

# CHINA

## Health Services in China

by Susan B. Rifkin\*

In the face of the adverse condition of overpopulation, limited resources and technological backwardness shared by the developing nations, at least one country, the People's Republic of China, is attempting to devise a health system which rejects Western standards of medical care and its inherent biases and is geared rather to meet the needs of the local population. This system relies on extensive and often intensive use of traditional practitioners, health teams and medical auxiliaries in an attempt to make health and medical care available to most of China's 80% rural population. By focusing on training and deployment of medical and health personnel, the Chinese are seeking to avoid the burden of large investments in curative medicine accessible only to wealthy urban elites which plagues many other developing countries.

The Chinese Communists recognised early the need to protect China's largest resource, her manpower. Health problems became the concern not only of medical professionals, but also of the economic and political strategists. For this reason, health policies are an integral part rather than a simple appendage of overall development planning.

The development of health services in China, like the country's development in general, has passed through various stages as economic development has advanced. Based on the principle that "to defend the life and health of the people by wiping out diseases means to protect the most important and the most important (*sic*) productive force in the world" (SCMP 1722, NCNA 12/2/58), health policies have been formulated within the broad guidelines promulgated by Mao Tse-tung. His four standards are: "medical care must serve the workers, peasants and soldiers"; "put prevention first"; "unite Western and traditional medicine"; "and co-ordinate medical campaigns with mass movements" (CMJ v.77. no.1, July 1958).

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The period from 1950-1952 was one of economic rehabilitation, reflected in the sphere of health services by the concern of the leadership to provide the basic organisation for health and medical care and in eradicating as quickly as possible epidemic diseases. In the first instance, the government not only established the Ministry of Public Health in 1949 and reconstituted existing hospitals and research centres but also took measures to mobilise the trained medical personnel who formed the foundations of the urban-based missionary hospital system in China from the 1860's until 1948. Private practice was strongly discouraged and Western-trained (?) doctors were urged to join practitioners of traditional medicine in organised United Clinics and make their services available to the state. Medical schools expanded to train more needed personnel for public service.

To disperse medical care from its heavily concentrated urban base and to get health-services to the 80 per cent of China's population which lives in the rural areas, other measures were taken. The most important of these was the establishment of health teams. The early work of the teams focused on anti-epidemic stations; establishing material and child care services; training local inhabitants to carry out preventive work, including health education and vaccination inoculations; and establishing health services among the minority tribes which were threatened by extinction due to the lack of disease control measures.

The health teams were composed mainly of a corps of auxiliary workers who, under the direction of the mere 18,000 - 20,000 Western-trained doctors in China at that time, could carry out a number of health and medical measures and release the precious time and skills of the professional physician. Auxiliaries were taught both curative and preventive techniques, and by participating in both types of activity, made maximum use of their much demanded skills. (Even today it is reported that both doctors and public health workers know how to do acupuncture and bandaging, prescribe and administer injections and master techniques for prevention and cure of endemic disease such as bronchitis, arthritis and gastroenteritis (FBIS 10/4/70; Peking Domestic Service 2/4/70). Such flexibility and disregard for previous conventions encouraged medical people to make use of indigenous resources and talents and to develop treatments and skills most appropriate for local conditions).

Relying on the growing medical organisation and the health teams, the leadership turned its attention to methods of disease eradication in order to cut mortality rates. In order to imple-

ment preventive measures such as health education, and vaccinations, and to impose conditions of sanitation for the control and eventual abolition of contagious diseases, the government-established mass campaign for health purposes, called "Patriotic Health Campaigns", were initiated in 1952 to urge the people to improve village water sanitation and to eradicate the "four pests" (rats, flies, mosquitos and bedbugs) which were the carriers of certain infections whose widespread presence was allegedly due to the use of germ warfare by the Americans in the Korean War. Poorly organised, these first campaigns were soon reconstituted as "Shock Attack" movements, providing mechanisms for instant participation of the people whenever the authorities felt a health campaign necessary "Shock Attacks", which proved effective for an intensive effort for a short period of time, reached their zenith in the Great Leap period of 1957-58, when agriculture became increasingly important in the economic development of China. Thereafter, seasonal campaigns were institutionalised, aimed at the eradication of all major communicable diseases as well as the four pests. They also had intrinsic value as a vehicle for health education and as machinery for the dissemination of health propaganda in both urban and rural areas.

The period of the First Five Year Plan, 1953-57, emphasised the development of heavy industry rather than agriculture and accordingly health policies focused on programs to benefit urban workers. The mass campaigns continued to hold an important place in health plans as did the training of new personnel, but little further attention was paid to the provision of direct personal health care in rural areas. Then, by 1956, economic planners realised the necessity for emphasising the role of agriculture and began to formulate plans which have marked the direction of both economic development and health care services until the present time.

With the promulgation of the Twelve Year Plan for Agricultural Development in 1956, the Chinese began to emphasise agriculture as the basis of its economic growth and to link health explicitly with this development. "Our aim is to fully utilise this favourable condition - large population and abundant manpower in China - in order to accelerate the development speed of production to the highest degree" (*Jen Min Jih Pao* 22/7/58). To protect rural manpower the government, with the aid of the medical profession, took extensive measures to expand existing and create new health programmes. To ensure all people had access to some type of medical care, medical facilities and manpower were expanded as the foundation for a

strong rural health system. The policies formulated at this time to achieve this goal have, with some modifications, remained the basis for the development of health services and the preventive health system in China.

By 1958, the communes had emerged as the cornerstone for the implementation of the economic infrastructure of the Great Leap Forward. (This fluid period culminated with the formation of the communes). The Decentralisation which permeated organisations throughout the country led to the formation of the rural health center or *hsien* hospital, which became responsible for all health activities of the commune and adjacent areas unable to support their own centre. Their major tasks included responsibility for out-patient and regional health work; the direction of mass campaigns; the investigation and control of contagious diseases; the inspection of public mess halls, nurseries, kindergartens and maternity hospitals; the delivery of medical care; and responsibility for all preventive work. By 1965, all of China's 2000 counties had at least one health centre or hospital.

In order to staff these new rural facilities, the Chinese took several important decisions. As a first measure, steps were taken to make serious use of the 500,000 practitioners of traditional medicine. As early as 1954, the Chinese Academy of Traditional Medicine was established and in the 1956-58 period, a concerted effort was begun to introduce both traditional doctors and medical theory into the university classroom. A synthesis was then sought between these two systems, and students were encouraged to study both systems; the call to study both types of medicine has become increasingly imperative in the period following the Cultural Revolution. In addition Western-trained doctors were urged to study traditional Chinese medicine, in special courses devised for this purpose. By 1958, there were reportedly over 13 colleges and several hundred secondary schools of traditional medicine, training 70,000 apprentices.

Under this new policy, traditional doctors joined the national and municipal public health services in increasing numbers. They were assigned to hospital and clinics of various types and integrated into the existing organisational system. In the rural areas, where "the traditional methods of treatment are preferred because they are simple and effective, and appropriate to the constitution and habits of the Chinese people" (*Chinese Medical Journal*, Feb., 1959, p. 103), their increased presence provided an alternative treatment to Western medicine. The traditional doctors staffed rural health centres, trained auxiliaries and carried out health team work. In 1956, 30,000 traditional

practitioners had been incorporated into government public health organs.

Another measure first taken during the Great Leap period to meet rural health needs was the transfer of urban medical personnel to the countryside to lead or serve on health teams in rural areas. Following the policies of decentralisation of authority, encouragement of development of local resources through the organisation of the communes, and uniting theory with practice, the Chinese leadership called for highly trained medical doctors to travel into the hinterland to treat the local people and to teach them to build and support local health services. On a rotation system which provided for one year's leave of absence from their urban institutions, city medical personnel rapidly expanded the ranks of rural medical services.

A third step was to create a new type of auxiliary worker, the forerunner of the present "barefoot doctor", who was educated in the training centers that proliferated during the Great Leap period. Studying medicine in a part-time or spare-time school, these workers were trained to carry out rudimentary treatment and preventive and sanitation work. The appearance of this type of personnel enabled these people to be employed in health work during slack seasons and provided means of on-the-spot treatment. It also created a corps of concerned locals with a stake in the good health of the commune.

When the Soviet Union withdrew its aid in 1960, the followers of China's "arch enemy" Liu Shao-chi'i reportedly reverted to an economic system which depended on a high degree of centralisation, and on skilled rather than political expertise, to health programs which stressed more capital-intensive curative techniques based in urban areas, providing prestige and recognition to highly trained doctors and researchers. (For a description of the politics of health at this period see *Current Scene*, May 1, 1968; June 15, 1969; and December 15, 1969). To counteract this trend, the Cultural Revolution was launched in 1966, and in the period that followed, economic strategies stressed decentralisation and self-reliance. The field of health became a precursor of these radical strategic shifts as the rural emphasis once again emerged in health activities. In the *June 26* (1965) directive, Chairman Mao called for stress to be placed on health work in the rural areas (J. Chen, *Mao Papers*, London: Oxford University Press, 1970, p. 100). In response to Mao's appeal, the medical profession, including the prestigious Chinese Academy of Medicine, marshalled their resources and sent teams to the rural areas. Led for the

first time by such figures as Dr. Huang Chia-ssu, President of the Academy, these teams were organised on a large scale to cover vast areas and to involve large numbers of health and medical people on all levels. In the post-1965 era, nearly all urban medical personnel sent to the countryside, become members of mobile medical teams. This transfer of personnel has become a permanent long range goal of the Chinese with efforts made to keep one third of all urban medical people in the rural areas at any given time.

A major task for the city teams is the education of China's new medical heroes, "the barefoot doctors", who like their Great Leap predecessors, are local people trained during the agricultural slack season in both Western and traditional methods to serve the community in which they live. Depending on a system of referral to more highly trained personnel, on periodic visits from the physicians of the mobile medical teams, on preventive medical techniques, and on the high morale of and acceptance by the people whom they treat, the medical workers give substance to the latest medical policies. Their duties include, in addition to treatment, the responsibility for the organisation of health education programmes, birth control programs, patriotic health campaigns and general sanitation work in their locale. (See Joshua Horn ...*Away with all Pests*, London, Paul Hamlyn, 1969. Horn is a British surgeon who spent 15 years in the British medical service).

Another development in this period which supported the rapid expansion of rural health services was the growth of a co-operative medical system at the commune level. Although such a plan had first appeared in 1958, it was not until this era that it made a widespread appearance. Basically, the system calls for both the production brigade and individual commune member to contribute a fixed amount per annum. In return, the patient pays only a minimal amount of money for treatment and medicines he receives.

While all these measures provided sensible solutions to an obvious need, the chaos of the Cultural Revolution made the firm establishment of the newly expanded health system difficult. By 1968 it was apparent that the professional medical people could not carry out their tasks as members of the mobile medical teams and undergo political rectification simultaneously. In order to prevent a breakdown of the health system, the political leadership turned to the one group that had remained relatively cohesive during this intense period of struggle, the army. By June 1969, the Peoples Liberation Army

(PLA) had sent more than 4,000 teams and 30,000 men into the countryside. In the one-year period ending July 1970 they had sent 6,700 teams with 80,000 members for rural health work. The PLA has become the model for emulation for all medical and health work. Medical professionals are urged to set up hospitals in the style of the Red Army hospitals for the civil war period (1937-49). To meet the directives for rural health work, medical colleges revamp their curriculum, often imitating the structure established at K'ang Ta (Anti-Japanese Political and Military School).

Despite the problems that continue to plague the present system, the Chinese have begun to make inroads into their massive health problems. By attempting to destroy the tradition of Western medical systems which continue to maintain an emphasis on curative medicine administered by "fully qualified" doctors, by necessity at the expense of the urban rich, the Chinese are discovering ways of letting health care "serve the people". Through the use of health teams and auxiliary workers, through the implementation of mass campaigns, through the integration of Western and traditional medicine and practitioners and through a continuing emphasis on health work in the rural areas, the health system sets guide-lines for dispensing medical resources in order that the majority of people have access to health care and protection. For this reason and for many others, the new Chinese medical and health system will continue to be of interest to both the medical profession and national policy makers who must find alternatives for the existing stagnation of medical care among the rural peoples of the world.

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#### List of Abbreviations

SCMP Survey of the China Mainland Press

NCNA New China News Agency

CMJ Chinese Medical Journal

FBIS Foreign Broadcast Information Service