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ARTICLE

Meeting Marginal Demands in New Welfare Governance? China's Contracting of Welfare Services in the Sectors of Disability and HIV/AIDS

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Abstract
Since 2013, China has rolled out a policy to contract welfare services to non-governmental forces. This has stimulated a growing body of research on the change of China's welfare governance. This article focuses on a topic that needs to be added, which is the variation of contracting across different service sectors and the operation of the policy in meeting the needs of marginal people. Based on policy analyses and in-depth interviews, we examine services contracting in the sectors of disability and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). We found a lack of services provision for the marginal groups in the general contracting of public service. Between the two sectors, we found variations in their definition of welfare services, institutional settings, and specific contracting practices. We argue that while contracting is often seen as a new welfare governance mechanism, it fails to revitalise social services and reproduces welfare inequalities across different groups in China.

Keywords: Services contracting; disability; HIV/AIDS; China's welfare governance; welfare inequalities

Introduction

In 2013 the Chinese central government issued the *Guiding Opinions on Government Purchasing of Services from Social Forces* (State Council, 2013; hereafter '2013 Guiding Opinions'), which rolled out a national policy to contract services to non-governmental forces. The policy contains multiple rationales to reform China's public sector, pluralise its welfare provision, and regulate social organisations (SOs; Howell *et al.*, 2021). Its implementation has stimulated a growing body of research on China's changing welfare governance and state-society relations, of which most empirical studies focus on the purchasing of common public services (Chan & Lei, 2017; Cho, 2017; Wen, 2017; Mok & Wen, 2022). Findings about the general contracting echo China's welfare shifts towards a 'moderate universal' (*shidu puhui*) provision, and at the same time, suggest the embrace of neoliberal ideas such as efficiency, scale, and performance management (Cho, 2017; Enjuto Martinez *et al.*, 2021). However, to our best knowledge, little research has analysed the variation of contracting across different service sectors and how services contracting is operating in meeting the needs of marginal people.

We address this gap in research by examining services contracting in two sectors – disability and HIV/AIDS. In China, disabled people (*canjiren*) are defined as '[those who] have abnormalities or loss of a certain organ or function, psychologically or physiologically, or in anatomical structure and have lost wholly or in part the ability to perform an activity in the way considered normal' (*Law on the Protection of Persons with Disabilities*, 1990). The concept

encompasses an established eighty-five million people, which accounts for nearly 6.4 per cent of China's population (China's Disabled Person's Federation [CDPF], 2010). Unlike in other countries, people infected with HIV/AIDS are not classified into the group. The most recent data shows that, as of 2020, more than one point four million people lived with HIV in China (UNAIDS, 2022). Both disabled people and people infected with HIV/AIDS live on society's margins, and their welfare demands are inadequately met (Zheng, 2018). Drawing upon empirical research conducted in four locations, we examine whether the shortcoming in welfare provision has changed in the new welfare agenda. We are concerned with the following questions: How are marginal demands represented and addressed in services contracting? How and why (if at all) are these addressed differently than in other sectors? What factors explain the variation across different sectors, specifically, between HIV/AIDS and disability?

Inspired by Jessop's (1999) concept of welfare governance, we develop our analyses from three perspectives: the definition of welfare services (as indicated in contracting policies); key institutions and their responsibilities, resources, and constraints; and contracting practices in the two sectors. Our arguments are threefold. First, welfare services for marginal people are notably lacking in general contracting, which shows a selective tendency in China's welfare provision that is not challenged but reinforced through contracting. Second, services contracting is practised differently across sectors, determined by a series of factors including the interpretation of the meaning of welfare at the local level, the responsibilities, resources and constraints of institutions, and the development of SOs and their relations with the state. Lastly, although often seen as a new welfare governance mechanism, contracting fails to revitalise social services but reproduces welfare inequalities across different groups.

The article starts with a brief overview of the key shifts in China's welfare system and its coverage of disabled people and people living with HIV/AIDS. We then examine the relevant literature and identify the research gaps, from which we develop our research question and analytical framework. The third section explains our research methods. What follows is our analysis of the meanings of services, key institutions, and contracting practices in the two sectors. The last section brings together the findings and discusses their implications for China's welfare governance.

Shifts in China's welfare provision and marginal people in the system

China's welfare system has experienced some of the most rapid and complex shifts in the past few decades. The country used to employ an egalitarian social security network, in which state-owned enterprises organised production and offered a wide range of services like housing, education, and health care (Bray, 2005). During the 1990s, reforms of marketisation and privatisation were initiated, which dismantled the system and resulted in negative consequences such as intensifying social inequality (Leung, 1994; Saunders & Shang, 2001). The issues have been addressed since Hu Jintao-Wen Jiabao's leadership (2003–2013), when the government initiated a range of social policy programmes, such as the abolition of rural taxes, to maintain political stability and promote social harmony (Leung & Xu, 2015; Howell & Duckett, 2019). Since then, China has notably increased its public expenditures and extended the content and coverage of services provision (Guan, 2017). In 2017, the central government published *The Promotion of Equal Public Services Provision during the Thirteenth Five-Year Plan*, which claimed 'a shift towards universalism' in welfare provision. This defines the provision of 'basic public service' as the key task. As summarised in President Xi Jinping's speech, the principle is 'do our best but also do what is possible' (People's Daily, 2021). These changes have led to intensive debates about whether China has achieved a historic welfare transition from residualisation to universalism (Wong, 1998; Wang, 2009) or whether it embraces a productivist approach like other Asian countries (Gough, 2004; Holliday, 2000, 2005; Hudson & Kühner, 2011; Hudson *et al.*, 2014; Mok *et al.*, 2017).

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The situation is complicated by the pluralisation of service providers. Echoing the global trends of welfare pluralism, neo-liberalism, and privatisation (Hood, 1991; Hill & Irving, 2009; Taylor-Gooby, 2013), China has launched public sector reforms and welfare restructuring. In 2002, China promulgated *The Government Procurement Law* to 'improve the efficacy of using governmental funds' (Article 1). This was followed by documents demonstrating the importance of mobilising social forces in providing services, such as the *Twelfth Five-Year Plan on the Development of Public Service*. The 2013 Guiding Opinions then claimed a new mechanism of services contracting, which selects non-state providers 'in a competitive and merit-based manner' to offer better-quality services and address unmet demands (Chapter 1; Chapter 3, Article 4). Scholars argue that services contracting shows a hybrid neoliberal-socialist rationality to China's welfarism: while the policy involves neoliberal ideas like market efficiency, competition, and choice, it also contains socialist rationales of regulating the societal sector (Cho, 2017; Howell *et al*., 2021). Empirical studies show that governments prefer SOs that are service-oriented and those have close connections with governments (Guan, 2015; Zhao *et al*., 2016; Mok & Wen, 2022). While it is widely agreed that services contracting has reconfigured China's welfare provision from state monopoly to a growing mix of state, market, and the third sector (Carrillo & Duckett, 2011; Li & Greve, 2011), whether this would lead to bureaucracy-dominant governance (e.g., Chan & Lei, 2017) or collaborative governance (e.g. Jing & Hu, 2017) remains debated.

While existing studies have predominantly focused on what type of welfare regime or welfare governance derives from the welfare shifts, an increasing number of scholars have noticed the fragmentation of China's welfare provision, given its regional variations and inequality between urban and rural areas (Li *et al*., 2015; He & Wu, 2016). Research has shown that specific policies like services contracting can be implemented in different forms across geographical locations (Guan & Xia, 2016; Wen, 2017; Cortis *et al*., 2018; Yu *et al*., 2021). However, little attention has been paid to variations and welfare inequalities across service sectors.

As stated, even under a narrow and medicalised concept, China has a large group of disabled people. These people are officially considered as both 'equal members of our social family' and 'a particularly difficult group that needs extra care' (Xinhua Web, 2019). In practice, however, they face significant marginalisation in multiple aspects, including the lack of a specific administrative institution within the government and the overlook in welfare provision (Kohrman, 2005; Qu, 2020). Though general social protection schemes often include disabled people, with some proclaiming particular attention and care for the group, their implementation has been questioned (Shang & Fisher, 2016; Wang *et al.,* 2022). In 2010 the State Council published the first specific document for disability service, *Guidance on Promoting the Development of the Social Security and Services Provision System for Disabled People,* which promised three aspects of welfare practices, including: (1) improving the social assistance for disabled people living with difficulties, such as those living in poverty or homeless; (2) guaranteeing their access to general social security; and (3) improving their welfare level, such as offering basic assistant devices and promoting rehabilitation services for disabled children. The document roughly listed a range of government institutions that should be involved in service provision without assigning the leading authority. In 2015 the government initiated a policy to offer subsidies for disabled people living in poverty and/or with severe impairment (State Council, 2015–52). The recent *Social Security and Development Plans for Disabled People during the Fourteenth Five-year* thus explicitly stated the 'inadequate, unbalanced, and low-quality public services' as a critical issue in China's disability affairs.

The sector of HIV/AIDS shows a more complex scenario. Due to the characteristics of the virus, such as infectiveness and the ways it spreads, people living with HIV/AIDS face severe discrimination and are more absent in policies and welfare provision (Zhou, 2009; Kaufman, 2011). Until the early 2000s, most HIV/AIDS programs in China were supported by global donors (Gåsemyr, 2015). International organisations such as the Global Fund and the Bill and Melinda Gates Foundation set up programmes to introduce prevention strategies, offer care services, and

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develop community-based organisations. In 2004 the Chinese government established the State Council AIDS Prevention and Treatment Committee, the first government unit in the sector. As shown in its name, the focus of the Committee's work is controlling the spread of the disease. In 2006 China initiated the policy of 'four free and one care', the only specific social welfare for people living with HIV/AIDS, which offers free testing and antiretroviral therapy. As international donors gradually wrapped up their programmes, the government also took on the fiscal responsibility of offering prevention services. This sector thus shows characters with a strong medical focus and the tradition of working with third-sector actors (Gåsemyr, 2015; Fang, 2022).

To recap, China's welfare system is undergoing vital shifts in expanding services provision and pluralising suppliers, in which people with disabilities and HIV/AIDS receive limited attention. We examine services contracting in the two sectors to see whether the inadequate services provision changes in new welfare governance. By analysing the two specific sectors, we elucidate if and how welfare policies represent the views and needs of all interested parties, particularly the most vulnerable sectors, and understand China's new welfare system more generally. The following sections explain our analytical framework and research methods.

The analytical framework

Government contracting of welfare services to non-governmental forces has been practised in Western countries for several decades and has aroused discussions on its implications for welfare changes, such as reducing cost, improving the quality and efficiency of services, and encouraging civic participation (Salamon, 1987; Smith & Lipsky, 1993; Hood, 1991; Boivard, 2007, 2014). In China, studies have emerged to examine issues like the roles of the state and SOs in welfare provision, services quality and capacity, the development of social work, and the transformation of state-society relations (see Enjuto Martinez *et al.*, 2021 for a review). Many have used the concept of welfare governance to describe the configuration of different actors in welfare production and provision (Howell, 2019; Mok *et al.*, 2021). While the literature offers significant insights, it suggests a need for more consideration of the complexity and diversity of social needs. Little empirical research is available to show how contracting is operating in marginal, or even stigmatised, sectors and whether this meets the demands of these people.

We adopt a broad framework to examine the changing welfare governance in the often-overlooked sectors. Based on his analyses of the transition from the Keynesian welfare national state to the Schumpeterian workfare post-national regime, Jessop (1999: 351) developed a generic concept of governance as 'any form of coordination of interdependent social relations'. He then identified three interrelated issues in welfare governance, which are 'the changing definitions of welfare; the changing institutions responsible for its delivery; and the practices in and through which welfare is delivered' (ibid). Compared to previous theories, Jessop's framework integrated the content and structure of social policy (Daly, 2003), making it particularly useful in analysing China's welfare shifts. The framework was proposed in the context of the transition from 'government to governance . . . on all scales' (Jessop, 2002: 35), a global trend China is experiencing. We thus believe the framework could be used in researching China's welfare governance to see whether it shows distinctive elements.

We develop our analytical framework by applying the three features proposed in Jessop's concept. First, we analyse policies and contracting catalogues to see how local governments understand the content and scope of services. Second, we identify essential institutions in welfare provision in the two sectors, including Civil Affairs Bureaus (CABs) that are expected to offer general public services and services for vulnerable people, and specific institutions in disability and HIV/AIDS affairs, and analyse their responsibilities, resources and constraints in contracting. Third, we examine contracting practices in the two sectors with empirical evidence. With this, we

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seek to understand whether services contracting can lead to a new welfare governance that meets the demands of marginal people.

Research methods

This article draws upon a research project on the politics of services contracting in China, which involved an extensive review of literature, an analysis of laws and policies, and fieldwork in four locations. We chose four locations (A, B, C, and D) that vary in their geographical region, social-economic context, and contracting trajectory: City A is a county-level city in eastern China that was relatively new to contracting and had a limited number of SOs. Cities B and C are located in southern China and were experienced in contracting, meaning they have a strong fiscal capacity, more SOs, and sophisticated contracting arrangements. Located in northern China, City D is widely believed to have a strong fiscal capacity and a highly tight political environment. By choosing cities in different regions of China we would capture the effects of different local policies and politics around contracting. We conducted an analysis of central and local policies, laws, and regulations, from 1998 to 2020. We also analysed ample public and acquired documents, including lists of service contracting projects, annual reports of government departments and SOs, and archive documents.

From 2018 to 2020, 121 interviews were conducted, with eighty-four SOs, twenty-nine academics, and sixteen government officials. SOs were sampled using various sources such as handbooks of SOs, websites and personal networks, lists of contracting programmes, contacts with government officials and stakeholders and snowballing techniques. Aware that this was not a representative sample, we adopted established practices in qualitative research of interviewing a sufficient range of stakeholders to minimise selection biases (Silverman, 2011; Bleich & Pekkanen, 2015). Among the interviewed organisations, twenty-seven offered HIV/AIDS-related services and twenty-seven offered services for disabled people. Where permission was granted, interviews were recorded and transcribed. The data was analysed using thematic codes linked to the interview protocols and project research questions. Data was triangulated with relevant sources such as sectoral and locational studies, policies, and websites. The article anonymised our locations and names of informants to protect their confidentiality.

Defining welfare services through the contracting policy

Following the 'fuzzy contract' tradition (Huang, 2015) in the Chinese policy process, services contracting is designed to be vague at the central level. The 2013 Guiding Opinions roughly defined the scope of services as 'public services that are suitable to be provided through market means and by social forces' (Article 3.3). The following *Interim Measures for the Administration of Government Purchase of Services* (2014–96, Article 14) further explained this with a list of categories including (1) basic public services such as education, employment, social insurance, health care, housing, cultural, and services to disabled people; (2) social management, (3) industry management and coordination services, (4) technical services, (5) services required by the government to perform its duties, and (6) other services that are suitable for SOs to undertake. The updated version of the document (2020) removed the list and gave even broader concepts as 'services governments offer to the public' and 'assistant services for governments to fulfil their duty' (Article 9). While local governments were required to determine the content of services according to their demands and situation, basic public services have been one of the key focuses.

As shown in Table 1, all our localities gave a broad interpretation of basic public services, including almost every aspect of services for the general public. Location B and C explicitly listed 'disabled people' as a targeted group in their contracting policy. All localities but location A included a third-level category of disability services under 'social protection' in its catalogue.

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Table 1. Content and scope of services as in local contracting policies

Location A	Local policy: 'basic public services including education, employment, social protection, medical care, housing, culture and sports, and services for disabled people.' (2013–175)
	Catalogue: 'civil affairs public services including caring for the elderly, community services, community assistance, and social welfare', but no explicit mention of disability or HIV/AIDs.
Location B	Local policy: 'services for the public: including education, employment, medical care, services for the elderly, social assistance, social welfare, services for disabled people, housing, culture and sports, public transportation, city management, water and environment protection, food and medicine safety, community affairs, technology services, and other public interest services.' (2014–15, Article 6.1)
	Catalogue: disabled services are listed as a third-level category, with a clear definition of 'prevention and rehabilitation services, education, employment, culture, sports, social work services, rights protection, and other services'; HIV/AIDs not specifically listed but there is a third-level category of 'infectious disease spreading control'.
Location C	Local policy: 'basic public services including education, health, culture, sports, public transportation, housing, social security and social affairs services including community affairs, services for the elderly and disabled people . . . ' (2012–48); 'basic public services and social affairs' (2014–33).
	Catalogue: disability as a third-level category under 'social protection'; HIV/AIDS not specifically listed but there is a third-level category of 'infectious disease spreading control'.
Location D	Local policy: the general definition of 'public services, administrative management services, assistance to the government'. (2014–34)
	Catalogue: disability as a third-level category under 'social protection'; HIV/AIDS not specifically listed but there is a third-level category of 'infectious disease spreading control'.

Only Location B gave explanations of what constitute disability services, which show a productivist approach for its emphasis on rehabilitation and employment. People living with HIV/AIDS were not mentioned in any contracting policies or catalogues in our four localities. However, Location B, C, and D all announced a third-level category of 'infectious disease spreading control' under 'public health services', which includes the control of the spread of HIV/AIDS. The definitions of services in policy documents indicate governments' welfare attitude towards these groups of people: while disabled people are seen as part of the vulnerable group that may be included in public services, people living with HIV/AIDS are less deserving, and when so, mainly to be considered in controlling the spread of the disease for the health of the public.

Finding the institutions: responsibilities, resource, and constraints

While the central-level policy suggested a complex institutional structure of 'financial bureau lead; civil affairs, industry and business bureaux cooperate; and other functional bureaux participate' for contracting (2013 Guiding Opinions, Chapter 4 Article 2), it required lower-level governments to assign institutions and arrange purchasing according to local conditions. The policy has been practised across China with models varying in institutional arrangements and contracting forms. Most existing studies regard the CAB as the primary implementor of the policy and examine its purchasing of public services (Chan & Lei, 2017; Cho, 2017; Wen, 2017; Mok & Wen, 2022; Qu *et al.*, 2023). In our localities, contracting also started with CABs' activities, such as defining contracting models, revealing names of eligible SOs, and setting the standards for evaluation. Other bureaux and street-level governments were involved in the general framework as services buyers, with their funds and preference for services. At the same time, CABs acted as the buyer and organised general programmes to purchase a wide range of public services. This relates to the

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assumed roles of CABs in services provision. As claimed in the roles and responsibilities of the Ministry of Civil Affairs (MCA), the work areas of 'civil affairs' include basic civil affairs provision (*jiben minsheng baozhang*) and services for special people, including the elderly, disabled people and children, and people in difficulties (Official Website of MCA, https://www.uschina.org/policy/ministry-civil-affairs). To fulfil its roles the civil affairs system is given the power to manage and distribute the Welfare Lottery Fund. Considering these CABs should be a key, if not the leading, institution in contracting welfare services for marginal people. A closer look at CABs suggests the institutional void of the groups of disabled people and people with HIV/AIDS. None of our researched localities had a separate disability office in its CAB. Disability affairs might be covered, such as in Location A and B, where services for disabled children were listed in the responsibilities of the 'children welfare' office. People with HIV/AIDS are more silenced as they are not defined as a target for any CAB's offices. This institutional void leads to overlooking the needs of these people in services contracting. Interviewed CAB officials claimed they focus on 'the majority of people', and they lacked 'staff or capabilities to assess too-special services' (Interview 16, 12.06.2018). Another official said 'we now get rid of disability-related affairs, following the cancellation of welfare enterprise [units]' (Interview 13, 12.06.2018).

We then turn our attention to the Disabled People's Federation (DPF), a key institution in China's disability affairs, and examine their contracting responsibilities and resources. DPFs are local branches of CDPF, which claims to be 'a national umbrella organization for persons with diverse disabilities'. In practice, however, local DPFs behave as both public institutions (*shiye danwei*) and people's organisations (*renmin tuanti*) and are the only administrative government agency responsible for making disability policies and administering relevant services (Qin & Zeng, 2014). DPFs have different institutional structures and work patterns depending on local demands, but rehabilitation and employment are the priority work of most DPFs (Kohrman, 2005). In all our localities, the DPF was part of the government and received budgeted money from the Finance Bureau. They secured special funding from *the Employment Guarantee for the Disabled*, which contributes to the DPF's fiscal capability to purchase services. Their dual role as public institutions and people's organisation leads to ambiguity in their role in contracting. For example, a senior official in location A's DPF claimed that they were unsure whether they should purchase services from SOs or undertake services from other government departments. But as the office had four full-time staff only, they 'can hardly deliver any services ourselves' (Interview 13, 12.06.2018).

In terms of HIV/AIDS, as no government unit has been set up to deal with the group's specific needs, relevant affairs are administered by Centres for Disease Control and Prevention (CDCs) and government-funded organisations (GONGOs). The former are public institutions responsible for controlling the spread of infectious diseases and promoting public health. They host the prevention, testing, and medical intervention of HIV/AIDS. Meanwhile, the government has created GONGOs such as the Chinese Association of STD and AIDS Prevention and the national grant AIDS Fund for Non-Governmental Organizations (CAFNGO). The latter has become the primary funder in the area, targeting the offer of prevention services for the so-called 'high-risk people'; and follow-up management and care for people living with HIV/AIDS. CAFNGO also helps to connect HIV organisations and governments: groups that cannot obtain legal registration status can cooperate with the foundation to apply for grants and work under their supervision.[1] This is particularly important in the agenda of services contracting, as registration is a prerequisite for SOs to participate in public bidding.

To recap, while CABs are defined with the responsibilities and resources to offer basic public service to all Chinese people, and welfare services to vulnerable people, they have no specific units representing marginal people's interests. Institutions like DPFs, CDCs, and GONGOs deal with practical issues in the sector of disability and HIV/AIDS. They, however, have fewer responsibilities or resources, and face more constraints, in terms of providing or contracting welfare services.

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Services contracting practices: different forms and processes

In what follows we examine contracting practices in the sector of disability and HIV/AIDS, including the representation of the two groups in general contracting of public services and specific contracting, shown as rehabilitation services for disabled people, particularly disabled children, and testing services for people living with HIV/AIDS.

General contracting and its coverage of marginal people

General contracting shows different foci and various forms across localities. In our research, Location A developed a "Creative Investment for Public Good" (*gongyi chuangtou,* CIPG) programme as its main contracting form. Location B and D combined project contracting with purchasing social work positions. Location C invented the model of community-based integrated services. The general frameworks targeted at offering 'basic public services' to mainstream people and used performance management and evaluation method to achieve the goal of large-scale, effective, and high-quality services. Both the target and the contracting techniques have led to the failure of care for marginal people. In accordance with the definition of public services, services for disabled people were covered in our location's general contracting framework. For example, in Location C, disabled people are a key group to cover in its community-based services provision. In Location B, a social organisation specialising in autism was invited to join in public bidding for projects, when autism was 'emphasised' in the service catalogue that year (Interview 44, 06.12.2018). In practice, however, disability services often constitute a small part of the provision. Location A's CAB purchased thirty-five projects in 2015, which included only one project on disabled children. In 2017 two (of fifty-one) purchased projects promised to offer service for children with autism and disabled adults. A community-based social worker in Location C argued that 'disabled people are invisible in the community', and social workers were overloaded with contracted tasks and were unable to design specific services for them (Interview 116, 07.12.2018). The evaluation methods of community-based services, such as using quantitative criteria like the number of users, mean disability services receive lower scores than services for mainstream people, which means such plans have lower chances to win contracts. Existing services in the framework were often isolated events, rather than long-term care. Interviewed SOs see the lack of sustainability as the main problem, as 'the governments always change its focus' and 'this is particularly an area that services take time to have real impacts' (Interview 89, 11.06.2019).

Services for people living with HIV/AIDS were even more ignored in general contracting. As stated, neither the group of people nor medical and public health services are seen as CAB's responsibilities. Also, as HIV/AIDS organisations are required to find a specific supervising unit to register, they are short in numbers and are less concerned in CAB's plan of developing the societal sector. The only relevant contracting we found was in Location B, as the CAB had the arrangement of paying professional social workers to work full-time in various government departments, including CDCs. While being interviewed, Location B's CDC had three contracted social workers, who offered counselling, testing, and follow-up services to people who visited the CDC. In practice, these social workers faced administrative work, such as writing reports and managing a digital system of people living with HIV/AIDS. This is, by nature, the transferring of government officials' work, rather than offering services to people in need. However, social workers claimed that they would like to offer 'real services' if 'our time is not seriously squeezed or overloaded with administrative tasks' (Interview 49, 07.12.2018).

To sum up, general contracting designed and hosted by CAB aims to provide basic services to the wide public, in which disabled people are covered in theory but not prioritised in practice; and people infected with HIV/AIDS receive little attention. This can be traced back to the wider shifts in China's welfare system, including an ongoing transition from residual to universal provision and a basic level of services provision. It is, however, reinforced in the institutional settings of

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government units and through the contracting policy, with new ideas such as the division of responsibilities and functions and the use of quantitative figures in measuring performance and service quality. In other words, service contracting fails to challenge welfare inequalities across different groups in providing public services.

Rehabilitation and supporting services for disabled people

Our study found two types of services contracting by DFPs: rehabilitation services offered by appointed institutions and supporting services designed by SOs. The former had been the priority work in all our researched locations.

Our locations had subsidies for children with disabilities for rehabilitation services. For example, Location A's DPF had a subsidy ranging from ¥15,000 to ¥32,000 every year, depending on age and the type of impairment. In Location B, the amount was between ¥12,000 and ¥20,000 for children with physical impairment. In Location D the amount was between ¥26,000 and ¥36,000 per child per year. The subsidies came from the same source, the *Employment Guarantee for the Disabled*. They were designed for 'recovery' services, such as training children with hearing impairments to speak or those with autism to force attention outward. They had a principle of prioritising children at a younger age. One interviewed official explained this as 'such "rescuing" services have the best effects for children' (Interview 13, 12.06.2018).

Rehabilitation services are often offered by appointed institutions (*dingdian jigou*), which are hospitals, care home and health centres, and special education institutions authorised by local DPFs. In Location A, public institutions and state-related SOs were given preference for their 'standardised practice, guaranteed quality of services, and a higher level of trust' (Interview 13, 12.06.2018). Families with disabled children need to register at the local DPF and pay rehabilitation centres for services; they can apply for reimbursement later. Other localities favoured SOs in offering such services, as 'it is our advantage to have these SOs-some of them have a national reputation, many people travel here for the services' (Interview 121, 05.12.2018). DPFs pay families with disabled children directly, allowing them to choose appointed institutions independently. In all the localities, once being approved as appointed institutions, the institutions had considerable flexibility in designing the content and forms of services. Local DPFs evaluate the appointed institutions every year, mainly in terms of their staffing, structure, and finance structure. This was often in formality as both DPF officials and the institutions argued that 'after all, it depends on the quality [of services]' (Interview 14, 12.06.2018).

Secondly, DPFs in some of our researched locations arranged supporting services for disabled people to live in an able-bodied society. These were developed by disability self-organisations that have established relationships with DPFs, in advanced cities like Location B and D. For example, a leading disability organisation in Location D designed projects to assist people with visible impairment in their daily life, such as helping them with shopping and attending hospital appointments. The idea came from the demands of disabled people, and the SO drafted services plans 'from the bottom'. The DPF amended the plans with more rigid quantitative criteria, for example, serving 2,000 disabled people every year or 110 people within three months. The director of the SO described the requirements as 'pat-the-head decisions' and was unhappy about the final offer of money (Interview 99, 21.06.2019). However, the SO still decided to sign the contract for the possibility of communicating with government officials for potential advocacy.

Between the above two types, rehabilitation services for disabled children is clearly in a larger scale, has more resources, and leads to a more formal collaboration between the government and SOs. We argue that the priority of rehabilitation in contracting confirms the approach in the disability sector to 'normalise' people with impairments to be ordinary, able-bodied members of society. A limited number of services are offered if they cannot 'recover', to assist them in participating in the able-bodied society; but this depended on informal relations with the

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government and was less stable. Current contracting thus show limited effects in addressing the actual needs of disabled people.

Testing and control in the sector of HIV/AIDS

Compared to disability, HIV/AIDS is a more sensitive issue, which leads to a higher level of marginalisation of the group. As stated, specialised services for people living with HIV/AIDS were almost entirely missing in the general contracting. We found relevant practices only within the work scope of health institutions, which suggests a strong focus on medical prevention and control.

With only a couple of exceptions, all our interviewed HIV/AIDS organisations were funded by CAFNGO. The grant promises to support services on publicity and health education, prevention and intervention, test and counselling, and care for people living with HIV/AIDS; but in practice, the priority was rapid medical testing to identify people infected with HIV/AIDS. CAFNGO employed a top-designed process to offer ¥100/person for SOs to test people seen as having a higher risk of infection, such as sex workers, gays, and drug users. As the content and price of the service are fixed, SOs can only decide the number of people they can serve, which is reviewed and approved by local CDCs based on their understanding of the capabilities of SOs. The selection process was described as 'really black-box, totally depends on your relations with CDCs' (Interview 60, 11.12.2018). Once approved, the contract would be signed between CAFNGO and SOs (CDCs not included). CDCs were responsible for monitoring SOs' services provision but this was seldom practised. Many interviewed SOs working with CAFNGO expressed their feeling that 'they [CAFNGO] just need statistics' (Interview 54, 08.12.2018).

This type of services provision has been found to have certain problems. First is the conflict between top-down design and practices. Interviewed SOs argued that some top-designed requirements were impossible to implement, such as keeping a record of sex workers who used the testing services (Interview 56, 09.12.2018). The second issue is financial pressure. CAFNGO offers ¥100 for each service user, which is inadequate for big cities like Location B and D. Third, slow funding transfer adds pressure to SOs. SOs thus had to apply for multiple projects to cover their cost and/or 'fake the data' (Interview 106, 08.08.2019). An interviewee summarised this as 'no real services, no care, no support, no anti-discrimination ideas at all' (Interview 95. 18.06.2019).

Compared to services suppliers in disability, HIV/AIDS organisations have stronger connections with service users. An interviewee shared a story when '[government officials] wanted to play [offer services] themselves and found they can't, and they let me clear the mess up' (Interview 106, 08.08.2019). Based on their experiences and good relations with local CDCs, some SOs were able to design new types of service. For example, a SO in Location B created a digital platform to collect data and inform service users of their testing results. This was believed to be more accurate, productive, and ethical; and was later purchased by the CDC. This, however, rarely happened as 'most HIV/AIDS are struggling to survive and how can they design services with this limited number of staff' (Interview 54, 08.12.2018).

To sum up, compared to the sector of disability, the sector of HIV/AIDS is even more marginalised in services contracting in terms of the limited availability of funding and the narrow, medicalised understanding of services. Current contracting practices suggest a strong approach to identifying, marking, and disciplining people who are seen as risks to society, at least to public health. Although the sector has SOs that are closely connected with the community, these SOs have few chances to improve service provision given the lack of funding, appropriate contracting arrangements, and space to advocate for the needs of their target group.

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Table 2. Services contracting in the sector of disability and HIV/AIDS

	General contracting	Disability	HIV/AIDS
Definition of welfare	Basic public services	Access to public services and social assistance for vulnerable people (not only for disabled people)	Not explicitly listed in the scope of public services;
		Productivist services such as rehabilitation and education	Special, medical-focused benefit
Institutions	• CABs	• DPFs	• CDC • GONGOs
Contracting practices	The lack of disability services due to contracting arrangements;	Subsidy and rehabilitation services for disabled children;	Medical testing and disciplining services
	The transfer of administrative work in CDCs	Supporting services in localities with more resources and SOs	
welfare governance characters	A collective tendency that is reinforced by contracting mechanisms	Normalising tendency	Disciplining tendency

Conclusions and discussions

This article has examined the operation of services contracting in China in the sector of disability and HIV/AIDS, including the representation of the two marginal groups in general contracting of public services and targeted services hosted and outsourced by specific government units. As summarised in Table 2, we examined the definition of welfare services in the two sectors, as indicated in local policies and service catalogues. Apart from CABs, which have the role of providing basic public services and services for vulnerable people, we identified key institutions in the two specific areas like DPFs, CDCs, and GONGOs, and explored their responsibilities, resources, and constraints. We then examined the contracting practices in different forms and processes in our researched localities.

Our research found that, although in the academic literature services contracting is claimed to revitalise social services (Enjuto Martinez *et al.*, 2021), the main focus of China's services contracting has been on 'basic public services' to the mainstream society. Marginal people like disabled people and people living with HIV/AIDS are considered 'less deserving' and do not constitute 'effective targets', especially when contracting involves mechanisms highlighting performance and efficiency. Their demands are thus subordinated and inadequately represented in common services contracting. In other words, the contracting of welfare services does not contribute to the claimed welfare transition to universalism, but reinforces its collective, selective tendency and entrenches welfare inequalities across different groups.

We also witness a limited extent of services contracting in the sectors of disability and HIV/AIDS, which vary in their content, forms, and processes. The disability sector prioritises rehabilitation services, especially for disabled children, supplemented with supporting services for people with disabilities to live in an able-bodied society. This shows a normalising and productivist tendency, with the target to 'rescue' as many people as possible to fit in mainstream society. In the sector of HIV/AIDS, services have concentrated on medical testing and disciplining people who are seen as having higher infection risks. The key aim is to identify, trace, and control the spread of the disease, whilst the welfare needs of people living with HIV/AIDS are overlooked. We argue that the variation in services contracting across the sectors is shaped by a range of factors, including the local interpretation of the meaning of disability and HIV/AIDS services, the responsibilities, resources and constraints of key institutions, and contracting forms and the

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development of SOs. Both the sectors, however, suggest the exclusion of user voices, which leads to limitations in addressing their needs and improving their marginal position.

While we do not claim our findings to be generalisable, we believe these findings in the sector of disability and HIV/AIDS shed light on China's services contracting and more generally, on its changing welfare governance, in the following ways. First, the article has provided empirical proof of the marginalisation of certain groups of people in the new policy mechanisms of services contracting, which has been missing in the existing literature. Second, our research contributes to the debates on China's welfare governance by presenting the diversity and complicity across different service sectors in the broader shifts. Finally, by paying attention to marginal people, we identify the selective, normalising, and disciplinary tendencies in China's welfare provision, which deserve further examination in other sectors and future research. From the practical perspective, our research suggests that for services contracting to be more inclusive of marginal groups, it should address their needs in the early design of service contracting, not only by ascertaining what these needs are, but also, by diversifying the evaluation mechanisms to ensure that these types of services can opt for broader resources. Otherwise, services contracting may just continue to reproduce welfare inequalities between sectors and solidify the marginalisation of certain groups.

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Note

1 Compared to the sector of disability, HIV/AIDS organisations face more difficulties to register. They need to find a 'professional supervising unit' (*yewu zhuguan danwei*) to obtain the legal status, but qualified bodies often 'do not understand our logic, or don't bother to take responsibilities' (Interview 86, 02.06.2019).

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