provide basic health care; (4) establishing a national essential drug system; and (5) piloting public hospital reform.' (1)

Following the 2009 reform, five sets of comprehensive policies were introduced (5). They are summarized and quoted below as follows:

- Medical security: to achieve universal coverage through insurance systems for urban residents (urban employees' and residents' basic medical insurance), farmers (New Rural Cooperative Medical Service), and those living in poverty in both urban and rural areas (medical assistance).
- Public health services: full government funding for a minimum package of nine essential services (including maternal and child health, immunization, mental health, aged care, chronic disease management, and health education) with a view to equal access to public health services for all.
- Primary care: establishing a comprehensive network of basic health services through a three-tier rural network and urban community health services, with Chinese medicine integrated into these service delivery networks rather than as a free-standing system.
- Pharmaceutical supply system reform: setting an essential drug list that is linked to basic medical insurance and cooperative medical service, with open tender based on government reference price.
- Pilot hospital reforms: trialing strategies for ownership and government, quality, regulation, training, and revenue oversight.

These new policies did not completely eliminate the earlier polices. Thus, the post-2009 policies coexist with many pre-2009 policies. Given the number and complexity of these policies it would be difficult to obtain their 'big picture' from the corresponding text documents. Despite the best intentions of the policy makers, the complexity of the formulation process and the associated negotiations are likely to introduce differential emphases and biases (5-7). It is necessary to map the text of the policies systemically and systematically to discover their emphases and biases. Such an analysis will help the health policy-advisors and -makers formulate better policies. It can provide feedback on the current policies and feed-forward to future ones (8).

Ontology of Health Care Policies

The ontology of health care policy represents our conceptualization of the health care policy domain (9). It is an 'explicit specification of [our] conceptualization,' (10) and can be used to systematize the description of a complex system such as national health care policies (11). The ontology organizes the terminologies and taxonomies that constitute health care policies. 'Our acceptance of [the] ontology is… similar in principle to our acceptance of a scientific theory, say a system of physics; we adopt, at least insofar as we are reasonable, the simplest conceptual scheme into which the disordered fragments of raw experience can be fitted and arranged.' (12)

The method of constructing and presenting an ontology for a domain is an iterative process (13, 14) that systemically and systematically deconstructs health care policy into its dimensions and associated elements. It is a new method of analyzing and synthesizing knowledge in a domain

- A method of mapping the national health care policies onto the ontology based on the original text of the policies (in this case Chinese); and
- A method of analyzing the dominant, less dominant and non-dominant focus of a nation's policies, and the consequent gaps in them.

China's health care policies have undergone waves of reform (4). In making these reforms there is a need for policy makers to understand the implications of the above findings for future planning, and prioritizing for formulation (and reformulation) of policy. Our research will allow the policy makers to ask, as discussed above, for example: Are the dominant foci e.g. preventative care, illness-episodic care, quality, and safety balanced against the low focus elements such as illness-chronic care, palliative care, and accessibility? Do they need to be? Ultimately ontological analysis such as this can provide a pragmatic basis for deliberations (7) by policy makers and interest groups for policy formulation.

The framework, the method, and the results can be useful to advance health policy making in general and China's health policies in particular. It can be used to assess the strengths and weaknesses of a country's health policy, and to compare and contrast policies of different countries based on a common framework. The present study is a continuation of our study of Chile, India, and Australia's healthcare policies and programs. Understanding the antecedents and consequences of the emphases in other countries can provide insights into the policies of the parent country.

In ending the discussion, we should also highlight some of the limitations of the research. The ontology may be incomplete or over-specified. In the future, should it be necessary, the ontology can be extended, reduced, refined, or coarsened as appropriate.

Considerable effort has been expended in the translation of the ontology, construction of the glossary, and the monitoring of coding to minimize errors. While the coders tried to stay true to the text of the policies without imputing their own expectations, one cannot exclude the possibility of over-coding and under-coding. Given the large population of programs (289) and the significant variation in the frequency of the elements, despite the potential errors, the results are likely to be robust.

Given the data, errors in the ontological map are unlikely. However, there is room for variation in the interpretation of the luminosity of the different elements. Since the method of construction of the map is completely transparent, it would be easy to compare and contrast different interpretations of the same.

In summary, despite the limitations, the insights are strong. Their explanation as to why the corpus is as described may vary, but there is little room for variation in the description of the policies corpus.

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Appendix: Glossary

Policy: Health care policy.

Scope: Reach of the health care policy.

Global: Policy applicable in all countries of the world.

National: Policy applicable everywhere in China.

Regional: Policy applicable to a region of China.

Local: Policy applicable within a defined part of China.

Urban: Policy applicable within local urban areas.

Rural: Policy applicable within local rural areas.

Provider: Policy applicable to a health care providing institution.

Focus: Focus of the health care policy.

Drugs: Policies regarding drugs used in health care.

Food: Policies regarding food and nutrition in health care.

Financial: Policies regarding health care finance.

Legal: Policies regarding legal issues in health care.

Insurance: Policies regarding health care insurance.

Technology: Policies regarding health care technology.

Information: Policies regarding health care information.

Treatment: Policies regarding treatment.

Personnel: Policies regarding health care personnel.

Physician: Policies regarding physicians.

General: Policies regarding general physicians.

Specialist: Policies regarding specialist physicians.

Nurses: Policies regarding health care nurses.

Staff: Policies regarding health care staff.

Administration: Policies regarding health care administration.

Outcomes: The intended outcomes of health care policy.

Accessibility: The accessibility of health care to the population.

Cost: The cost of health care to the population.

Quality: The quality of health care delivered to the population.

Satisfaction: The population's satisfaction with health care.

Safety: The safety of health care delivered to the population.

Parity: The parity of health care delivered to the population segments.

Timeliness: The timeliness of health care delivery to the population.

Care: The different types of health care.

Preventive: Care to prevent illnesses and diseases in the population.

Illness: Care of illnesses when they occur.

Mental: Care of mental illness.

Physiological: Treatment of physiological illness

Episodic: Care during illness episodes -- time bound.

Chronic: Care of chronic illnesses -- continuing.

Occupational: Treatment of occupational illness.

Palliative: Care to alleviate pain and suffering.

Emergency: Care of emergency illness

Population: The population targeted by the policy.

Individual: Individual recipients of health care.

Children: Children who are recipients of health care.

Adolescents: Adolescents receiving health care.

Adults: Adults receiving health care.

Female: Women receiving health care.

Pregnant women: Pregnant women receiving maternal health care.

Workers: Workers receiving occupational/work related health care.

Disabled: Disabled adults receiving health care.

Other: Adults other than mothers and workers.

Aged: Older people receiving elderly health care.

Family: Family, as an entity, receiving health care.

Community/group: Community/group as an entity receiving health care.