017; L2G8, personal communication, 2 January 2018).

Consultant: Academic professionals

The academic professionals play the bridge between the international movement and the local programme, from preparing the research basis to convincing the local government to take up the initiative.

As discussed in chapter 1, the scholars introduced the concept of a Healthy City to China. Since 1997, some scholars already published papers in Chinese about the concept and debates about Healthy City (Fu, Xuan and Li, 2006; Huang, 2002; Yu and Qian, 1998; Zhou *et al.*, 2000). Since 1999, scholars also conducted the feasibility of the Healthy City programme in Shanghai (Gu, 2009; Xuan *et al.*, 2003; Zhao, 2010). In 2001, several experts organised a seminar on Healthy City together (F2H3, personal communication, 1

November 2017), who became the key informants in the Healthy City programme in Shanghai later.

In the agenda setting process, scholars played an important role in influencing the local government. First, scholars work as consultants for both WHO and local government. Therefore, they were involved in the international movement early on. Second, their connections with the local governor help to deliver the idea of cooperating Healthy City concept into local action plans (*ibid.*).

The scholars are major actors in the evaluation of the Healthy City Action Plan in Shanghai, which is designed to be a three-year action plan. During the three-year process, a baseline survey would be conducted in the first year to investigate the demand for the action plan, a mid-term evaluation in the second year to check the progress, and the final evaluation in the last year to measure the outcome of the action plan after implementation. These evaluations are authorised by the local government to the experts from the universities and research institutes (L5H4, personal communication, 23 October 2017; F2H3, personal communication, 1 November 2017; Z4X9, personal communication, 6 November 2017).

The scholars recognise the government as the key actor in the policy-making process, while recognising their own identity as consultants. Therefore, they need to influence the local governors in order to implement the programme. The trust of the governor is essential for their proposal to be accepted. The negotiation worked when one of the leading academics suggested starting a Healthy City programme in Shanghai to the director of the Office of Patriotic Health Campaign Committee (*ibid.*). The coordinating role of the scholars could be essential in an intersectoral programme.

The scholars also recognise that in the hierarchical system in China, a top-down process is effective for getting priority of programmes. Since Healthy China has become a national priority, the scholars also become more positive about the Healthy City Action Plan in Shanghai (G2S9, personal communication, 27 October 2017; Z5D5, personal communication, 31 October 2017; F2H3, personal communication, 1 November 2017).

However, while some scholars think the implementation process is quite democratic and comprehensive, other scholars recognise that there is a lack of public participation (L5H4, personal communication, 23 October 2017; G2S9, personal communication, 27 October 2017). For example, surveys were conducted in the public before deciding on the themes of the Healthy City Action Plan Phase II (2006-2008), but the questions were close-ended, which did not allow the public to express themselves enough (Gu, 2009).

Members: various government departments

Various government departments such as the health commission, education commission, and sports bureau are members of the Patriotic Health Campaign Committee (PHCC) at the municipal and the district level. These members are responsible for contributing to the Healthy City Action Plan and take accountability in implementation under the coordination of the Office of Patriotic Health Campaign Committee (PHCCO), or more specifically, under the supervision of the deputy mayor in charge of health, education and culture. For each one of the indicators in the action plan, there is one leading department in charge and other departments in participation.

The coordination work on the horizontal level is complicated. As discussed in section 4.3, in Phase I (2003-2005) of Shanghai's Healthy City Action Plan, the PHCCO took all the 192 indicators from WHO and distributed them according to the relevance to each department. However, it requires not only a huge amount of effort to communicate with all the departments involved but also an extra amount of work for each department which would not ally with their routine work plan. Therefore, the number of indicators reduced drastically since the second round, to better cooperate the regular work plans of each department.

Eventually, the indicators of the action plan are basically the reflection of the regular work of each department. Most advancements of the programme occurred in the health department, education department and cultural department which are working closely together at the municipal level under the supervision of the same deputy mayor.

At the district level, horizontal coordination works in a similar way to the municipal level. The negotiation of the Office of Patriotic Health Campaign Committee (PHCCO) is not very effective with other departments since they are at the same level. It is mostly a direct order from the deputy director of the district that effectively drove the implementation of the programme (Z5J8, personal communication, 27 October 2017; Z5B6, personal communication, 3 November 2017).

In the interactions between the coordinator and participants, the policy problem of coordination can be modelled with the battle of sexes, where both players prefer to coordinate, rather than not reach an agreement. The problem is strategic uncertainty, since each player has her preferred equilibrium strategy, despite the scope for negotiation.

Regarding the Healthy City Action Plan in Shanghai, the Office of Patriotic Health Campaign Committee as the negotiator of the project can be seen as a column player, whose preferred option is B: expanding the indicators to the international standard; while

the row player, the partner departments in the project, preferred to stay with the indicators of their on-going projects.

Since not all the departments involved are directly supervised by the vice-mayor in charge, they have the option to not comply and sacrifice their reputation. In addition, the Office of Patriotic Health Campaign Committee does not have expertise in the broad range of topics included in Healthy City, they could not force all the departments to implement the indicators, but only accept what each department can provide, in any case, it is better than losing a partner in the programme.

In order to enforce the international standards, the Office of Patriotic Health Campaign Committee could only use the social connections with other departments, which is easier with those also supervised by the same vice-mayor since they meet more often at common work meetings, or with those they know in person, these personal connections matter a lot in Chinese society, which will be explained in the next chapter on institutions.

5.1.3 Perceptions and actions

The fields of public health and urban planning are closely related to the Healthy City Action Plan. In the section, public health and urban planning are taken as an example to demonstrate the gaps in perceptions and actions of Healthy Cities from different fields.

Although it has been repeated by researchers that public health and urban planning are connected, there is little overlap between the fields today. While public health has been increasingly concentrating on epidemiology studies, urban planning is showing few signs to address the health issue of the population (Corburn, 2004). The loss of close collaboration between urban planning and public health have limited the design and implementation of effective interventions (Northridge, Sclar and Biswas, 2003).

Undoubtfully, both disciplines are essential for developing Healthy Cities programmes. Therefore, the theoretical discussion about Healthy City planning started as early as the beginning of the WHO Healthy Cities programme in the 1980s and became a major topic in Healthy Cities practice in Europe in the 1990s. In China, the academia has caught up with Healthy City planning in 2006, it also became part of the Healthy Cities action plan in 2009, however, the actions are not coordinated systematically.

As a trained urban planner before, I can see the disparities in the perceptions and methodologies between the fields of public health and urban planning. Thus, the actors from public health and urban planning are interviewed in the field to present the perspectives of these two disciplines, the current work has been done between public health researchers and urban planners, and to see the potential for partnerships in the future.

Public health

Public health experts are the ones working closely with the health sector, especially the Office of Patriotic Health Campaign Committee (PHCCO). Therefore, their perspective on Healthy Cities is the most influential on the policy process. From the public health point of view, research is done around the factors of health and disease.

During the miasma and contagion in the late 19th century, public health and urban planning are regularly connected to limit hazardous exposures through such measures as sewerage, garbage collection, and rodent control (Corburn, 2004).

By the end of the 19th century, public health research shifted from investigating ways to improve urban infrastructure to laboratory investigations of microbes and interventions focused on specific immunization plans, with physicians, not planners, emerging as the new class of public health professionals. This trend continued through the first half of the 20th century (*ibid.*).

In the latter half of the 20th century, public health shifted toward addressing the individual factors of disease, because the environmental factors were harder for physicians to influence. During this era, public health largely ignored the social dimensions of disease and emphasized modifying individual "risk factors" reflected in one's lifestyle, such as diet, exercise, and smoking (*ibid.*).

Public health researchers have shifted from micro biotic experiments in epidemiology, and biology to macro factor studies about the social, psychological, and environmental factors of health. The environment works as a risk factor or promotion factor for health. In one way, it is easier for designing the experiments. In another way, it is difficult to tackle the environment as a whole.

The same challenge appears in the governmental departments. The public health department works with clinics and physicians, there is no connection with the urban planning and construction department. Thus, there is no power to influence the urban environment outside the health facilities and services.

Public health experts recognised the importance of urban planning in the Healthy City Action Plan and expressed the willingness to collaborate with urban planners to build a Healthy City beyond what the public health department can do. However, the lack of personal connections seemed to be a barrier for public health workers and urban planners to establish a partnership (F2H3, personal communication, 1 November 2017).

Urban planning

Modern urban planning started with industrialization and the deterioration of the urban environment. Public health and urban planning are working together to improve the housing and working conditions and provide sanitation and ventilation to reduce the risk of communicable disease. In the era of contagion, planning is affiliated with the power of the state to separate suspected cases (Corburn, 2004, p. 541).

In the first half of the 19th century, the "zoning" model has taken hold of the field, which focused on functionality and a hierarchical ordering of land use that separated housing from industrial areas. In the post-war era, planning shifted to support economic growth with large infrastructure and transportation projects. Planning shifted from attempting to restrain harmful "spillovers" from private market activities in urban areas to promoting suburban economic development. An era of urban divestment and residential segregation took hold (Corburn, 2004, p. 542).

In the latter half of the 20th century, urban planning underwent an analogous shift in its orientation toward environmental health by adapting the environmental impact assessment (EIA) process. However, EIA has been widely criticized as a method for assessing population health because they tend to restrict analyses to quantitative data while minimizing or ignoring other kinds of information and limiting the discourse and practice to experts (*ibid.*).

In recent decades, urban planning is shifting from zoning areas of different functions to a more integrated model of land use. Studies have been done in Europe and North America that proved the health benefits of greenery and walkability (Maas *et al.*, 2006; Tran, 2016; Wolch, Byrne and Newell, 2014). The health benefit of a walking-friendly urban environment has not been measured and emphasized in China by the time the Healthy Cities action plan was developed. However, urban planners still see health as part of the public service planning and distribution of hospitals and health services. The environmental factors of health such as green space are valued, not from a health perspective but from an economic perspective (Z5D5, personal communication, 31 October 2017).

Urban planners are constantly influencing individual factors of health with the design of urban space, but they are not aware of the health benefits. For example, many urban planning policies and projects are designed around the everyday life of the population. The Shanghai Master Plan 2040 developed community design guidelines, including the Shanghai Planning Guidance of 15-Minute Community-Life Circle, and Shanghai Street Design Guidance. It is the first time in Shanghai that a guidance for community planning is issued. Community planning is aimed at improving the quality of life-based in

communities. The main target of this guidance is residential areas, within 15-minute walking distance, around 3-5 sq. km, with 50-100 thousand residents. It focuses on all the aspects of the everyday life of people, including residence, job opportunity, travel, service and recreation, to promote quality of life and bottom-up community governance. It provides targets and requirements and also showcases to demonstrate the pathway to planning a community based on problem-solving. Samples of surveys are also attached to identify the need of the residents (Shanghai Urban Planning and Land Resources Administration Bureau, 2016).

To support the Urban Master Plan, the guidance recognizes the streets as the basic public product in the city, which belong to the public. The activities of pedestrians, the flow of vehicles and space formed the street. Streets play multiple roles in people's life. It is more than infrastructure in the city, it should enhance people's communications and interactions, contain people's emotions and memories, and also promote environmental protection and innovation at the community level. During more than one year of the policy making process, which integrated participation from the public, multiple government departments, design teams and experts from various fields (Shanghai Urban Planning and Land Resources Administration Bureau, Shanghai Municipal Transportation Commission and Shanghai Urban Planning and Design Research Institute, 2016).

Both plans contribute to the construction of a Healthy City, to provide a community where people can access the basic service and engage in the process of place-making from their own perspectives. The challenge is how to provide resources for the communities to implement the ideas. Although it seems more directly related to urban planning, it is either not clear what the term 'healthy' means in the Chinese institutional context, or the role of urban planning is recognised in the practices of Healthy Cities in China, the role of other public sectors including urban planning institutes is weak (Luo, 2011).

Although urban planners recognise the importance of health, there are no tools to measure the benefits or damages of urban planning projects. Some urban planners suggested Health Impact Analysis (HIA) be introduced to urban planning to evaluate the impact of planning projects on health. However, with the failure of EIA in China, the future of HIA is unclear (W4L3, personal communication, 25 October 2017). Other urban planners recognise the importance of awareness at the highest level possible. For example, Shanghai implemented the planning for more greenery immediately after the mayor made it the priority of the municipality. They believed health being recognised as a priority at the national level policies would direct the planning projects towards health as well (Z5D5, personal communication, 31 October 2017).

5.2 ACTOR CONSTELLATIONS

After identifying the main actors of the Healthy City Action Plan in Shanghai, the actor constellations are analysed according to the level of leading actors in initiating and implementing the programmes. Two examples from the Healthy City Action Plan, the Citizen health self-management group programme (CHSMG) and Fitness for all action plan (FAAP), are chosen to represent two major types of constellations.

5.2.1 Nationally initiated, municipally implemented: FAAP

The Fitness for All Action Plan (FAAP) in Healthy City Action Plan is an example of a national plan implemented at the municipal level. The National Fitness for All Plan was initiated in 1995 by the General Administration of Sport of China (GASC). The Municipal Administration of Sport has been implementing the plan since 1995. The FAP became one of the major projects in the Healthy City Action Plan since Phase I (2003-2005).

The Fitness for All Action Plan in Shanghai began in December 2003. The leading group of Shanghai Fitness for All issued the FAAP. Shanghai Municipal Administration of Sport (SMAS) was responsible for implementing the action plan. The FAAP was aimed to make fitness a lifestyle and a lifelong habit of citizens. The theme for the Healthy City Action Plan Phase I (2003-2005) was to make citizens interested in, learn, and participate in one sport. The programme encouraged citizens to join sports organisations, participate in community sports activities, exercise at least once a week, watch a game live, and get physical examinations once a year (Shanghai Municipal Administration of Sport, 2005).

According to the Shanghai Municipal Administration of Sport, the Fitness for All Action Plan was part of the National Plan 'Fitness for All Plan Outline 1995-2010'. It was then integrated into the Healthy City Action Plan because of its relevance to health. The SMAS was in charge of setting the goals, implementing the plan, and reporting on the effects of the programme (C4H3, personal communication, 1 November 2017). Shanghai Institute of Physical Education Public Sports Service Development Research Center published the Shanghai Fitness for All development report in 2016. According to the report, the government's annual expenditure on sports reached 770 million RMB in 2016, the expenditure per capita increased from 3.7 RMB in 2012 to 17.7 RMB in 2016. The sports facilities per capita increased from 1.72 m^2 in 2013 to 1.83 m^2 in 2016. By 2016, the population exercising regularly accounted for 42.2% of the total population (Shanghai Institute of Physical Education Public Sports Service Development Research Center, 2017).

The Fitness for All Action Plan represents how a national plan was reflected in a municipal programme and implemented at the local level. The implementation relied on the resources from the municipality, the districts, and communities. The Fitness for All Action

Plan is different from national awards such as the National Hygienic City and the National Civilised City mentioned in chapter 4 as there is no systematic evaluation by national agencies.

5.2.2 Locally initiated, municipally implemented: CHSMG

The citizen health self-management group programme (CHSMG) was one of the signature programmes in the Healthy City Action Plan. The bottom-up policy making process distinguishes the CHSMG from most projects of the Healthy City Action Plan. The CHSMG was initiated at the community level and then implemented in the whole municipality. It was originally a six-month research project on chronic disease self-management. When the project proved to be successful, the Shanghai Patriotic Health Campaign Committee adopted it and supported the implementation at the municipal level. The programme also became part of the regular programmes in the Healthy City Action Plan.

The research project 'Shanghai Chronic disease self-management programme (CDSMP)' was conducted by the Faculty of Public Health, Fudan University from June 1999 to February 2000. The research project was conducted in five communities in Shanghai, involving more than 900 volunteer patients in the treatment and controlled groups. The CDSMP was designed to help patients with one or more chronic conditions by maintaining and improving patients' health behaviour and health status while lowering dependency on healthcare facilities through improved self-management skills, and better communications between patients and health workers. The results of the studies in Shanghai showed that the CDSMP improved patients' health behaviour, self-efficacy, and health status, and resulted in fewer visits to the emergency room and hospitalisation after six months of implementation (Fu *et al.*, 2003).

At the end of 2007, Shanghai Patriotic Health Campaign Committee began implementing the Chronic disease self-management programme in all the communities in Shanghai. In 2009, the title was changed to Citizen Health Self-Management Programme (CHSMG) to expand the target audience to healthy citizens. The CHSMG was also included in the Healthy City Action Plan since Phase III (2009-2011). By the end of 2013, CHSMG had been implemented in 5473 communities in Shanghai. More than 350,000 participants joined the CHSMG regularly in more than 21,000 groups in Shanghai. Evaluations showed that the CHSMG improved the health status and self-efficacy of chronic disease patients, and saved each participant an average of 726 RMB in yearly health expenditure. The CHSMG also improved the health literacy and health behaviour of a healthy population in the communities (Wu *et al.*, 2016).

The Chronic Disease Self-Management Programme (CDSMP) is a good example of mobilising the resources of communities. The neighbourhood committees provide the

space for group meetings. The group leaders of the CDSMP are volunteers from the neighbourhood committees. The health workers from neighbourhood health centres are consultants of the groups. These community agencies are essential in the implementation of the CDSMP (L2G8, personal communication, 2 January 2018).

The Chronic Disease Self-Management Programme (CDSMP) plays an essential role in the Healthy City Action Plan in providing an alternative to the majority of top-down models currently used in policy implementation. It empowers civil society to advance health and wellbeing at the community level. Officials from the World Health Organisation and the Ministry of Health visited the CDSMP in Shanghai and appraised the social mobilisation and the successful partnership between the government, academic institutions, community leaders, and the civil society (Wu *et al.*, 2016).

5.2.3 Mixed approaches in the Healthy City Action Plan

Although the Healthy City Action Plan is initiated by the municipal government, and implemented at local levels, the impact of the international and national actors cannot be ignored (as discussed in Chapter 4 and section 5.1). After analysing the sub-projects in the Healthy City Action Plan, it became more evident that the Healthy City Action Plan involved actors at various levels ranging from the international organisations to the neighbourhood committees, from public health professionals to urban planners.

The Healthy City Action Plan was decided by different sectors and the actor constellations vary in each programme and each stage. A project could be initiated and implemented by any level of actors and any profession. The Chronic Disease Self-Management Programme, for example, was initiated by public health professionals and became a governmental programme widely implemented. It is hard to conclude it as a bottom-up approach since the larger-scale implementation was through a top-down approach.

Therefore, it is difficult to conclude that the policy process of the Healthy City Action Plan is a single approach. To understand the policy interactions more clearly, the modes of interaction will be introduced in the following sections to illustrate the complex policy process from horizontal and hierarchical perspectives.

5.3 MODES OF INTERACTION

In this section, the modes of interactions between the actors are analysed. In general, two types of interactions were apparent: hierarchical interactions, which occur between the superior and the subordinate in the hierarchical structure of the organisation, and horizontal interactions, which are when the actors in the same level of the organisation negotiate.

5.3.1 Hierarchical interaction

The interactions in the hierarchical direction are largely influenced by the hierarchy in the organisation, however, hierarchical direction is different from hierarchy itself. In this section, the basic features of hierarchical coordination are presented, and the strategies of the principal and agent are analysed.

A principal-agent relation

Hierarchical direction is a mode of interaction in which the principal can specify some of the agent's decision premises, which may arise from the principal's superior capacity to offer rewards or punishment or legitimate hierarchical authority. The rewards could be financial or nominal. The sources of the sanctions could be feelings of guilt; the fear of shame, and perhaps social ostracism, if conformity is required by social norms (Scharpf, 1997).

In the Healthy City Action Plan, a principal is a superior in a higher position, and the agents are subordinates at lower levels. The principal sends instructions to agents through meetings or issuing official papers or both. For example, the Municipal People's Government announced commending the Healthy City Action Plan in a meeting and issued the document. The plan is then distributed to the district and subdistrict governments. After the district government made the HDAP, it is distributed to subdistrict offices and neighbourhood committees.

In the hierarchical direction of interactions, the holders of power can override the preferences of others. If these power holders could have complete information and be motivated by public interest, then hierarchical coordination can generate outcomes with both welfare efficiency and distributive justice. The challenge of hierarchical coordination is to resolve the flow of information problem under restrictive mechanisms of accountability to assure the approximation of public interests (Scharpf, 1997).

In the Chinese governmental system, which is mainly based on centralisation and authoritarianism, there is still a huge range of discretion that the people outside the government do not expect, for example in the way of the administrative subcontract, which is a governance structure of bureaucracy and pure subcontract among independent actors without hierarchical relations combined. The principal exercises hierarchical prerogatives-formal authority and residual control rights, such as the power to appoint and remove, to supervise and censor, to intervene when necessary; the agent has discretion and residual claimant over the budget or revenues either collected or allocated by the principal. The control over administrative subcontracts is rather outcome-oriented than process-oriented (Zhou, 2014).

Strategies in hierarchical interaction

- ***Hierarchical authority***

The hierarchical structure of government has a huge influence on the actor constellation. All the governmental institutes follow the same structure at the national level. The superior level has the authority over the subordinate level. The constellation can be illustrated by the administrative divisions in China, which also determine the civil service rank accordingly (see Appendix 5).

According to principal-agent theory, hierarchical authority creates a capacity to override the preferences of other actors. If it were exercised from a policy perspective, it could eliminate the transaction costs of policy coordination. Therefore, it is an efficient way of interaction in terms of the transaction cost. However, there are certain limits in ensuring social welfare if the principals do not take public interest into account (Scharpf, 1997).

China is an authoritarian state, as mentioned in section 1.2.3. There is an unwritten rule that the subordinates follow the instructions of the superior. The superior with authority is usually referred to as *lingdao.* The words from *lingdao* are powerful. This can be observed in public programmes such as the Healthy City Action Plan, National Hygienic City, and National Civilised City, as well as in everyday life in China. Children should follow the instructions of their parents; students ought to follow the instructions of their teachers; subordinates should follow the instructions of their supervisors.

The benefit of hierarchical authority is that top-down instructions would be followed unconditionally. The challenge is that the subordinates cannot express their doubts directly to the superior, instead, they could choose to passively disobey by not implementing the plan yet reporting it as finished. The strategies of the agents will be explained in the next section.

- ***Control rights***

The distribution of the residual right of control, according to principal-agent theory, largely influences the outcome of negotiations and the incentive system, which means the control over the use of assets possessed by the individual or the group. The control strategy can be very effective if the process is strictly monitored. However, it requires a large amount of time and resources from the organisation. Therefore, control rights are more common in campaigns or awards such as National Hygienic City and National Civilised City than in daily bureaucratic work.

The capacity of the principal could be the control over the assets in the organisation. The principal could have the power to distribute financial and human resources. Regarding financial strategies, the Healthy City Action Plan did not have specific funding for the

project. It is difficult for the municipality to take control through the hierarchy of administration. Furthermore, in municipal bureaus such as the Shanghai Municipal Administration of Sport, the budget cannot be distributed from the municipal level to the district level. Each level of government has its own budget (C4H3, personal communication, 1 November 2017).

When the financial capacity could not be utilised, the principals use the residual control rights. In the policy process, the principal has control over the goals, the incentive system and evaluation. The agents are required to fulfil the targets of the policy with agreements. To motivate the implementation, the principals would distribute certain residual control rights to the agents so that the agents have the resources to implement the policy in their administrated divisions (Zhou and Lian, 2012).

In National Civilised City, National Hygienic City, and the Healthy City Action Plan, the control over the nomination, goal setting, and evaluation was distributed from the principal to the agents, as shown in Table 5.2. In National Civilised City and National Hygienic City, the central government gave the municipal government the right to the nomination. The national government had total control over the goal setting and evaluation. The incentive from the central government to the locals was nominal. The municipalities had the right to motivate the local level governments. There was no nomination process in the Healthy City Action Plan. The municipal government had control over goal setting as the standard was beyond the national requirements. The municipality negotiated with the municipal bureaus and commissions about the goals of the Healthy City Action Plan and did not control the evaluation process. The members conducted self-evaluation. There was no incentive from the municipal government for the lack of funding (L2G8, personal communication, 2 January 2018).

Table 5.2 Types of Control rights distributed in National Civilised City, National Hygienic City, and the Healthy City Action Plan

	National Civilised City	National Hygienic City	Healthy City Action Plan
Nomination	X	X	-
Goal setting	-	-	X
Evaluation	-	(-)	(X)
Incentives	X	X	-

Source: own compilation

Challenges in hierarchical coordination

Although hierarchical interactions have different characteristics, there are some similar challenges for both.

- ***Motivation***

Motivation is important for the policy process. In a hierarchical interaction, the principal needs the motivation to maximise the overall welfare of the organisation. The agents need the motivation to fulfil the contract. The Lack of motivation from either the principal or the agent could influence the policy outcome.

In the Healthy City Action Plan, the principal at the municipal level had motivations to implement the programme and improve the organisation, because the success of the programme can influence its legitimacy. The major role of the Patriotic Health Campaign Committee as a political propaganda organisation was declining since the economic reformation in the 1980s. Adapting the international Healthy City programme could update the image of the Patriotic Health Campaign Committee and gain a reputation at the international level. The success of the programme would also prove the legitimacy of the Office of Patriotic Health Campaign Committee.

The agents would not have as many gains as the principal if there were no incentives. The principal needed to provide rewards or sanctions to motivate the agents. As mentioned in section 5.3.1, the principals in the Healthy City Action Plan did not have the resources to give financial rewards, only nominal ones. There were no sanctions for noncompliance. The setting was not providing enough motivation for agents, which made it challenging for the implementation.

Besides, the agents had to face multiple principals delegating authority to them and evaluating them. In the Healthy City Action Plan, the municipal departments receive assignments from the ministries and the Shanghai Municipal People's Government. They were evaluated by the SMPG but not necessarily the Vice Mayor overseeing the Healthy City Action Plan. Therefore, it was a priority for the municipal departments to fulfil the tasks of the ministry. The Fitness for All Action Plan is a good example of adapting the central government's plan to the municipal programme. But if the municipal government required new tasks in the Healthy City Action Plan, it would create extra work but not enough motivation. It would be reasonable for the agent to decline the contract or not fulfilling the contract.

- ***Asymmetric information***

The challenge of asymmetric information is another important factor for policy interaction. In hierarchical interaction, the agents might possess more information at the

local level than the principals at the central level. In horizontal interaction, player A can have more expertise in professional field A than player B from another field.

As mentioned in section 5.3.1, usually the agents possess more complete and precise information about the local settings, which significantly increased the strategic capacity of the agents in bargaining. Therefore, the agents would provide private information or use the ambiguity of the information to establish legitimacy for their action. The risks for the principals are that without enough knowledge about the actions, it is difficult for them to observe the agent's behaviour or evaluate the agent's performance according to relevant external conditions due to basic information asymmetries.

In order to cope with the paradox of asymmetric information, the Patriotic Health Campaign Committee would hire third-party experts as evaluators. However, a basic trust in the expertise and the loyalty of the evaluators are required.

- ***Time***

Table 5.3 Governmental plans in terms of scope

Type of plan	**Name of plans**	**Start**	**End**
Long term plan	*Shanghai Master Plan*	2017	2035
	Healthy Shanghai 2030	2017	2030
	Shanghai Health Promotion Plan	2011	2020
	New Health Reform	2009	-
5-year plan	*13th Five-Year Social and Economic Development Plan*	2016	2020
3-year plan	*Shanghai Healthy City Action Plan*	2015	2017
	Shanghai Environmental Protection Action Plan	2018	2020
	Shanghai Public Health Action Plan	2015	2017
Yearly plan	*Shanghai Municipal Yearly Substantial Projects*		

Source: own compilation

Time is an important factor in policy interaction. It is an essential resource of strategic capacity (Rubinstein, 1985). Players with more patience can expect a bigger share in the end; the player who cannot afford procrastination have to make more compromise. However, the risk is losing long-term welfare in a short timeframe.

Time can be an effective instrument for the principal to control the agents' actions. It is often used in a hierarchical structure like the Chinese government. From the famous

National Five-year plans to the annual budget, the agents have to deal with different scopes of time constantly (see Table 5.3). The principal at the higher tier can determine the time scopes for financial budget, implementation and evaluation. In the case that agents at the lower tier fail to meet a deadline, they might gain a poor reputation and risk future chances of promotion.

The operation of governments is continuously vacillating between different time horizons for setting priorities, allocating budgets, making decisions, and implementing policies (Hart, 2017). There are plans in different time frames. There are long term plans that last from 10 to 20 years, Social and Economic Development plans that establish the foundation for all other plans within 5 years, three-year plans that are based on actions and programmes, and yearly plans based on projects.

The longer the time frame used for the assessment of policy outcomes the more controversial their meaning and evaluation can be. Similarly, it is more difficult to monitor policies with iterative objectives than unique outcomes since the recurrent one needs to be renegotiated and adapted constantly by different stakeholders and according to the current situation (Hart, 2017).

Therefore, time influences the actor's choice of policy goals. Short-term effects are easier to register than long-term effects, but long-term effects might be more beneficial for all (Hart, 2017). It was quite often that the governors had to judge feedback about past policies first and optimize their short-term political implications while making decisions about policy priorities (Hart, 2017; Zhou and Lian, 2011). If the agents want to show the principal positive progress of their work, short-term projects are favourable. This choice may influence the impact of policies in the long term.

For example, in 1986 the Mayor of Shanghai required the Shanghai Municipal People's Government to accomplish 15 tasks to set proper short-term goals based on the economic development strategy of Shanghai. Because of the visible and accessible effects of the annual projects to the public, the mechanism was kept (Shanghai Municipal Administration of Sport, 2003). However, the solutions to health issues usually take a longer time to show the effects. Using short-term goals to show progress in health status might exclude the needs of certain groups. For example, life expectancy measurement could not be applied to migrant workers since longitudinal studies required repeated observations of the same variables over years.

5.3.2 Horizontal interaction

Horizontal interactions happen between the actors at the same level. In this section, the characteristics of horizontal interactions in the Healthy City Action Plan are identified. The strategies of the coordinator and members are presented.

Reaching agreement through negotiations

Horizontal interactions happened when the Patriotic Health Campaign Committee negotiated with government departments at the same administrative level, and also when the government was collaborating with academia to conduct surveys or evaluations.

There is a dilemma between efficient production and fair distribution in reaching an agreement through negotiations. On one hand, a better overall solution requires creativity, effective communication, and mutual trust. On the other hand, a successful distribution depends on the strategic and even opportunistic communication with retaining available information, and distrust of potential misinformation (Scharpf, 1997). Therefore, the coordinator such as the Office of Patriotic Health Campaign Committee might be vulnerable to information asymmetries, dissimulation, and opportunistic stratagems.

In the production dimension, the coordinator would choose the solution with the highest welfare according to Coase Theorem. However, this option might not be in the zone of common interest players (Scharpf, 1997). For example, in Phase I of the Healthy City Action Plan, the Office of Patriotic Health Campaign Committee (PHCCO) wanted to adapt the international Healthy City programme for a better solution to urban health issues, but it required much effort from other players. As a result, the targets in Phase I were not completely fulfilled (see Table 4.11) and the indicators were largely reduced in Phase II of the Healthy City Action Plan (As mentioned in section 4.3). According to the researcher involved in the evaluation of the Healthy City Action Plan Phase I, it was the consequence of difficulties in coordination. It was not feasible for the director of PHCCO to coordinate with each department at the same administrative level without personal connection with the directors of these departments (G2S9, personal communication, 27 October 2017).

The Office of Patriotic Health Campaign Committee (PHCCO) needed to provide plausible rules that share the value with other partners to keep them in the programme. In the following phases, the Healthy City Action Plan gradually became a compilation of individual department actions. As the former officer in Municipal PHCCO admitted, the department did not have expertise in all different fields. Each department had the capacity to make its own professional planning, implementation and evaluation. Therefore, as the coordinator of the Healthy City Action Plan, PHCCO would let each

department decide which indicators were feasible to achieve within the timeframe of the action plan (Officer L2G8, personal communication, 2 January 2018).

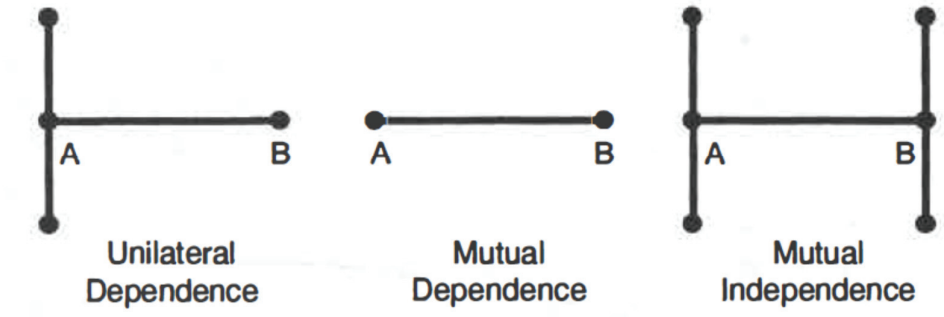
Strategies in horizontal coordination

To make negotiations in the horizontal interaction, players could use external resources to get agreement from others. Players could also improve communication channels to share information and build trust. In contrast to hierarchical coordination, the ambiguity of goals could be used as an effective strategy to reach an agreement.

- ***Resources***

One way to reach an agreement is for one player to exercise power over the other. Dependence is an essential attribute of power. Dependence implies the capacity or potential player A can influence the behaviour of B so that B comply with the intentions of A. Dependence is defined by both the importance of the resources (or services) provided by A and the non-availability of alternative resources. Asymmetric dependence is created when only one of the players has access to alternative resources (see unilateral dependence in Figure 5.4). Power will be neutralized, if A also requires resources from B, or on the other hand, B gets access to the same resources, either by itself or through other partners (Scharpf, 1997, p. 139).

Figure 5.4 Forms of dependence in a relationship between A and B



Source: Scharpf (1997, p. 140)

The relationship between the Office of Patriotic Health Campaign Committee (PHCCO) and the committee members before the negotiation process can be described as “unilateral dependence” (see Figure 5.4) concerning only the power resulting from the exchange of positively valued resources. The members of the committee were “independent” participants, represented as A in Figure 5.4, which means their actions did not require the resources from the PHCCO. The PHCCO needed the input from the members, in other words, it is dependent on the members like B presented in Figure 5.4. It was a predictable outcome that the PHCCO accepted suggestions from the partners to

modify the proposed Healthy City Action Plan, as long as the partners were willing to participate.

However, the Office of Patriotic Health Campaign Committee (PHCCO) could gain alternative resources by introducing negative sanctions, coercion, or punishment power from the superior level. National awarding systems such as National Hygienic City and National Civilised City made it possible for the PHCCO to gain support from the supervisor in charge. The members had to obey the directors because of authority. The relationship between PHCCO and the members then shifted towards "mutual dependence" (see Figure 5.4). The coordination also became hierarchical.

- ***Communication***

Information and trust are two key elements of cooperation. Through regular meetings, the actors in the Healthy City Action Plan can share information, and establish trust.

A joint meeting mechanism was established for the Healthy City Action Plan to ensure the communication of the members of the Shanghai Municipal Health Promotion Committee. This is because that if the programme was a single-shot encounter, it would be a Prisoner's Dilemma game. Then the players would prefer the noncooperative option to protect their own benefits. But if the programme was a repeated game, the players would have built trust to choose the option which would bring a better benefit for all.

The challenge for Shanghai Municipal Health Promotion Committee was maintaining the joint meeting mechanism. It required a huge amount of time and resources from the Office of Patriotic Health Campaign Committee (PHCCO). But PHCCO did not have the financial resources. It also did not have the level of power of political propaganda as it did before the 1980s. The PHCCO had to refer to the superior level or use personal connections.

As mentioned in sections 4.3 and 5.1, personal connections (*guanxi*) were essential in communications and partnerships in the Healthy City Action Plan. It was easier to communicate with people working in the same field, because of the same professional background. People had more chances to meet on different occasions, both inside and outside the office. For intersectoral communications, personal connections would make collaboration easier. However, it was not easy to build such connections if there were no occasions for people from different fields to meet.

- ***Ambiguity in goals***

Ambiguity is one of the ways to limit conflict. The less clear goals are the less likely they are to lead to conflict. Ambiguity in language allows diverse actors to interpret the same act in different ways. Therefore, ambiguity is often a prerequisite for new policies to pass

the legitimation stage. (Matland, 1995). When the Office of Patriotic Health Campaign Committee was making the new Healthy City Action Plan accepted by diverse actors, it was necessary to make the programme ambiguous enough to get passed.

The coordinator also needed to consider the extent to which to impose rules upon others and how easily actors can exercise autonomy. Since goals are contestable and can change over time. (Hill, 2009). In order to secure the implementation of the Healthy City Action Plan, the coordinator had to control the feasibility of the programme. For example, the organisations at the municipal level decided on the baseline for all the districts. The district office then decided on more specific goals at the district level (C4H3, personal communication, 1 November 2017). Therefore, the higher level the plans were made, the more ambiguous the goals were.

The ambiguity made the implementation more feasible for different levels of development. In the municipality of Shanghai, the disparities between districts can be huge. For example, the average expenditure per capita for Fitness for All Action Plan in Chongming District was more than ten times that in Songjiang District (Shanghai Institute of Physical Education Public Sports Service Development Research Center, 2017). Therefore, the municipal bureau needed to consider the average level of all districts and make sure the baseline goal in the municipal plan could be met by the majority (C4H3, personal communication, November 1, 2017).

These advantages of ambiguity are usually not recognised in top-down models, where goal clarity is an important variable for successful implementation. Goal ambiguity is negatively seen as the source of misunderstanding and uncertainty (Matland, 1995). For example, the implementation process of National Hygienic City and National Civilised City was a traditional top-down approach. Both programmes had clear goals and incentives for implementation. The central authority took control over the information, technology, resources, and sanction capabilities to enact the desired policy. Implementation was ordered in a hierarchical manner. The policy was spelt out explicitly at each level, and each actor had a clear idea of their responsibilities and tasks.

In top-down models, the implementation process lacks flexibility. There are standard operating procedures to expedite their work as the actors are stable over time. The transparency of the technology makes it clear which resources are required, and resource procurement is built into the implementation process. However, implementation fails when technical problems occur: misunderstanding, poor coordination, insufficient resources, insufficient time to use the correct technology or lack of an effective monitoring strategy to control and sanction deviant behaviour (Matland, 1995).

Challenges in horizontal coordination

In horizontal interactions, the main challenges include fragmented authoritarianism and asymmetric resources between the actors. Because the member departments had expertise in their field of work, the negotiator did not have the capacity of knowledge and information to negotiate. Moreover, there were no clear sanctions of noncompliance for the members if they did not fulfil the targets of the Healthy City Action Plan.

As mentioned in section 1.2.2, the fragmentation of organisations at the horizontal creates challenges to coordination. The structure of each department was strongly hierarchical. The budget and priority projects were separated in each department. Since there was no specific budget for the Healthy Cities programme, the resources including human resources, financial resources, and administrative power all belonged to the departments. Therefore, when the Office of Patriotic Health Campaign Committee coordinated the implementation of the programme, there were no resources they can offer.

This uncoordinated outcome was closely related to the segments within the government body. For example, the Ministry of Health, the Ministry of Education, and the General Administration of Sport were under the supervision of the same Vice Premier. These ministers would meet more frequently during regular meetings with the Vice Premier. The same pattern was followed by the municipality, the Vice Mayor would be overseeing these departments at the municipal level.

As a result, the Chairman of the committee, the Vice Mayor per se, would expect more compliance from the departments of Health, Education and Sport, while less compliance from the other departments since they are not directly under the supervision and evaluation of the Vice Mayor. These departments would still comply with the minimum level because of the ranking difference in the municipal government.

Even if the person in charge of the programme from each department has paid much attention, there is not always enough support from the director of each department, as reflected in the interviews with representatives of government departments and experts (Zhao, 2010).

5.4 SUMMARY

Actors involved in the Healthy City programme were diverse in scale and domain, ranging from international organisations to the local district governments. The government was playing a major role in setting the agenda, implementing the policies, and coordinating with other sectors. The academicians were important in giving consultation to the government and providing professional evaluation. The members of the Shanghai

Municipal Health Promotion Committee were essential for the implementation of the Healthy City Action Plan. However, the examples of public health and urban planning showed the gaps in perceptions and actions between the sectors involved in the Healthy City Action Plan.

Two types of actor constellations in the Healthy City Action Plan were presented. The Fitness for All Action Plan (FAAP) represented the top-down model of policy implementation. The Citizen Health Self-Management Group (CHSMG) represented the potential of the bottom-up model. The analysis showed the mixed approaches in the Healthy City Action Plan.

Actors at different levels and sectors had different orientations and capacities in the policy interactions. The power relations were predetermined by the hierarchical structure in the governmental system and the imbalance among the sectors. The modes of interactions were interpreted mainly from interactions in the hierarchical direction and negotiations at the horizontal level.

The hierarchical interaction was dominant in the hierarchy system, which was explained based on the principal-agent theory. The principal had the authority to override the choices of the agents. The principal also distributed the residual right of control to the agents in order to implement the policy. The major determinants of hierarchical interactions include time, information and motivation. The principal could use time pressure and incentives to gain the compliance of agents. The agent could also use asymmetry of information as an instrument.

On the horizontal level, negotiations were needed for coordination. Power dependency played an important role in the negotiation process. The capacity of actors to gain resources or acquire alternatives determines the constellation during the policy process. Communication allowed actors to share information and could be beneficial for building trust in partnerships. In contrast to hierarchical coordination, the ambiguity of goals was an effective instrument for conflict resolution.

The horizontal and vertical interactions constantly interplay during the policy process of the Healthy City Action Plan. In the agenda-setting process, the vertical dialogues from the international level to the national level, and to the municipal level were the main triggers. In the policy-making and implementation period, horizontal negotiations were gaining importance, however, they often failed since the coordinator was dependent on the members in the horizontal direction. Thus, the coordinator referred to the hierarchical direction to change the power dependency.

In actor-centered institutionalism, a policy is treated as the outcome of interactions of rational actors, which are largely shaped by the institutionalized norms, within which the

capabilities, preferences, and perceptions of actors are restrained as well (Scharpf, 1997). It deals with not only the interdependency of actors but also the institutional environment the actors are embedded in. In the next chapter, further investigations into the institutional settings will be presented.

6 INSTITUTIONS IN POLICY INTERACTION

This chapter is dedicated to a deeper insight into the local institutions, which are specific in the case of China. The characteristics of the institutions are identified. The influence of the institutions on the interactions in the Healthy City Action Plan was examined. As mentioned in section 1.2, two aspects are taken into account to portray the Chinese context accurately: the role of the Chinese Communist Party; the meaning ascribed to hierarchy and centralization (Zheng, De Jong and Koppenjan, 2010).

6.1 FORMAL INSTITUTIONS

In this section, three formal institutions that influenced the Healthy City Action Plan will be analysed, including the bureaucratic-authoritarianism, legal-rational authority, and rank-order tournament. Empirical knowledge is included to come to a sound interpretation of how the influence of formal institutions works.

There are two settings of formal institutions in China: the hierarchical one with the CCP as the network manager; and the horizontal one which is spread among different ministries and can be characterized by fragmentation, interdependencies, stalemates and breakthroughs in the policy making process (Zheng, De Jong and Koppenjan, 2010).

In order to get a reliable interpretation of the actual policy-making process in China, the *de facto* one-party state needs to be taken into account. A parallel CCP hierarchy exists alongside governmental bodies. Party committees are set inside government bodies to monitor compliance. In general, compliance in the lower tiers of government is substantially greater than in Western countries. Maintaining order and stability are highly valued in Chinese culture. Meanwhile, Chinese officials also remain flexible, impervious and opaque to less informed outsiders (Bond, 2010). Strict structures make them feel uncomfortable (Zheng, De Jong and Koppenjan, 2010).

6.1.1 Bureaucratic authoritarianism

The pyramid of Chinese politics is a loose construction, with horizontal and vertical fragmentations between different layers (Ding, 2010). Organisations are increasingly homogeneous inside and outside the government. Bureaucratization and other forms of organisational change occur because of processes that make organisations more homogeneous without making them more efficient. Highly structured organisational fields like the government provide a context in which individuals tend to deal with uncertainty and constraint with similar structure, culture and output collectively. As a

result, organisations of the government and related public sectors are converging (DiMaggio and Powell, 1983).

In the governmental system in China, there are high unity and homogeneity of governmental functions, responsibilities, and set-ups at different levels of government. Such isomorphic responsibilities in the governmental system are a major feature of the vertical governmental structure. The organisational structures of the Communist Party and social organisations are isomorphic with the five-level administrative divisions of governments (Zhu and Zhang, 2005).

The main challenge for an isomorphic governmental system is the incompatibility of the functions of the organisations and the set of environmental conditions the organisations face. Within the governmental system, different levels of administrative divisions encounter different problems. Even though the central government and the provincial levels are mainly responsible for agenda setting, and policy implementation depends largely on the County, Township and basic autonomy levels, they still follow the same structure (Zhu and Zhang, 2005).

The actors in the Healthy City Action Plan represented the isomorphic organisations at various levels of governance in China (see section 5.1.1). The Patriotic Health Campaign Committee (PHCC) as the coordinator of the Healthy City Action Plan is an Advisory and Coordinating Agency. Its vertical structure is defined by the administrative divisions in China. The PHCC at municipal, district and sub-district levels were following the structure and plans of the national PHCC. There are huge disparities in the country. While some areas were dealing with constructing toilets and water pipes, Shanghai had fulfilled most of the national PHCC requirements in improving the urban and rural environment. Therefore, the municipal PHCC could initiate the Healthy City Action Plan to accomplish more than the national plans.

The isomorphic structure is also the outcome of government segregation in China, which can be traced back to the planned economy in the 1950s when the distribution of resources was solely decided by the central government. It was a rational choice of the subordinate government to acquire more benefits from the central government. In order to gain support and trust from superiors, the local governments chose to imitate the structure of the central government voluntarily (Liu and Zhao, 2011).

When the Healthy City Action Plan was issued in 2002, the municipal government consisted of nine Mayors, including one Mayor and eight Vice Mayors. Each Vice Mayor was overseeing a certain field of Shanghai Municipal People's Government. For example, Mayor A who approved the initiation of the Healthy City programme was in charge of health, demography and family planning, cultural and broadcasting, publishing and

sports; Mayor B was in charge of technology, education, intelligence property; Mayor C was in charge of urban construction and administration, real estate development, water, transportation, urban environment, greenery and environmental protection. At the district level, there was a similar government organisation, consisting of one District Mayor and several Deputy District Mayors. For example, District A had one District Mayor and five Deputy District Mayors, who were overseeing five different areas. The Deputy District Mayor overseeing health was also in charge of education, sports, culture and religions.

This division of responsibilities made the administration more effective but at the same time caused fragmentation in the government. Therefore, the departments that were under the supervision of the same Vice Mayors had closer relations with each other, and it was easier for the Mayor in charge to convey their orders to these departments. On the other hand, it was difficult to coordinate with the other departments without having permission from other Mayors in charge or having a good personal connection.

The isomorphic system reduced the efficiency of the government since all five levels had the same set of responsibilities. The concept of "almighty" government was not conducive to the distribution and organisation of social functions. It also increased the cost of governmental operation and decreases the credibility of the government. In order to establish a rational intersectoral scheme, effective reformation of the organisations needs to be done, then other reforms can happen. Researchers suggested focusing on partnerships among the governments at different levels and a rational division of functions between the central and local governments to restructure its intersectoral relations (Zhu and Zhang, 2005).

6.1.2 Legal-rational authority

Authority was one of the resources available to incumbents of a formal position. Weber (1978) divided authority into three types: tradition, charisma and formal legality. The legal-rational authority depends for its legitimacy on formal rules and established laws of the state; traditional authority derives from long-term established norms, habits and social structure when power passes from one generation to another; the charismatic authority comes from the charisma of an individual or the leader and is supported by his or her followers. These three types of authority interplay with each other constantly.

The legal-rational authority based on officers' ranks existed at all levels of the government. As mentioned in section 5.1.1, the deputy director of the Municipal Health Bureau was the Director of the Municipal Office of the Patriotic Health Campaign Committee (PHCCO). The bureaucratic rank of the Director of General office was equivalent to the other committee members. In this case, the PHCCO as the coordinator of the Healthy City Action Plan could

not exercise legal authority over its members. The office had to use either informal institutions like personal connections or refer to the Director of the Patriotic Health Campaign Committee who possessed a higher rank position to get compliance from the members with legal authority.

Therefore, the Vice Mayor as the legal director of the Patriotic Health Campaign Committee and the legitimate leader of the Healthy City Action Plan played an important role at the municipal level. During the agenda setting process, the vice mayor was an officer with medical education background, who accepted the advice of initiating the Healthy City programme from the Office of Patriotic Health Campaign Committee and supported the enforcement until promoted to another position in 2006.

The speech of the Vice Mayor at the 50th Anniversary of Patriotic Health Campaign in Shanghai in June 2002 was the first time establishing a Healthy City and promoting "health for all" were mentioned from the municipal level. In the seasonal working meeting of the municipality two months later, the Vice Mayor further pointed out the necessity to focus on the goal of building a Healthy City, conduct further research, and formulate an action plan.

The Shanghai Patriotic Health Campaign Committee (SPHCC) was rebranded as Shanghai Municipal Health Promotion Committee in 2005, meaning Health Promotion as the additional function of the SPHCC was officially recognised by the government (see section 5.1.1). However, the new brand did not leverage the ranking of SPHCC in legal authority.

6.1.3 Rank-order tournaments

Researches show that the promotion of a civil servant is often the outcome of the combined effects of formal and informal factors. Formal criteria including the economic performance of the municipalities, working experience at the province level or central government or Communist Youth League, have a direct influence on promotions. For instance, there is a basic line of economic growth for the tournament of promotion, the central government or superior level can make personnel arrangements based on these criteria. For instance, Party Secretaries of municipalities with the top ten growth rates of the economy had more chances to get promoted than the others at the same administrative level. Informal factors like personal connections with a certain group in the party, the political background, and social networks also influence the promotions (Bo, 1996; Chen and Liu, 2011; Yang and Zheng, 2013).

It is a common phenomenon that municipalities are working for the awards. On one hand, it reflects the achievements made by the governors; on the other hand, it is a way to gain a financial budget from a superior level for certain development activities. It is also an

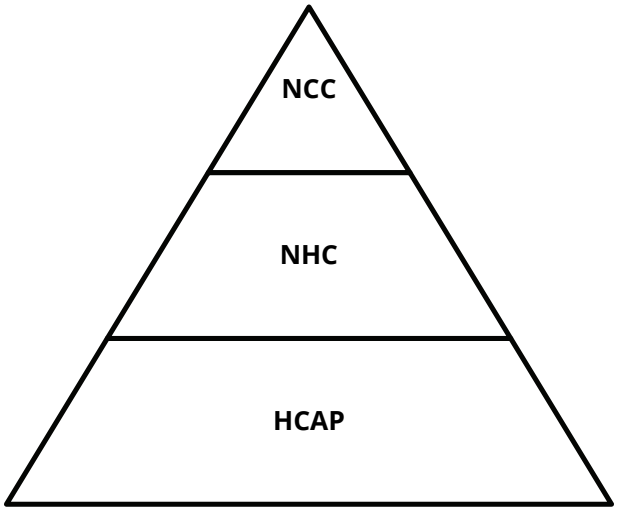
issue of image and reputation (*Mianzi*) in case of a failure while the other municipalities succeeded. Therefore, local governors utilise the political resources to put pressure on their subordinates to achieve the awards. Although the National Congress has stressed eliminating unnecessary assessment and evaluation, the awards have become an "image movement" in which the local actors concentrate all the resources shortly for the evaluation but the effects are just temporary (Xinhua, 2016).

In the current performance evaluation of civil servants, besides the economic statistics like Gross Domestic Product (GDP), urban awards such as "Hygienic City", "Civilized City", "Garden City", and "Creative City" are very important for the promotion of civil servants. As an evaluation system to enforce the implementation, these titles are commended by ministries and commissions of the National Congress- the Health Commission, the Central Civilisation Commission, the Ministry of Housing and Urban-Rural Development, the Ministry of Science and Technology, etc. (Xinhua, 2016).

The tournament of promotion is an incentive mechanism for civil servants under strict control and inevitable in the political environment. It is essential for the miracle of economic performance in China. In a highly centralised authoritarian system, the phenomenon of tournaments appears in the administration system. In tournaments, the central government decentralises the control over the economy to the local governments and encourages the local governments to compete on major indicators of the economy. Since the central government have all-round control over politics, economy and ideology, the tournaments are strictly constructed. All levels of government and the public are mobilised to participate, similar to competitions (Chen and Liu, 2011; Zhou, 2009; Zhou, 2007).

The tournament of awards makes different units connected and sensitive to each other's reactions, while in the regular routine, the units are loosely connected, thus making a lot of space for bargaining. Therefore, from the perspective of the organisation, the "campaign" mode is an efficient way of policy implementation. But it is resource-demanding at the same time, and the sanction is too high for long-term performance control (Zhou and Lian, 2011).

Figure 6.1 Hierarchy of City Awards



Source: own compilation

According to the level of control over the outcomes (see Table 5.2), there is a hierarchy of the awards. The National Civilised City (NCC) is on the top of the pyramid because of its strict monitoring and limited awards; the National Hygienic City (NHC) comes second for the uniform standards it used for evaluation; the Healthy City Action Plan (HCAP) is the least demanding in the hierarchy since it has less pressure on setting the goal and the time to observe the effect (Figure 6.1).

The national awards might be effective in institutionalising benchmark urban quality standards, with emphasis on periodic re-evaluation, attaining and maintaining the honour. The ultimate outcome of national awards would theoretically produce a national landscape of uniformed places (Cartier, 2016). The negative side is uniformity does not favour deviations. It could potentially limit the space for innovation, such as the Citizen Health Self-Management Groups in the Healthy City Action Plan.

6.2 INFORMAL INSTITUTIONS

Three main types of informal institutions in the Healthy City Action Plan are presented in this section, including traditional/charismatic authority, reputation, and personal connections. Informal institutions might be particularly used to pursue a political agenda, and can be seen as an effective way of making up for the lack of efficiency in a formal institution (Helmke and Levitsky, 2004).

Informal institutions in China play an essential role. In the policy process, it can be characterised by the dislike of structure, transparency and initiative; and the meaning of personal relations and personal networks. The public elites play a more important role in decision making, keeping the influence of private organisations and the public limited.

This manner is inherited from Confucian traditions than from the more recent Communist era (Bell, 2010; Zhang, 2005).

Besides that, the personal relations (*guanxi*) between high officials are a vital feature in understanding policy-making in China (Bond, 2010; Saich, 2010). These personal links cut across organisations, sometimes they work as a lubricant in processes where formal institutions cannot work. Meanwhile, these personal connections could also be abused for career advancement and the exchange of favours rather than for policy problem solving (Zheng, De Jong and Koppenjan, 2010).

6.2.1 Traditional/Charismatic authority

Paternal power is important in Chinese society. It comes from the paternal culture that shapes the individuals before they have an independent will. The will of the authority shall not be disobeyed, and it has already become an object of social recognition. The value of paternal power is so recognised in society that no explanation is required. Individual will can be essential in maintaining consensual order, but not in paternal power (Fei, 1992).

In general, the leader holds a traditional authority from patriarchy in the society. In a traditional family, the father has the ultimate power of making decisions; from the distribution of the family properties to the marriages of the children, everything is under patriarchal control and the legitimacy comes naturally from the tradition (Fei, 1992).

The authority related to a specific figure represents the charismatic type of domination, which throughout the history of the Communist Party can be traced back from Chairman Mao, the founder of the People's Republic of China, until the return of such phenomenon around President Xi recently.

Mao was the spiritual leader of the country. He was worshipped through his words and mass campaign, including the Patriotic Health Campaign. Since the leader stressed the importance of health for revolutions, people replied to his words with great passion, they went out of the house to clean the streets together with their own tools, and they took part in controlling the vector species as a demonstration to fight imperialism from the west, which is still vivid and impressive memory for the elder generation (CCTV, 2017).

Nowadays, the personality cult phenomenon has emerged around President Xi. It is driven not only by local government officials but also by individual Chinese 'netizens'[2] to a greater extent. During the interviews, scholars and local governors refer to the president

[2] According to Merriam-Webster Dictionary, netizen is a blend of net and citizen. It means an active participant in the online community of the Internet. A similar term is cybercitizen.

as a strong and capable figure with insights that correspond to the national anxiety in the transitional period of China (Yin and Flew, 2018).

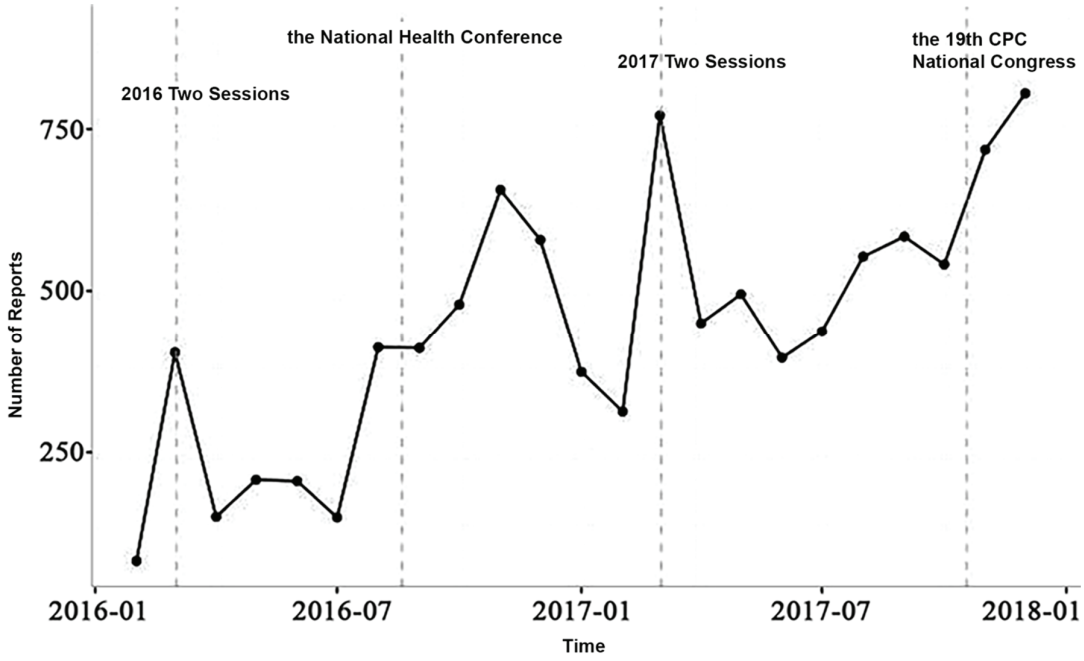
Ling-dao is the Chinese word for leader, which was mentioned by most interviewees. Within the government, it is mostly referred to as the direct supervisor; outside the governmental department, it is mentioned as the decision-maker from the government, sometimes specifically referring to the President or the Mayor.

As discussed in section 5.1.2, the scholars recognised that the judgement of the leader had a determinant role in the Healthy City Action Plan because final decisions were made by the government. The scholars also recognised their role as consultants in the Healthy City Action Plan. The chance of an initiative from the scholars becoming a priority in policy depends on whether the governor trusted in the ability of the scholar and accepted what the scholar suggested (F2H3, personal communication, 1 November 2017).

The attention from the leader had a large influence on the motivation for execution. The higher the position of the governor was, the better the programme would be executed. For example, since Healthy China was mentioned by President Xi, health issues suddenly got a higher rank in the priorities of local governments. The relationships between the experts and local governments had changed. Before Healthy China was issued, the scholars tried very hard to raise the health awareness of local governors to push HCP. After Healthy China was issued, the local governments approached the scholars to ask for consultation (F2H3, personal communication, 1 November 2017).

This dramatic shift of attention can also be observed in the media. After the “Healthy China 2030” policy was released in October 2015, it received a lot of attention from the media, amounting to more than 22,000 reports in 2015. Following important events such as the National People’s Congress, National Health Conference and 19th National Congress of the Communist Party of China, reports on Healthy China kept growing in 2016 and 2017. They were mainly interpretations from policy environment and market environment perspectives (Liu, Huang and Liang, 2016).

Figure 6.2 Reports on Healthy China 2016-2017



Source: Jiang, Zhou and Yang (2018)

The effect of traditional/charismatic authority was quite extensive in China. The discourse of *Ling-dao* could often be found in everyday conversation. The public believed the outcome of action was largely determined by the leader: a capable leader can leverage the project to another level, and a poor leader can destroy the effort of the whole team.

In policy interactions in the Healthy City Action Plan, the influence of traditional/charismatic authority, if not stronger than the legal authority, was at least reinforcing. The concept of authority is so deeply embedded in Chinese society that compliance with the supervisor is taken for granted. The advantage is that it made coordination in a hierarchical direction more efficient. The weakness is that potential innovations from the subordinates could be easily undermined.

6.2.2 Reputation

As discussed in section 5.3, both hierarchical and horizontal interactions face the challenge of asymmetric information. From a game theory perspective, the way to avoid opportunism and maintain reputation is to promote institutions that transform non-repeated games into repeated games (Zhou, 2003). Therefore, reputation is an effective way to solve the problem of asymmetric information.

Reputation as proof of the past behaviours of actors provides important information for the other actors during interaction and secures the possibility for future collaboration. Economists take reputation as social capital when the future reward can be expected with

current investment. The expectation of rewards leads to the investment and maintenance of reputation.

For instance, forming a committee can increase the volume of information exchange and demonstrate the behaviours of agents in front of a group. It can be a powerful constraint to the opportunists in the group (Zhou, 2003). The network relationships will reduce the risk of opportunism by two mechanisms: the longer "shadow of the future" and the higher visibility of transactions to relevant others (Scharpf, 1997).

The regular meetings of the Shanghai Municipal Health Promotion Committee or special sessions for the Healthy City Action Plan evaluation were such occasions for information exchange. All the district level governments had to participate and present their results of Healthy City construction. Not only the best practices were shared with the participants, but also the underperformed cases were exposed to the whole group. The Director from the municipal level can praise the districts performing well and criticise the districts for not putting enough effort (L5H4, personal communication, 23 October 2017).

Trust between the players could also determine the outcome of the game. If one player makes a promise or threat to the other, this player would have more control over the strategies. It is necessary during the sequential games to acquire information about the credibility of the other players involved. In a hierarchical organisation, the supervision body has the official power, which makes it more possible for them to make a promise or threat to the agent in the lower tier.

Trust can alleviate the difficulties related to the "Negotiator's Dilemma". It operates weakly at the level of communication, and strongly at the level of strategy choices, which can be equated to "weak ties" and "strong ties". Weak trust means at least the other actors are honest about the information communicated regarding their own options and preferences, rather than misleading on purpose, and that the commitments will be honoured. Strong trust, on a more demanding level, implies the actor will avoid strategy options that would hurt the other actor's interest no matter how attractive they are to its self-interest (Scharpf, 1997).

Being able to trust can be an advantage, but the cost to achieve it is high. Plus, the maintenance of strong ties that one actor can afford is limited. There might be incompatibility if the linkages are beyond dyadic relationships. In other words, networks that are composed of strong ties at the level of the dyad tend to have a highly selective structure at the level of the network (Scharpf, 1997).

In China, reputation also has a social basis that came from the evaluation of the public. It is essential because of the stable behavioural patterns and social structure that are based on a hierarchical system and personal connections. The stability of cultural traditions

secures efficiency. The judgement of good and bad are accepted in a common meaning system, which is based on legitimacy, generating powerful social expectations. On a macro level, legitimacy stimulates new institutions to emerge, enforcing more constraints on actors to converge; on the micro level, legitimacy attracts people to choose appropriate social roles and behaviours in order to be recognised and conversely encourages the institutions to develop. In most cases, it is not efficiency but appropriateness forming the basis of social recognition. The social value of legitimacy is closely related to nature and ration. Society needs a stable and formal structure to fit into nature so that the artefact becomes invisible (Fei, 1992).

The distribution and effectiveness of reputation depend on the organisational capacity. The more concentrated the resource of symbols, the better for the emergence and stabilisation of reputation. The more organised the evaluator is, the more effective the reputation is (Zhou, 2003). The central government in China has centralised control over the resources (economic and political) and symbols (national awards), which nurtures the reputation mechanism in the bureaucratic system that is highly organised. In the bureaucratic system in China, the lower the level is the more stable the organisations are. It is more likely to have repeated games between the actors. Therefore, reputation as a mechanism works well between the organisations since they have long-term connections.

6.2.3 Personal connections

Guanxi, loosely translated as “connections” and “relationships”, is a personalized tie (Bian, 2019). The grounds of *guanxi* include tacit mutual commitments, reciprocity, and trust, which are also elements for successful partnerships (Luo, Huang and Wang, 2012). Some people believe *guanxi* is essential in China to complete any tasks in all spheres of social life. However, critics correlate *guanxi* with corruption in China and see it as an obstacle to becoming a state based on the rule of law (Gold, Guthrie and Wank, 2002).

Guanxi was an effective strategy in hierarchical coordination as mentioned in section 5.3. In the hierarchical interaction, principals at higher levels depend on the agents at lower levels for policy implementation. Better personal connections supported better communication and trust. For example, the Office of Patriotic Health Campaign Committee at the district level used to organise team activities with subdistrict offices and neighbourhood committees to keep the connections. After the anti-corruption movement, these informal gatherings were no longer possible. Building personal connections between the principal and agents became difficult (Z5B6, personal communication, 3 November 2017).

Guanxi played an important role in horizontal interactions (see section 5.3.2). *Guanxi* resembles social capital that can be converted into economic, political, or symbolic capital

(Gold, Guthrie and Wank, 2002). Coordinating different sectors without enough resources was challenging. *Guanxi* offered an efficient information transmission channel for *guanxi* members to identify potential and trustworthy partners. *Guanxi* also had negative connotations. It could be a barrier to intersectoral collaborations (see section 5.1.3). Actors from different sectors had few chances to meet to build personal connections. People's belief in *guanxi* made building trust in partnerships difficult.

In a political context, *guanxi* ties are especially important when informal rules are more practical and effective than formal rules in a centralized power structure (Bian, 2019). Despite the efforts the Chinese government made to minimise the influence of informal institutions, *guanxi* continued to play an important role in policy interactions, as an effective tool for communication, and as social capital that convert into resources. Therefore, *guanxi* could be used with positive connotations if proper guidelines are provided.

6.3 SUMMARY

This chapter intended to gain deeper insights into the local institutions that work behind the Chinese organisations. Both formal and informal institutions influenced the actors and modes of interactions in the policy process of the Healthy City Action Plan in Shanghai.

Regarding formal institutions, there is the vertical or hierarchical setting from central government to local, with a Parallel Chinese Communist Party system; and the horizontal setting defined by different departments, where the competing institutional logics and power imbalances play an important role. The bureaucracy made organisations more isomorphic without making them more efficient.

Authority based on legal ranking in the bureaucratic system played an important role in determining the priority of the programme. The principals were able to exercise power over the agents based on their superior positions. Campaign as a model was used by the superior to mobilise the subordinates.

The hierarchy of awards was an effective incentive in concentrating the resources to implement the uniform standards in a short period of time. Its potential implication in the tournament of promotions generated competition among the agents, which led to improved performance of agents and higher efficiency in policy implementation.

In the informal institutions, the traditional and charismatic authority also helped the formal institution to function. The orders from a higher rank governor can be delivered by the subordinates.

Reputation mechanism was essential in information exchange, building social networks and promoting trust. It could help to solve the information asymmetry problem in principal-agent relations. Reputation is sensitive to the stability of the social environment. The more stable, the more effective reputation works.

The positive effects of personal connections were registered, especially when informal rules are more practical and effective than formal rules. Personal connections can help to partnerships if there are clearer guidelines.

To conclude, modes of interactions are deeply embedded in social norms no matter how much the state is emphasizing the legal-rational aspect. The effectiveness of informal institutions should be considered when it comes to implementation on the individual level.

7 CONCLUSION AND DISCUSSION

This concluding chapter is divided into three parts. First, to sum up the results of the empirical studies, with regard to the research questions. Second, to connect the empirical findings with theoretical discussions. Then it is finalised by the implications and recommendations for future practices and research.

7.1 SUMMARY OF RESULTS

The overall research question is "***how was the Healthy City programme in Shanghai shaped by the interactions of actors and institutions***" from the perspective of local actors between the forces of globalisation and local institutions. Three interrelated sub-questions were structured within the conceptual framework of actor-centered institutionalism. This research intended to understand the procedural and outcome effectiveness in the policy process of the Healthy City Action Plan. The research questions were analysed in Chapters 4, 5, and 6. The results of the analysis are presented as follows.

RQ1 How did the international movement and the national campaign influence the local policy?

The first research question dealt with policy change related to Healthy City Action Plan in Shanghai at the international and national levels. It investigated the extent to which the local actions converge with national and international movements. Evidence shows that the international movement of the Healthy City programme, and the National Patriotic Health Campaign had jointly influenced the formulation of the Healthy City Action Plan in Shanghai (see chapter 4).

Comparisons show that the international Healthy City programme and national programmes (National Hygienic City and National Civilised City) all aimed to improve urban environments. The international Healthy City programme covered more topics regarding urban health than the National Hygienic City and the National Civilised City, but the international guidelines were more ambiguous than the national standards. The municipality followed the national standards as baselines for the Healthy City Action Plan in Shanghai. The discourse on 'health' and 'environment' was expanded at the beginning of Shanghai's Healthy City Action Plan based on international guidelines but got restricted by challenges in coordination.

The timeline of Shanghai's Healthy City Action Plan coincided with the national programmes. It took the same three-year cycle as the National Hygienic City and the National Civilised City. The organisational structure of Shanghai's Healthy City Action Plan

was also following the hierarchical structure of the Patriotic Health Campaign in China. The existing structure of the Patriotic Health Campaign Committees helped Shanghai to build the Shanghai Municipal Health Promotion Committee overseeing the Healthy City Action Plan, which fulfilled the requirement of international guidelines. In return, the Healthy City Action Plan provided the opportunity for Patriotic Health Campaign Committee to engage more partners in Shanghai Municipal Health Promotion Committee.

The main proposition was based on the legitimacy mechanism that organisations adopt similar structures, and standards to gain recognition. There was clearly convergence of the organisations at the local, national, and international levels. The legitimacy mechanism is strongly influencing the behaviour of local actors. On one hand, it pursues an international reputation to gain attraction in the global market. On the other hand, it requires the approval of the state to gain the legitimacy of the organisation.

The municipality of Shanghai aimed towards being an international metropolis since the 2000s (see Table 3.4) and had a strong motivation to take up the international initiative. However, the national standards were essential in the implementation and evaluation process of the programme.

No matter how divergent the interests of actors become in the globalised world, organisations are becoming more homogeneous. As DiMaggio and Powell (1983) argued, bureaucracy remains the common organisational form, and highly structured organisational fields offer a context which often leads to homogeneity in structure, culture, and output. On one hand, dealing with uncertainty tends to happen in a rapidly changing environment. On the other hand, organisations mimic successful examples not only for efficiency but also for gaining legitimacy, since a similar structure is not related to a more efficient outcome.

RQ2 How do the actors and their interactions influence the policy process?

The second research question focused on the actors and the modes of interactions in the Healthy City Action Plan in Shanghai. The actors which shaped the Healthy City Action Plan at various levels were identified. The actor constellations in two projects in the Healthy City Action Plan were presented. The modes of interaction were analysed from hierarchical and horizontal perspectives. The strategies and challenges involved in these interactions were identified.

Actors at various levels and different fields had different capacities and roles in the Healthy City Action Plan. The actors who took essential roles, such as the coordinator, had limited capacities to implement the Healthy City Action Plan. The actors who possessed essential resources for implementation did not take important positions. For example, the Office of Patriotic Health Campaign Committee as the coordinator of the Healthy City

Action Plan had limited resources to motivate the members of the Shanghai Municipal Health Promotion Committee. The negotiation ended up reducing the content of the Healthy City Action Plan after Phase I.

The analysis of actors from different sectors in the Healthy City Action Plan showed the gaps in perceptions and actions. Public health and urban planning were taken as examples. The understanding of actors on concepts in the Healthy City Action Plan such as health and environment were different. They were making separate actions towards better urban health but were not aware of actions from other actors. Intersectoral collaboration in the Healthy City Action Plan was difficult when these consensus and connections were missing.

Two types of actor constellations in the Healthy City Action Plan were presented, one representing the top-down model of policy implementation, and the other representing the potential of the bottom-up model. The analysis showed the mixed approaches in the Healthy City Action Plan. It also reflected the tensions in the partnerships in the Healthy City Action Plan, which was a 'top down' initiation that aimed to be a 'bottom-up' approach, which implied inevitable power imbalances (Stern and Green, 2005).

Power imbalances could be observed in both hierarchical and horizontal interactions. Actors also tried to create an imbalance of power to get compliance from others. In hierarchical coordination, the principals used authority and control rights to influence the agent's choice. In horizontal interaction, the coordinator used ambiguity in goals and personal connections to make the members cooperate.

However, there were risks behind these strategies. For example, the control over short-term goals could affect the long-term benefit; the asymmetric information could make the effects of policy hard to evaluate, and the lack of incentives would affect the actor's motivation for implementation. Fragmented authoritarianism in the government organisation made horizontal coordination more difficult. As a result, hierarchical authority was introduced when negotiations did not work.

The interplay of horizontal and vertical interactions happened constantly during the policy process of the Healthy City Action Plan. In the agenda setting process, the vertical dialogues from the international level to the national level, and the municipal level were the main triggers. In the policy-making and implementation period, horizontal negotiations were gaining importance, however, they often failed since the coordinator was dependent on the members in the horizontal direction. Thus, the coordinator referred to the hierarchical direction to change the power dependency.

These interactions between the actors shaped the Healthy City Action Plan. The government's interaction with actors outside the government, such as international

organisations and academia, brought the motivation for change in the PHC. These policy interactions were largely shaped by the institutionalised norms. The identification of actors and their modes of interaction provided the clue of influential institutions in the policy process.

RQ3 How do the local institutions influence the interaction of actors?

The third question investigated the institutions from Patriotic Health Campaign to the Healthy City Action Plan, which were divided into formal and informal types. The formal institutions include the form of government, legislation, and standards. The informal institutions include traditions, customs, and rituals that are defining the social interactions in general.

The formal institutions played important role in the Healthy City Action Plan, including the bureaucracy, legal-rational authority, and rank-order tournaments. The bureaucratic system made the governmental settings isomorphic from the central to the local level. The horizontal departments were fragmented. Such fragmentation was emphasized by the isomorphic responsibilities in the governmental settings. The isomorphic structure dealt with uncertainty but reduced efficiency in the organisation.

The legal-formal authority was an important instrument for the principal to get compliance from the agent. The rank-order tournament was used as an incentive system by the central government to mobilise the local governments. The hierarchy of awards (National Civilised City, National Hygienic City, and the Healthy City programme) was an example of such tournaments. The level of control from the central government influenced the implementation of the three programmes. The challenge is, with more control from the central government, less space there is for innovation from local organisations, such as CHSMG in the Healthy City Action Plan.

The informal institutions largely influenced social patterns in the policy process, such as the authoritarian culture, reputation (*mianzi*) and personal connections (*guanxi*). The traditional authority supported bureaucratic authoritarianism in the government settings. Reputation and personal connections are social norms not recognised in rules and regulations, but essential elements for bridging the actors from diverse scales and domains. To make official partnerships work, the impact of informal institutions needs to be taken into consideration.

The formal and informal institutions interplay in the policy process. When the formal rules try to eliminate the social norms, conflicts between formal and informal institutions are inevitable. The example of the Healthy City Action Plan showed the value of informal institutions in resolving conflict and nurturing partnerships, which should be considered in future policy development.

7.2 DISCUSSIONS

7.2.1 Discussion of the results

This section aims to connect the results with the discussions around actors, modes of interactions and institutions. It will be focused on the convergence of organisations, control and discretion in principal-agent theory, and the interplay between the formal and informal institutions.

This research has explored the possibility of adapting analytical frameworks developed in a western context to a non-western case. It generated empirical evidence from the Healthy City Action Plan in Shanghai to support the plausibility of the actor-centered institutionalism framework in China. Moreover, as identified by Li (2020), there are several concepts and models from China that could be integrated with the actor-centered institutionalism, including 'rank-tournament' model, 'the shadow of hierarchy', and 'control rights' model. Such connection and integration of the actor-centered institutionalism framework and Chinese concepts and models were realised in this research.

First, the theoretical lenses provided in the framework have explanatory power in the case study. The examination of international, national, and municipal programmes proved that legitimacy is one of the biggest motivations for organisations to converge. Second, the main concepts in principal-agent theory such as control, information, and motivation are applicable in the case of the Healthy City Action Plan. Third, institutional settings are unique in each country or even each city, which is recognised in institutional theories. After incorporating local institutions such as authoritarianism and personal connections, the general logic between the actors, modes of interaction and institutional settings still stands.

Convergence of organisations

The convergence of organisations observed in this research is proof of legitimacy theory. This is the main motivation for actors in the Healthy City Action Plan to adopt a certain mode of organisation. The divergence of organisations from the efficiency perspective was not observed in the Healthy City Action Plan.

One of the major characteristics of the Chinese government is the isomorphism of organisations at different levels, from the central to the local. Studies on organisations in the private sector and the public sector found the public sector is even more septic to isomorphism pressure (DiMaggio and Powell, 1983). In the Healthy City Action Plan, the local government had the isomorphism pressure from both national and international organisations. Shanghai Municipal Health Promotion Committee, the local organisation

overseeing the Healthy City Action Plan, converged with national Patriotic Health Campaign Committee and international guidelines on Health City Committee.

However, the pressure that triggers the isomorphism process was different. The process of the municipal government adopting the same organisation as the national government and the district government adopting the same as the municipal government was coercive. It was defined by the establishment of the Office of Patriotic Health Campaign Committee in the 1950s. On the other hand, the motivation of the municipal government to adopt the international organisation of the Healthy City programme was more mimetic and normative. It was not a mandate from the WHO, but desired by the local government to be recognised at the international level, although the work on health promotion was done in PHC since the 1950s.

On a positive connotation, the isomorphism of organisations made the management process easier. However, the limitations of isomorphism should also be recognised. If all the organisations are trying to mimic the same model, the innovation of the organisations can be challenged. From the practitioners' point of view, there were many potentials in the community actions. The communities could collaborate with academia and the public. It could also get support from the private sector (Z5B6, personal communication, 3 November 2017). The worship of authority had limited the policy making process to a strongly top-down model, in which controlling the performance of actors was the key to the successful delivery of policy. However, the possibilities of allowing bottom-up innovation were neglected for too long.

The isomorphism theory provided a valuable explanatory tool on the rationality of convergence of organisations from the legitimacy perspective. For a deeper understanding of institutional isomorphism, the data collected from the current research was not enough for generalisation on a larger scale. Further studies on the organisations of the Healthy City Action Plan can be conducted through the comparison of several case studies and in various types of organisations. By comparing cases in cities with similar social-economic status, or other organisations in the same city, further analysis can be made.

Control and discretion

In principal-agent theory, control is a strategy often used by principals. This is also connected to the top-down approach in a hierarchical organisation. However, it is often neglected the level of discretion the principals distribute to the agents. China is formally centralised, but local organisations had more autonomy in practice (Kroeber, 2016).

The Chinese government used rank-order tournaments to control the behaviour of officials. Because of the highly hierarchical structure of the government, the ranks of the

officers are highly relevant for the benefits they get. The benefits are not only monetary benefits like salaries but also intangible benefits like power and reputation.

It is a rational choice of the ruling party and the government under rationalism and pragmatism to use instruments such as campaigns and tournaments to complement the routines. The state power can be reproduced and further extended by campaigns to ensure the continuity and maintenance of legitimacy in political order during the transition period. From an institutional perspective, it is rational in terms of institutional demand causing the compulsory institutional supply by the government, and inevitable in the institutional background of administration and social governance (Tang, 2007; Xu and Zhu, 2011).

However, the more closed and mandatory the institution is, the cost of implementation is higher. Besides, efficiency cannot be guaranteed. The tensions between routines and these tournaments will lead to malpractices, opportunistic attitudes and more centralised administration. The more centralised it becomes, the cost will be even higher (Feng, 2007; Xu and Zhu, 2011; Yang, 2015; Ye, 2013).

Regarding national awards such as National Hygienic City and National Civilised City, statistics on health and environmental status did prove the efficiency of the programmes. But the effects of the awards are temporary, as mentioned by many local officials. To make the award part of the routine, National Hygienic City and National Civilised City introduced a re-confirmation process of previously awarded cities to maintain the positive effects of the standards. However, the re-evaluation process is still bounded to the cycle of three years, it is hard to make awards a sustainable way of governance.

In contrast, the Citizen Health Self-Management Group programme in the Healthy City Action Plan proved the potential of bottom-up programmes. In the top-down model, many variables need to be controlled in the whole policy process, so establishing the incentive system is costly. In the bottom-up projects, the incentive cost from the government is lower. The incentives came from various sources, such as the private sector, and voluntary workers. It is also more efficient in addressing the public interest.

Formal and informal institutions

Researches done in the Western countries emphasize the influence of the one-party system in China. This research argued that it was not only the legal system that makes actors comply during the policy process. It is the power of authority that is embedded in society that drives compliance in daily life.

In modern society, we seem to focus on formal institutions like constitutions, and legislations a lot. We tend to think these are the reasons why institutions work. However, in the empirical studies, there are many key points of the policy process that are not

managed by formal institutions. On the contrary, practitioners identified difficulties when the informal way of maintaining relations was discouraged. As a result, it was difficult to build trust in partnerships.

We need to understand, that society is the outcome of two processes: first is the natural outcome of human interactions of acquaintances, which is organised by rituals and customs. The other type is organising strangers for explicit goals which are based on the legal-rational system. In the ritual-based society, people seek connections, and distinctive networks spreading out from each individual's personal connections formed the basic pattern of the society; in the legal-rational society, people fight for their rights and the organisation of associations where the personal relationships depend on a common structure.

In the transition period of urbanisation, the Chinese society is struggling between the ritual-based traditional society and the legal-rational modern society. Since the traditional society in China is more ritual and custom based, which has been stable for hundreds of years, therefore some institutions are still valid. However, the urban society is transforming towards more legal-rational planning, but the organisation of the society cannot be changed instantly.

The same tension exists in the interaction in the governmental settings. The higher-level governors are shifting every five years, which is much more often than the local-level civil servants. From the community level to the local level, civil servants are comparatively more stable in their positions, and traditions like rituals, and reputations are more dominant in interactions. While the higher-level governors are trying hard to prepare the society with a more legal-rational system design.

Therefore, the closer to the local level, the practices based on social norms are dominant. The rapid urban development has changed society to more and more individualism. However, we forget that the basis of our society is largely rural, traditional, and cultural. Without these personal connections, consensus cannot be reached, actions cannot be united. It is as important to look back as to look forward.

7.2.2 Discussion of the research design

The overall research design is a case study conducted in a qualitative manner. The qualitative methods are plausible in answering the research question, but also pose challenges during the research process, especially in the empirical part.

It was two years between the research project was proposed to the fieldwork was conducted. The Healthy Cities development in China was under rapid change every year. Dozens of new policy papers and regulations were issued. It was necessary to have a

certain range of time that the research focuses on, although it might lose some up-to-date information on the topic.

Data collection is crucial for the time plan of the project. Secondary data was collected as a first step. A variety of documents that are related to the issue of Healthy City development and its actors constitute the pillar of information, including current documents and those covering the time span since the 1950s are taken into account.

Primary data as empirical evidence was essential for the research on the policy process per se. Therefore, in-depth interviews with local actors are necessary, which consists of 4 groups and over 10 organisations in Shanghai, mainly from the government. However, considering the special settings of the Chinese government, this process entails various challenges both on- and off-site.

Access

Informal connections are essential in reaching the interviewees. The first informant was contacted through the personal connection of the author. This personal approach proved to be practical in a snowballing process.

People prefer meeting face-to-face to take phone calls or responding to emails. The researcher had to be on-site and waiting for the meeting. After building up connections with the initial informants, more interviewees can therefore be accessed.

The challenge is to conduct research in relevant organisations without personal connections. Some interviewees explicitly expressed that the interviews would not be done without the recommendation through personal contact. One of the first questions interviewees asked was often how the interviewer gets to know the informant.

Access through the scholars conducting research for the government is the most feasible way to reach the interviewees. The potential disadvantage is that the researcher might get biased if the connection is very personal, or feel constrained about what can be expressed in front of authority.

Timing

In research design, timing is an important factor that deserves more attention. It is related to the possibilities of getting contacts and the content of the information to be obtained, thus influencing the results to be generated. A well-designed schedule can support the research significantly.

When the fieldwork was conducted, the 19th National Congress of the Communist Party of China was held, which is considered a sensitive period in the Chinese context. During this period, censorships intensified, and meeting governors was more difficult. Also, the

interviewees felt uncertain about the future direction of the policies and showed hesitation in giving opinions on governmental actions.

Methods

Qualitative methods have been used for empirical investigation. The process of interviewing, sampling and target groups all had to be adjusted on site since gaining trust in interviewees in a short time was difficult. Therefore, the interviews were not conducted fully according to the plan, but rather depended on the schedule of the interviewees and the actual information provided during the interviews. It follows the approach to start from the district level to the municipal level. The actual number of interviews conducted was below expectation (13 compared to 30). Although it covered the groups of actors targeted, the actors may be inadequately represented in the sample. While code saturation was reached in the study, the sample size might not be enough to reach meaning saturation (16 – 24 interviews are needed) (Hennink, Kaiser and Marconi, 2017).

The methods adapted also determined the constant loop between theory and data: to clarify the elements and definitions; to find logical relations between them; to eliminate the false views and to state or restate the questions of fact remains. Each interview with the practitioners provides an intense shift of understanding and perspectives for the researcher (Mills, 2000). However, the whole process of in-depth interviews was time-consuming; from getting access to conducting the interview, it was difficult to do time planning. The experience of the researcher also affected the whole process; as a new-comer to the qualitative research field, there is still a lot to be improved.

In the original research design, on-site observation and focus-group discussion were identified as sources of information after reviewing similar studies on Hygienic Cities and environmental governance in China (Li, 2014; Ran, 2013). The advantages include close observation of the routines of the participants, verification of the statements of the interviewees. These data collection methods could be included in future research to improve the validity of the results.

However, it was not realised because of limited time for fieldwork. There was no regular meetings of the Shanghai Health Promotion Committee during the fieldwork, and time was not enough to arrange a focus-group discussion. Because it was around the same time of the 19th National Congress of the Chinese Community, the timing was sensitive and the continuity of the Healthy City Action Plan was not clear.

7.3 IMPLICATIONS AND RECOMMENDATIONS

In this final section, recommendations are deduced from the analysis of Healthy Cities development in China. They are based on the experience from the case of Shanghai but included international and national programmes. Although the major influence on the policy process came from the national government, the suggestions cover improvement at international, national and local levels.

7.3.1 Policy recommendations

There are two parts of policy recommendations generated. First, the recommendations are generated from the modes of interactions (hierarchical and horizontal) and the related institutions. Second, regarding the two gaps identified in the policy process of the Healthy City Action Plan, including public participation and international collaborations. Lessons were drawn from good practices. This chapter concludes with implications for future research.

Recommendations for policy interactions

As discussed in section 5.3.1, in hierarchical interaction, the authority and control are effective but not efficient. A top-down approach is effective in daily routine. But the government should limit the centralisation to give more discretion to the local actors. The gaps in information asymmetry and motivation need to be considered in improving health governance.

The motivation problem can be solved by giving more incentives from the top-down or distributing more control right from the bottom-up. The case of national awards showed the efficiency of top-down control. However, it cannot be the long-term solution. The case of the Healthy City Action Plan showed the potential to give more freedom to the local communities.

China is a big economy in the global market, yet there are huge disparities between the urban and the rural, the East and the West. To close the gaps of unequal development, it is necessary to keep the standard flexible. Discretion of local actors can build the local capacity for development.

In the trend toward decentralisation and flat hierarchies in organisations, the hierarchical superior needs to change its role into a “coach”, by enabling small, independent, and flexible units to exploit the opportunities in a highly diverse and rapidly changing society, based on sufficient financial, technical and informational resources. In public services, lean administration, deregulation, privatisation and radical decentralisation are also

encouraged in response to diverse local environments in a globalised world (Scharpf, 1997).

In horizontal interactions, there is also the problem of asymmetric information. Communication and trust are essential to building a partnership. In the Healthy City Action Plan, there were both formal and informal communication mechanisms.

The formal inter-ministerial coordination was conducted by the Patriotic Health Campaign Committee. However, the members of the task force could not be excused from their ordinary duties and free from hierarchical directives within their home departments. Successful inter-ministerial coordination shows that the working groups would be able to develop innovative approaches that departed from the established policy routines of the ministries but were eventually accepted by these ministries if these conditions were provided.

Another formal way of communication in the Healthy City Action Plan was the mechanism of joint meetings. It was effective in sharing information with actors. It was not able to be sustained because of the limited capacity of the Shanghai Municipal Health Promotion Committee. Another limitation of the joint meeting mechanism was the groups of actors were separated. There were meetings of governmental departments, the meeting of the experts, and the meeting of the public. The groups were not included in the same meeting.

For future improvements, the example of international Healthy Cities conferences could be taken. It is a tradition in the WHO European Healthy Cities Network. These meetings are characterized by the wide range of countries and stakeholders involved. Practitioners and scholars from all over the world came together to share their experience in Healthy Cities development. For example, representatives from 60 countries and more than 200 cities, roughly half of which are located in the WHO European Region, participated in the International Healthy Cities Conference in Belfast in 2018. As the essential partner of Healthy Cities, mayors gather in the Mayor's Forum to exchange their views and reach a consensus on developing Healthy Cities (WHO Regional Office for Europe, 2018b).

Box 4. Healthy Cities Conferences

Thousands of cities worldwide are part of the Healthy Cities movement, and their diversity is one of the movement’s greatest strengths. The International Healthy Cities Conference, which takes place every 5 years, offers the chance for cities to engage with their international counterparts and benefit from the Healthy Cities Network’s experience (WHO Regional Office for Europe, 2018a).

The conferences of the WHO European Healthy Cities Network and the Network of European National Healthy Cities Networks are political and strategic and always include a

strong political presence from the participating cities and networks. Each year, a key theme is addressed (Belfast Healthy Cities, 2018):

- 2018, Belfast, United Kingdom: International Healthy Cities Conference, *Changing cities to change the world*
- 2017, Pécs, Hungary: *Building Healthy Cities: inclusive, safe, resilient and sustainable*
- 2015, Kuopio, Finland: *Political choices for Healthy Cities*
- 2014, Athens, Greece: International Healthy Cities Conference, *Celebrating 25 years of the Healthy Cities movement*
- 2013, Izmir, Turkey: *Innovation through leadership and shared governance for health and well-being*
- 2012, St Petersburg, Russian Federation: *Health and Well-being: from an early start in life to healthy ageing*
- 2011, Liège, Belgium: *Governance for health at the local level: People, citizens and assets for health*
- 2010, Sandnes, Norway: *The Hidden Cities: Addressing Equity in Health and Inclusiveness in Cities*

At the 9th Global Conference on Health Promotion in 2016, the Shanghai Consensus on Healthy Cities was endorsed by more than 100 mayors participating in the meeting. It was not only a great opportunity to connect with the world, but also to showcase the Healthy City development in Shanghai.

If the joint meeting for the Healthy City Action Plan is to be sustained, it should break the walls between the stakeholders and bring them together. Because it is not only a formal conference, it also creates chances for informal communications. It can promote the coordination between the ministries, and the communication between public-private sectors. It should also be the platform for gathering public interests.

Implications for public participation

> *"Policy makers should try to obtain the current and future dynamics of 'the public mood' about what is and what should be the substance and form of public affairs". (Hart, 2017)*

Health is a topic within the general public interest. Here we have the case of the Healthy City programme in Shanghai representing the past, and with the future "Healthy China 2030" in mind, the public mood cannot be ignored in the future planning and institutional design.

It is necessary to provide channels to communicate with the public in an effective way. The form of surveys in the Healthy City Action Plan needs to be changed. Close-ended questions cannot identify the wide range of public interests. In future surveys, more open-ended questions should be included to allow the public to fully express themselves.

The Shanghai Municipal government had already established several platforms to communicate with the citizens. The institute of mayor's mailbox allows the public to send their requests to the municipal government via mail and email. The information and requirements about Healthy Cities could be used in the agenda setting in the Healthy City Action Plan.

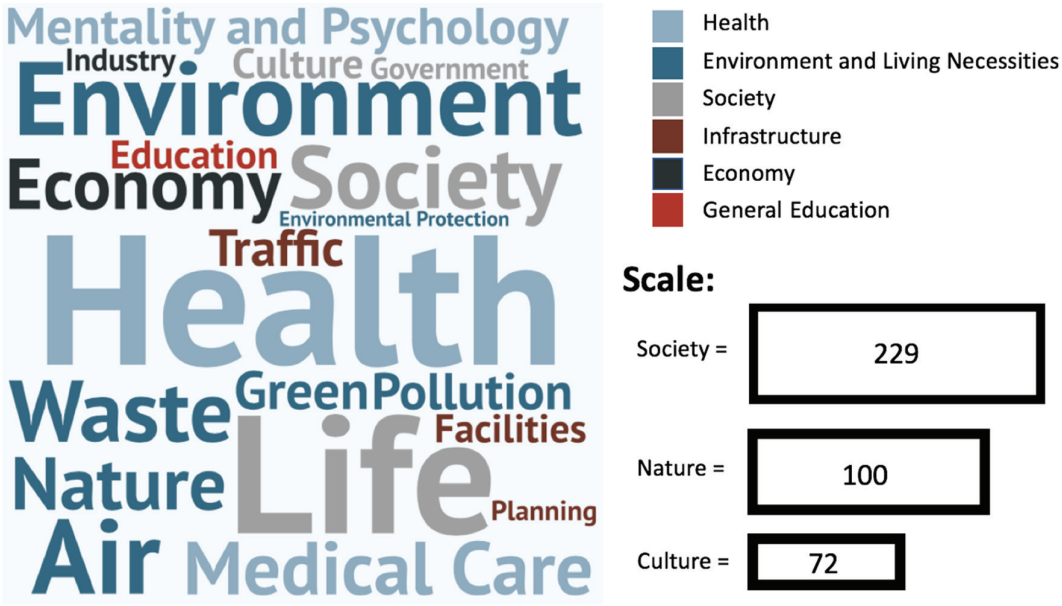
Other channels of communication with the public should also be explored. The Shanghai Municipal Health Promotion Committee used Weibo to update the latest knowledge and information on health. It was also used to improve the health literacy of the citizens. Unfortunately, the Shanghai Municipal Health Promotion Committee page has not been updated frequently. Several municipal and district departments also use WeChat to update the latest decisions and related work of the municipal government.

Strategies for facilitating effective community participation are often scarce in China. The crowdsourcing Healthy Cities contest organised by Tsinghua University, The Lancet, and SESH Global could be an example of using online channels to understand public perceptions about Healthy Cities in China. In five weeks, the contest received 449 entries of descriptions, images and videos from 29 provinces. A broad range of community perspectives and solutions for Healthy Cities in China were identified, including vertical farming for limited urban space, sponge cities approach for urban floods, and an online solid waste recycling system for waste management (Wu *et al.*, 2018).

Crowdsourcing, the process of having a community solve a problem and then sharing the solutions with the public, was used to solicit public perceptions of Healthy Cities (see Figure 7.1). Such grassroots perspectives could increase the accountability, transparency, and effectiveness of Healthy City policies (*ibid.*). The crowdsourcing approach can be applied in the policy making process at the municipal level to identify grassroot solutions to local problems.

Since the COVID-19 pandemic outbreak, face-to-face communications have become challenging. However, it is also a great opportunity to explore the potential of social media and other online presence. With the support of an online meeting platform, there are possibilities for more online events with higher frequency than physical meetings. Healthy Cities could take the chance provided by the pandemic to promote health for all at a scale larger than ever.

Figure 7.1 Colour-coded word cloud for the text submissions in the Healthy Cities Contest in China, 2017



Source: supplementary appendix p. 3, Wu D. et al, 2018

Implications for international collaborations

The World Health Organisation played an important role in developing Healthy Cities programmes on the regional and international scale. The offices of WHO in various regions in the world are still actively organising health promotion programmes and facilitating international collaborations. However, international organisations are dependent on the member states' resources, both financial resources and human resources. For example, the WHO's total annual budget in 2020 is around $5.6 billion. By comparison, the Australian federal health budget for 2019–20 was $120 billion (Jiang, 2020).

The complexity of the coordination problem is not leaving the international organisation with many options other than compromise with the member states. In contrast, the national governments have the capacity to choose strategies based on their own interest rather than the interest of the international movement, such as Healthy Cities Programmes. Member states and municipalities join the programme to obtain the international brand rather than following the content. But the discourse on health did expand when the municipality adopted the international guidelines.

However, after the outbreak COVID-19 pandemic, the impact of global health governance has become prominent. Virus does not have a nationality. It can easily travel across borders. In the global economy, countries and cities cannot afford to be isolated for a long time. The importance of cross-border collaborations became more and more important.

The pandemic provided a chance for policymakers in the world to reflect on the importance of global health governance.

While some countries do not have the resources and the capacity to control the pandemic or conduct research on their own, countries like China have accumulated information and experience in coping with the situation. As mentioned in section 1.1.3, community-based monitoring strategies proved to be effective in stopping the spread of the virus in urban areas with high density. A shared challenge for all humanity facilitated the actions in global health governance. Researchers are collaborating around the world to develop vaccines and find the cure. Cities should also share their experiences to promote global health governance.

In the global crisis, the role of international organisations such as WHO became important again in facilitating international collaborations. The experience of the Healthy City Action Plan showed the influence of international programmes on local programmes might be seen in the long term. If countries took an active role in global health governance, changes might also be seen in local health governance in the following years. This crisis might be the trigger for some radical change in the organisations of health governance.

7.3.2 Recommendations for further research

This research investigated how the actors, their interactions and the local institutions shaped the health city programme in Shanghai. It showed the potential of adapting the framework of actor-centered institutionalism in the Chinese context. There are still many questions to be answered and progress to be followed.

The case study can be extended in terms of time and scale. In the policy process, there is a paradox of time, which means past successes could lead to future failures, which might be valuable for prescriptions: as life expectancy increases, public health is faced with an older population with more difficult disabilities to deal with, which means time converts one decade's achievements into the next decade's dilemmas (Hart, 2017).

The Healthy City development in Shanghai is more than twenty-five years. It began as a collaborative project with WHO in Jiading and turned into six rounds of a local action plan. However, Healthy City is still a project rather than a policy. After the national blueprint Health China 2030 was issued in 2016, more changes in Healthy City development and health governance are expected. It would be valuable to follow the future development of the programme, to register the long-term effects. In practice, people tend to focus on the short-term effects since it is easier to register. However, as a research topic, the discussion on the temporal effects needs to be elaborated with more empirical evidence.

We still need more theoretical discussions and empirical research to test the feasibility of the framework and the instruments identified. More empirical evidence could be generated using observation and focus group discussion. Comparative studies can be conducted with the same methodology to generate more evidence on the plausibility of the framework. Cases can be chosen from China or other countries where hierarchical government and authoritarian culture are dominant.

There is still more to be explored regarding the actors in Healthy City development. While this research tried to include as many groups as possible, it was still beyond the capability of the researcher to reach all the actors. The actors in this study were mostly from the policy making stage. More research could be done focusing on the implementation stage of Shanghai's Healthy City Action Plan, actors at the community levels and the residents could be included since the community level is essential in Healthy City development (reference including de Leeuw, 2009 and so on).

Moreover, gaps between disciplines such as public health and urban planning are still big in understanding health. If there is a chance to conduct a collaborative project with researchers from different fields, it would be truly valuable for Healthy City development. As identified in section 2.1, we need more collaborations in academia first to promote the collaborations in the Healthy Cities programme.

Regarding the policy instruments, there is some unique experience in China such as tournaments, campaigns, and customs. The researchers from the occidental world already noticed these institutions from China, such as *guanxi.* In fact, I learned a lot through their perspectives. Therefore, I would be truly grateful if some collaborative work would be done to generate further implications of the case for a broader audience.

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APPENDICES

Appendix 1 Healthy Cities pilot projects in China until 2016

Source: own compilation based on NPHCCO (2016b)

Appendix 2 Principles of Healthy Cities

Year	Author	Principles
1991	Tsouros	1) The importance of local action in all aspects of developing health; 2) The specificity and importance of urban settings for health and well-being; 3) The key role of local governments in creating conditions and supportive environments for healthy living for all
2003	Awofeso	1) Explicit political commitment; 2) Establishment of new organizational structures to manage change; 3) Commitment developing a shared vision for the city; 4) Investment in formal and informal networking and cooperation
2015	WHO Europe	1) Political commitment; 2) Administrative infrastructure; 3) Evidence-based policies- city health profile; 4) Prioritized action; 5) City health plans; 6) Partnership; 7) Capacity- building; 8) Participation in networking activities; 9) Attend WHO European Healthy Cities Network meetings; 10) Monitoring and evaluation mechanisms.
2016	WPRO	1) Governance and coordination infrastructure; 2) Programme planning, management and quality improvement; 3) Information and surveillance system; 4) Workforce and network capacities; 5) Health system roles and functions

Source: own compilation based on literature

Appendix 3 Healthy Cities and the SDGs

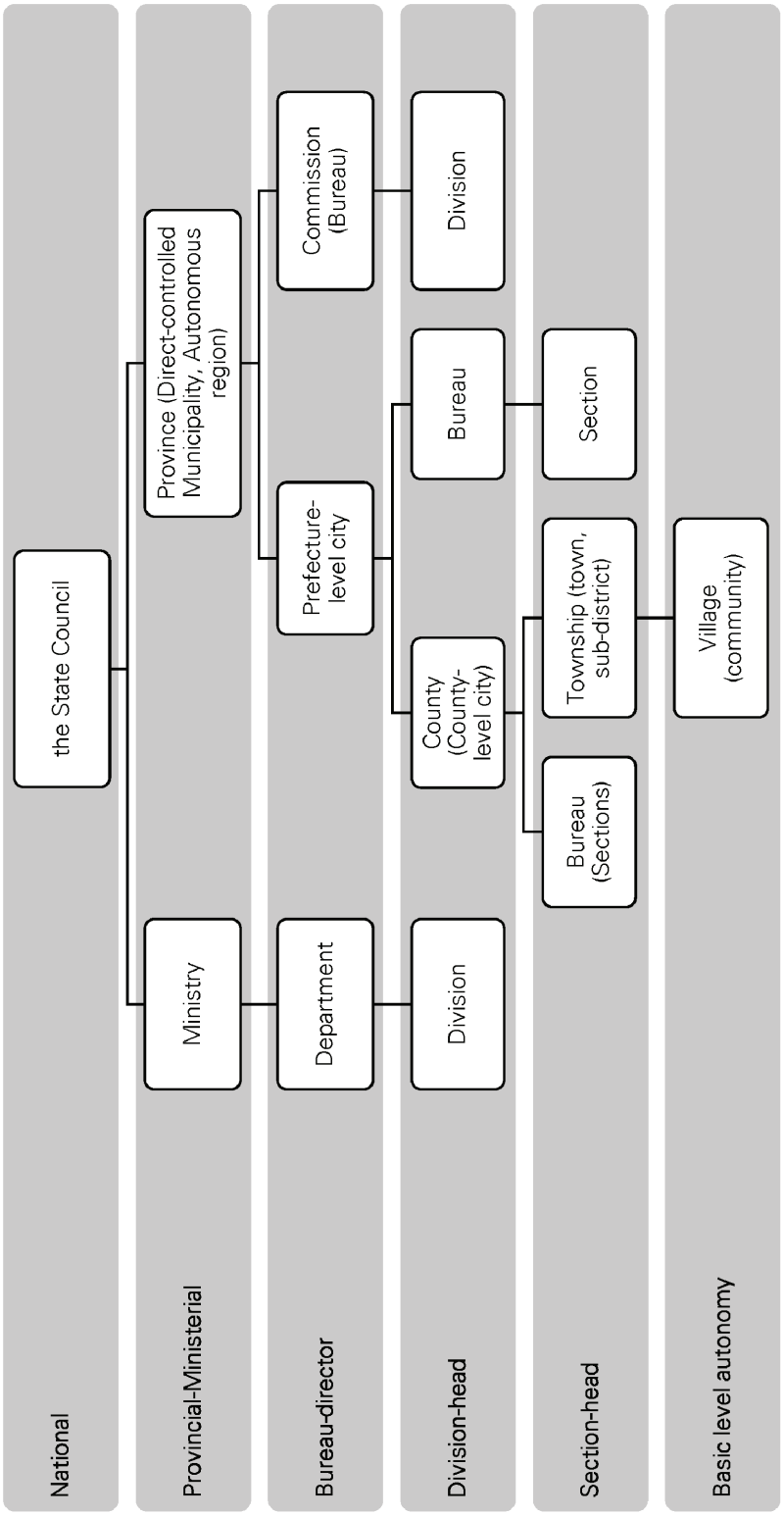
SDGs	Healthy Cities
	Urbanization promises efficiencies, better infrastructure, and technology. A healthy cities approach ensures that these efforts give due attention to increasing access to safe drinking water and improved sanitation for large segments of the population, as well as proper waste disposal, pollution management and good hygiene. Informal as well as formal settlements warrant attention for adequate sanitation standards.
	A healthy cities approach views better housing and sanitation, reduced overcrowding and upgraded slums as public health priorities. Substandard housing and sanitation increases the risk of TB and other airborne illnesses, allowing malaria, yellow fever and now Zika to flourish, especially where there is stagnant water. Healthy cities also encourage better urban planning to prioritize increased access to safe transport systems, green and public spaces, and emergency responses to natural disasters, which together reduce road traffic deaths, improve air quality, promote physical activity and save lives from disasters.
	Unsustainable consumption and production patterns that harm the environment also harm health, whether through air pollutants, contaminated water supplies or food losses. Healthy cities are, therefore, sustainable cities. They push transnational corporations, and support individuals, to adopt sustainable practices for the health of both the planet and its people.
	A healthy cities approach recognizes that extreme weather events bear significantly on health, through disrupting food supply chains, spreading water borne illness, causing uprooting and migration, and resulting in physical injuries. Healthy cities aim to reduce carbon emissions, thereby improving air quality and promoting physical activity (e.g. replacing cars with walking and cycling) simultaneously. With large segments of the population, including poorer populations, now concentrated in cities, a healthy cities approach is a major pathway toward climate change mitigation.

Source: WHO and UNDP (2016)

Appendix 4 Themes of Shanghai Healthy City Action Plan (2003-2017)

Source: own compilation

Appendix 5 Administrative divisions and civil service rank in China



Source: own compilation

Appendix 6 Comparison of indicators in Healthy City Action Plan, National Hygienic City and National Civilised City

Indicators	Shanghai Healthy City Action Plan (2003-2005)	National Hygienic City Standard (2000)	National Civilised City Evaluation System (2005)
Air Quality	The number of days when the annual API index is less than 100 (Grade II) should reach 85%	The annual mean of total suspended particulates (TSP): Northern cities ≤ 0.350 mg/day; Southern cities ≤ 0.25 mg/day	Air pollution index (the number of days when the annual API index is less than 100) (%): A. ＞ 80%; B: >75%; C: ≤75%
Water treatment	Centralized urban sewage treatment rate 70%		Urban sewage treatment rate (%)
Green Space	The green area percentage of the built-up area should be 37%, and the green area per capita should be 11 square meters, and free access to parks in urban area and residential area, etc.	The green area percentage of the built-up area is ≥30%, and the green area per capita is ≥5 square meters.	The green area coverage of total land area; the green area percentage of the built-up area.
Waste	Access to regular garbage removal system; Average daily weight of waste per population; Recycled waste as a percentage of total weight of waste collected	The harmless treatment rate of municipal waste is ≥80%; Actively carry out waste sorting collection, waste reduction and comprehensive utilization of resources	The harmless treatment rate of residential waste: A. ≥80%; B. ＞65%; C: ≤65%; C#:＜50%

Food safety	Coverage rate of various food safety testing; Revocation of slaughterhouses that do not meet national standards; reduce the use of chemical fertilizers and pesticides in the suburbs	Implement the "National Quality Sanitation Law of the People's Republic of China" and seven other indicators.	Food hygiene meets the relevant quality standards of the health department; no expired, spoiled, or counterfeit food is sold; no major food poisoning accidents.
Sports	Public sports facilities per capita (square meters); the number of social sports instructors per 10,000 people (person/10,000 people); the number of people who regularly participate in physical exercise (%), and 6 in total	-	Public sports facilities per capita (square meters); the number of social sports instructors per 10,000 people (person/10,000 people); the number of people who regularly participate in physical exercise (%)
Smoking and drinking	Restrictions on tobacco sales; promote no smoking in public places; prevent and control underage from smoking; establish 30% smoke-free schools, 50% smoke-free medical institutions and 500 smoke-free enterprises.	laws and regulations promulgated by the Municipal People's Congress or the municipal government to prohibit smoking in public places; No tobacco advertisements in urban built-up areas.	No smoking in non-smoking places; no tobacco ads in public places

Health literacy	School health education class opening rate 100%; Students with basic health knowledge and abilities account for the total number of students 100%; spread of knowledge about reproductive health and AIDS prevention, etc.	All schools have health education class; citizens with basic health knowledge; health education about no-smoking and AIDS	-
Health service	50% of communities have established healthy behavior consultation points; 94% of schools conduct mental health consultation; Community Population and Family Planning Comprehensive Service Station; Set up a monitoring station for citizens' health	Health education	Community health service center (station); number of ambulances (vehicles) per 50,000 people

Disease Control	build 80% of National Hygienic Districts and 20% of National Hygienic Towns; 60% Municipal Hygienic Villages; Build advanced system of patriotic health; Build National Advanced City for Fly Control	The city has a sound epidemic report network, and the underreporting rate of legal infectious diseases in medical institutions is less than 2%	Government departments establish a unified emergency command system for public health emergencies; Establish a smooth public health emergency information network, and strictly implement the epidemic notification and information release system; Establish a disease prevention and control center to improve disease prevention and control and emergency treatment systems.
Social environment	-	-	Poverty rate (%); urban minimum living guarantee; number of social welfare beds per 100 elderly population (pieces)

Source: own compilation

Appendix 7 The examples of National Patriotic Health Campaign Committee Members and the level of ranking

Position in the National Patriotic Health Campaign Committee	Level	Level name	Party positions	Government positions
Director of the Committee	2	Sub-national leader	Member of the Politburo Standing Committee	Vice-Premier of the State Council
Deputy Director of the Committee	3	Ministerial level	Party Secretary of the National Health Commission	Minister of the National Health Commission
			Party Secretary of the Ministry of Ecology and Environment	Minister of the Ministry of Ecology and Environment
			Party Secretary of Ministry of Housing and Urban-Rural Development	Minister of the Ministry of Housing and Urban-Rural Development
			Ministry of Agriculture and Rural Affairs	Minister of the Ministry of Agriculture and Rural Affairs
	4	Sub-Ministerial level		Deputy Secretary-General of the State Council
				Deputy Minister of the Publicity Department of the Communist Party of China
				Deputy Director of the National Development and Reform Commission of the People's Republic of China

			Deputy Minister of the Logistic Support Department of the Central Military Commission	
Committee members	4	Sub-Ministerial (Provincial) level	Vice Director of the General Office of the Communist Party of China	
				Deputy Minister of the Ministry of Education
				Vice President of Xinhua News Agency
			Vice President of All-China Federation of Trade Unions	
			Member of the Secretariat of the Communist Youth League of China	
Director of General Office	4	Sub-Ministerial level	Party Member of the National Health Commission	Deputy Minister of the National Health Commission

Source: own compilation based on (General Office of the State Council, 2018)

Appendix 8 The levels of civil servants in the Shanghai Patriotic Health Campaign Committee

Position in the Municipal Patriotic Health Campaign Committee	**Level**	**Level name**	**Party positions**	**Government positions**
Director of the Committee	4	Sub-Provincial level		Vice Mayor of Shanghai Municipal People's Government
Deputy Director of the Committee	5	Bureau-Director level		Deputy Secretary-General of the Municipal People's Government
			Party Secretary of the National Health Commission	Director of the Municipal Health Commission
			Party Secretary of the Ministry of Ecology and Environment	Minister of the Ministry of Ecology and Environment
			Party Secretary of Ministry of Housing and Urban-Rural Development	Minister of the Ministry of Housing and Urban-Rural Development
			Ministry of Agriculture and Rural Affairs	Minister of the Ministry of Agriculture and Rural Affairs
	6	Deputy-Bureau-Director level		Deputy Minister of the Publicity Department of the Communist Party of China
				Deputy Director of the National Development and Reform Commission of the People's Republic of China

			Deputy Minister of the Logistic Support Department of the Central Military Commission	
Committee members	6	Deputy-Bureau-Director level	Vice Director of the General Office of the Communist Party of China	
				Deputy Minister of the Ministry of Education
				Vice President of Xinhua News Agency
			Vice President of All-China Federation of Trade Unions	
			Member of the Secretariat of the Communist Youth League of China	
				Vice Mayor of Beijing Municipal People's Government
Director of General Office	6	Deputy-Bureau-Director level	Party Member of the National Health Commission	Deputy Minister of the National Health Commission

Source: own compilation based on General Office of Shanghai Municipal People's Government (2017)

Appendix 9 Members of the Health Promotion Committee at the District level

Role	Government Sector	Position
Chairman	District People's Government	Deputy District Mayor
Vice Chairmen	District Health Bureau	Director-General
	District Environmental Protection Bureau	Deputy Director-General
	District Health Bureau	Director-General Assistant
Members	Publicity Department of CPC District Committee	Deputy Director-General
	General Office of District People's Government	Deputy Director
	District Development and Reform Commission	Deputy Director
	District Commission of Economy and Informatization	Deputy Director
	District Commission of Commerce	Deputy Director
	District Education Commission	Director-General Assistant
	District Science and Technology Commission	Deputy Director
	District Bureau of Civil Affairs	Deputy Director-General
	District Bureau of Justice	Deputy Director-General
	District Finance Bureau	Deputy Director-General
	District Bureau of Human Resources and Social Security	Deputy Director-General
	District Commission of City Development and Transport	Chief Economist
	District Agriculture Commission	Deputy Director

District Administration of Planning, Land and Resources	Deputy Director-General
District Bureau of Public Security	Deputy Secretary
District Office of Financial Services	Deputy Secretary
District Administration of Industry and Commerce	Deputy Director-General
(District) Food and Drug Administration	Deputy Director-General
District Bureau of Technical Supervision of Quality	Director-General Assistant
District Federation of Trade Unions	Vice-Chairman
District Committee of the Chinese Communist Youth League	Deputy Secretary
District Women's Federation	Vice-Chairman
District Branch of the Red Cross Society of China	Vice-Chairman
District Health Promotion Centre	Vice-Chairman

Source: own compilation based on Shanghai Pudong New Area Government (2017)

Appendix 10 Major National Policy Papers Analysed

Policy	Issuing agency	Year
The "Healthy China 2030" blueprint	the Communist Party of China Central Committee and the State Council	2016
Guidance on the construction of healthy urban health villages and towns	the Office of Patriotic Health Campaign Committee (PHCCO)	2016
National Health City Assessment and Management Measures	the Office of Patriotic Health Campaign Committee (PHCCO)	2015
National Health City Standard (2014)	the Office of Patriotic Health Campaign Committee (PHCCO)	2014
National health literacy promotion action plan 2014-2020	National Health and Family Planning Commission of the PRC	2013
2013 air pollution (haze) health effects monitoring programs workplan	Bureau of Disease Prevention and Control (Office of the National Patriotic Health Campaign Committee), National Health and Family Planning Commission of the PRC	2013
China chronic disease prevention and treatment work plan (2012-2015)	National Health and Family Planning Commission of the PRC	2011
The 12th Five-Year Plan for the Environmental Health Work of National Environmental Protection	Ministry of Environmental Protection	2011
Action Plan on Environment and Health (2007-2015)	Ministry of Public Health	2007
Indoor Air Quality Standard	Ministry of Environmental Protection & Ministry of Public Health	2003

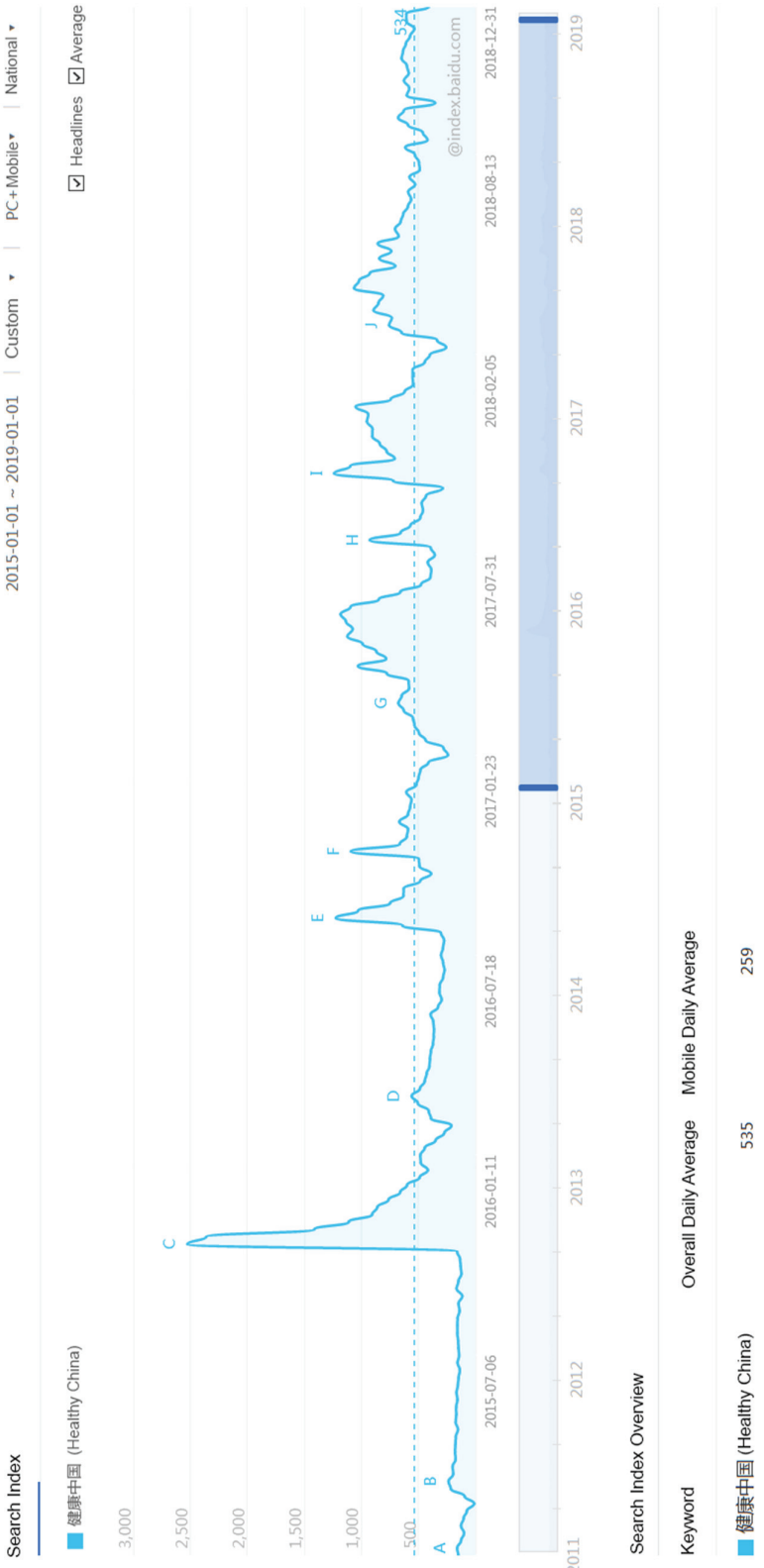
Source: own compilation

Appendix 11 Major Municipal Policy Papers Analysed

Policy	Issuing agency	Year
Shanghai Healthy City Action Plan 2003-2005	Shanghai Municipal People's Government	2002
The Opinions on the Implementation of Healthy Community Activities in Shanghai	Shanghai Municipal Commission of Patriotic Health Campaign	2003
Shanghai Health Community Guidance Indicators (Trial)	Shanghai Municipal People's Government	2003
Notice on the Work of Building Healthy Community, Community, Unit and Family Demonstration in Shanghai	Shanghai Municipal Commission of Patriotic Health Campaign	2003
Notice on Strengthening the Work of Building Healthy Communities in Shanghai	Shanghai Municipal Commission of Patriotic Health Campaign	2004
Shanghai Healthy City Action Plan 2006-2008	Shanghai Municipal People's Government	2005
Shanghai Healthy City Action Plan 2009-2011	Evaluation: Shanghai Healthy City Technical Steering Group	2008
Shanghai Health Promotion Plan 2011-2020	Shanghai Municipal Commission of Health and Family Planning	2010
Shanghai Healthy City Action Plan 2012-2014	Shanghai Municipal People's Government	2011
Shanghai Healthy City Action Plan 2015-2017	Shanghai Municipal People's Government	2014

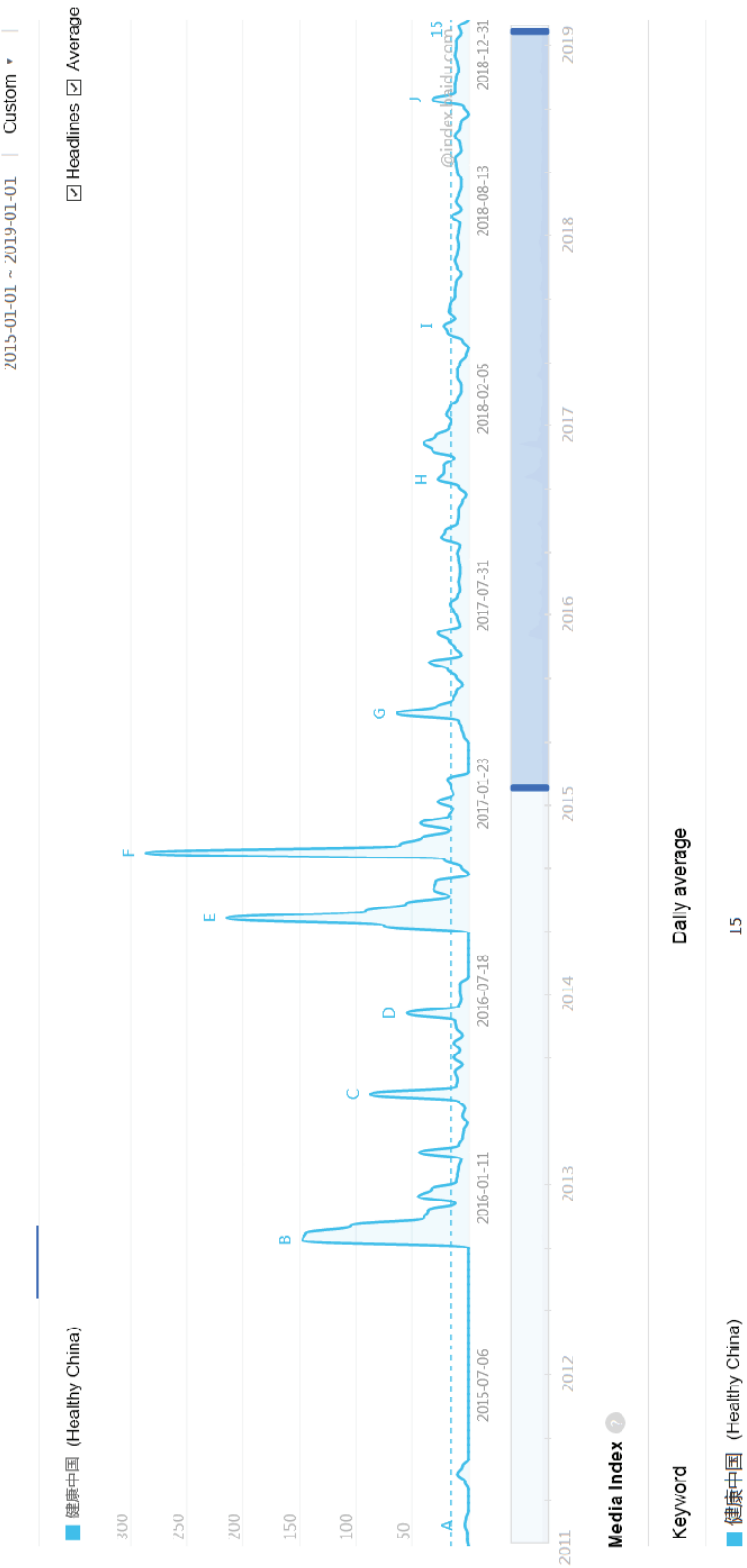
Source: own compilation

Appendix 12 Search Index of Healthy China 2015-2018



Source: Baidu Index (accessed: 1 January 2019)

Appendix 13 Reports on Healthy China 2015-2018



Source: Baidu Index (accessed: 1 January 2019)

Appendix 14 Interview guideline

Interview Guide: Interactions of Actors and Local Institutions in Policy Process - From Patriotic Health Campaign to Healthy City in Shanghai

Local area:

Name and position of the interviewee:

Date:

Introduction:

Project background: DLGS overall theme of Sustainable Development Goals focused on "Sustainable, Resilient and Inclusive Cities and Regions".

Aim of my PhD thesis: to understand how Healthy City programme is developed from policy making to policy implementation by actors at different scales.

- How do the main actors influence the Healthy City programme?
- How do the actor constellations influence the Healthy City programme?
- How do the institutional settings influence the Healthy City programme?

Aim of the interview: Learn about the policy development process

Style of interview: open-ended questions

Coding of interview: anonymous

Recording may apply with confirmation.

Do you have any questions before we start?

Process:

- How did the Healthy City programme come about in your local area? (triggers, actors, point in time?) Influence from international/national levels?
- How did it come about that your organisation/department participated in Healthy City programme? (triggers, actors, when did the topic come up first?)
- Could you tell me about the process of developing the HCP? (important steps/phases)
- Apart from your institution/organisation who else has been involved? (important persons/groups, their roles, their interest, their means to influence)
- What brought the process forward? Have there been any obstacles and setbacks?
- What kind of outcome have been achieved? (public policy on health)

Actor's orientations

- What are the main challenges of HCP in the local area? Do you think the challenges are tackled adequately? (if not, why?)
- Could you please describe the goals of your institution/organisation in planning for HCP? (role more generally, to influence development, benefits)
- Position of the topic in the local area today, e.g. as compared to other programs like Garden City, Eco city, Smart city, etc. (political commitment) How far does it influence the success in HCP?
- How has own perception/attitude changed and how did it influence the process? Value changes in general?

Actor's capabilities

- How many people in your organisation/department participated in HCP? How much time are spent each year into HCP?
- How much budget does your organisation/department invest in HCP? Where does the financial resources come about?

Institutions:

- Which partners do you cooperate with? How does the cooperation look like? Who leads? How decisions are made (majorities…)? Is it better to have more sectors involved?
- What kind of interdependencies are there between organisations/departments? Which role do partnerships play? Does it bring benefits to involve?
- In how far have actors and actor constellations changed during the process?
- Are there any unofficial connections (e.g. WeChat)? How do they influence partnerships in HCP?
- Successful factors for partnerships or governance structure in general? (e.g. the role of community participation in HCP)

Specific information on actor, HCP, etc.

That's it from my side. Is there anything else you would like to mention?

Thank you very much for your time!