Challenging the Economic Reform Paradigm: Policy and Politics in the Early 1980s' Collapse of the Rural Co-operative Medical System

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ABSTRACT Over the last two decades an economic reform paradigm has dominated social security and health research: economic reform policies have defined its parameters, established its premises, generated its questions and even furnished its answers. This paradigm has been particularly influential in accounts of the early 1980s' collapse of China's rural co-operative medical system (CMS), which is depicted almost exclusively as the outcome of the post-Mao economic policies that decollectivized agriculture. This article draws primarily on government documents and newspaper reports from the late 1970s and early 1980s to argue that CMS collapse is better explained by a change in health policy. It shows that this policy change was in turn shaped both by post-Mao elite politics and by CMS institutions dating back to the late 1960s. The article concludes by discussing how an explanation of CMS collapse that is centred on health policy and politics reveals the limitations of the economic reform paradigm and contributes to a fuller understanding of the post-Mao period.

Over the last two decades, an economic reform paradigm has dominated research on social security and health in China.[1] The "economic reform period" has become the standard time frame for investigation, and economic policies adopted since the December 1978 Third Plenum are the common premise of inquiry.[2] Core questions revolve around the outcomes of these economic policies, which have also sometimes been seen as determinants of social change and systemic

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1 I use the term "paradigm" here in the Kuhnian sense, as defining the parameters of enquiry and establishing its central premises and questions, but I do not claim, as Kuhn does for the natural sciences, that the economic reform paradigm encompasses scientific laws and particular research methods or techniques. See Thomas S. Kuhn, *The Structure of Scientific Revolutions* 3rd ed. (Chicago: University of Chicago Press, 1996 (1962)).

2 The Third Plenum of the Chinese Communist Party's 11th Central Committee is conventionally taken as having initiated the economic reforms.

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pressures to which social policies must adapt. They are, for example, said to have led to rising poverty and inequality, and so to changes in urban poverty relief programmes, while state enterprise reforms have resulted in new pension policies.[3] Similarly, enterprise restructuring and the problems created "as China's economy took a market-oriented direction"[4] are argued to have led to the 1990s' urban health insurance reforms.[5] In the same vein, the economic policies that decollectivized agriculture and introduced household farming are conventionally argued to have caused the early 1980s' collapse of the rural co-operative medical system (*hezuo yiliao zhidu* 合作医疗制度, CMS).[6]

There are good reasons for the emergence and persistence of the economic reform paradigm. First, the Chinese government itself has put economic growth-oriented policies at the centre of its development strategy since 1978 and presents them as inevitable.[7] Second, studies of social security and health policies have often focused on finance, which may have oriented them towards economic matters. Third, researchers have often been concerned with influencing policies rather than explaining them. This is particularly true of Chinese social scientists for whom probing too deeply the reasons for change might be politically risky. Fourth, the economic reform paradigm has been influential in part because political scientists have paid little attention to social security and health policy.[8] Finally, and most importantly, the impact of economic reform policies on China's social security and health systems *has* been enormous.

3 Joe C.B. Leung, "Dismantling the 'iron rice bowl': welfare reforms in the People's Republic of China," *Journal of Social Policy*, Vol. 23, No. 3 (1994), pp. 341–61; Nelson Chow and Yuebin Xu, "Pension reform in China," in C. Jones Finer (ed.), *Social Policy Reform in China* (Aldershot: Ashgate, 2003).

4 Chack-kie Wong, Vai Io Lo and Kwong-leung Tang, *China's Urban Health Care Reform: From State Protection to Individual Responsibility* (Lanham, MD: Lexington, 2006). For a similar argument see Therese Hesketh and Wei Xing Zhu, "Health in China: the health care market," *British Medical Journal*, No. 314 (1997), pp. 1616–18.

5 Colleen M. Grogan, "Urban economic reform and access to health care coverage in the People's Republic of China," *Social Science and Medicine*, Vol. 41, No. 8 (1995), pp. 1073–84; X.Y. Gu and S.L. Tang, "Reform of the Chinese health care financing system," *Health Policy*, No. 32 (1995), pp. 181–91; L. S Ho, "Market reforms and China's health care system," *Social Science and Medicine*, Vol. 41, No. 8 (1995), pp. 1065–72.

6 See e.g. Xue-Shan Feng, Sheng-lan Tang, Gerald Bloom, Malcolm Segall and Xingyuan Gu, "Cooperative medical schemes in contemporary rural China," *Social Science and Medicine*, Vol. 41, No. 8 (1995), pp. 1111–18; Sheila Hillier and Shen Jie, "Health care systems in transition: People's Republic of China. Part 1: an overview of China's health care system," *Journal of Public Health Medicine*, Vol. 18, No. 3 (1996), pp. 258–65; Xuegai Kan, "Village health workers in China: reappraising the current situation," *Health Policy and Planning*, Vol. 5, No. 1 (1990), pp. 40–48; David Blumenthal and William C. Hsiao, "Privatization and its discontents: the evolving Chinese health care system," *New England Journal of Medicine*, Vol. 353, No. 11 (2005), pp. 1165–69.

7 Official policy has since at least 1992 taken the position that people who resist reform – whether officials or disgruntled workers for example – are simply conservatives who "need to change their thinking."

8 Exceptions include Tony Saich, *Providing Public Goods in Transitional China* (New York: Palgrave Macmillan, 2008); Gordon White, "Social security reforms in China: towards an East Asian model?" in R. Goodman, G. White and H.-J. Kwon (eds.), *The East Asian Welfare Model* (London and New York: Routledge, 1998); Mark L. Frazier, *Socialist Insecurity: Pensions and the Politics of Uneven Development in China* (Ithaca, NY: Cornell University Press, 2010); Dorothy J. Solinger, "Path dependency reexamined: Chinese welfare policy in the transition to unemployment," *Comparative Politics*, Vol. 38, No. 1 (2005), pp. 83–101.

While acknowledging the significant impact of economic policies, this article challenges the economic reform paradigm. It does so by showing that health policy (including pre-reform policy) and politics mattered just as much as economic policy in the early 1980s' collapse of CMS. Using State Council and Ministry of Health documents and Chinese newspaper reports, the article argues that CMS collapse was not simply a consequence of economic decollectivization after 1978. [9] In fact it was more precisely the result of a 1981 reversal in Ministry of Health policy. That reversal, like the economic reforms themselves, was in turn the product of elite leadership and ideological changes in the late 1970s. After the pre-Cultural Revolution Minister of Health was rehabilitated, CMS became labelled a Cultural Revolution policy and was abandoned. But while post-Mao politics created a critical juncture for CMS, the seeds of its demise can be traced back to 1960s' policies that established its core institutions.[10] CMS institutions failed to create strong stakeholders into the 1980s: the programme was locally funded and thus underfinanced, often delivered poor quality health services and did not put significant resources under the control of the health bureaucracy.[11] Other potential stakeholders, such as the local officials charged with running CMS, barefoot doctors who supplied the basic health services and the farmers who received those services, were either unwilling or unable to defend it.[12]

The article begins by introducing CMS, its Maoist and Cultural Revolution ties, and its institutional design, before setting out conventional explanations of its collapse. It then examines the Ministry's CMS policy reversal from the late 1970s into the early 1980s and shows how elite politics and institutional design contributed to that reversal. It considers why there was not greater opposition to the collapse of CMS from China's barefoot doctors and farmers. In conclusion, the article reflects on how attention to health policy and politics enhances our understanding of the wider post-Mao reforms and reminds us that economic policies are themselves politically driven. Finally, it sets out the reasons why political scientists should pay greater attention to Chinese social and health policy.

9 Although I have interviewed both national and local Chinese health researchers and officials, I have found none involved in late 1970s and early 1980s health reform initiatives (now 30 years ago) and able to comment authoritatively on them.

10 My analysis here has been influenced by other institutionalist work, notably that of Paul Pierson on policy feedback. See Paul Pierson, *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment* (Cambridge: Cambridge University Press, 1994).

11 My argument here is congruent with that of Linda Cook, who has shown bureaucratic stakeholders to be important to the fate of welfare and health in European authoritarian post-communist states. See Linda J. Cook, *Postcommunist Welfare States: Reform Politics in Russia and Eastern Europe* (Ithaca, NY: Cornell University Press, 2007).

12 In contrast, urban health insurance protections were better defended because they had a credible funding source – enterprises – and therefore brought resources to the bureaucratic stakeholders (local labour and social security bureaus) in control of them. They were also untainted by Cultural Revolution associations, had been longer established, and provided access to better quality health care. See Jane Duckett, *The Chinese State's Retreat from Health: Policy and the Politics of Retrenchment* (London and New York: Routledge, 2011).

The Co-operative Medical System

A Maoist initiative

The co-operative medical system is the name given to the totality of locally organized and funded rural health schemes that operated across China from the mid-1950s.[13] CMS was closely associated with Mao Zedong, and was promoted during periods when he was most influential: the mid-to-late 1950s and the 1966–76 Cultural Revolution.[14] Although it had collapsed in the economic and social disaster that followed the Great Leap Forward,[15] in 1965 CMS was reported in counties across more than ten provinces.[16] From summer 1968 it became a central feature of national health policy and, alongside barefoot doctors, part of a high profile Cultural Revolution initiative to improve rural health services.[17] At this time CMS was promoted using Maoist class rhetoric and in line with Mao's 1965 criticism of the Ministry of Health for urban bias and elitism.

Institutional design

Although CMS was an important part of national health policy in the late 1960s and 1970s, it was organized and delivered locally through sub-county communes and production brigades. The communes, brigades and their members contributed to the schemes, which then paid for some medical treatment and medicines. According to the Ministry of Health, the system worked as follows:

> Commune and brigade public welfare funds (*gongyijin* 公益金) and commune members each contributed to co-operative medical [system] funds (*hezuo yiliao jingfei* 合作医疗经费), collecting contributions of on average about 1.5 to 3 yuan per person once each year. When people then went to the health clinic (*yiliao zhan* 医疗站) for treatment the fee was reduced or exempted (*jianmian* 减免). The methods for reducing or exempting fees were manifold: sometimes patients paid the treatment fee but did not pay for medicine; sometimes their treatment and medicine costs were reduced or exempted; and sometimes they paid for medicine but not for such things as registration fees, injections and acupuncture.[18]

The CMS schemes were usually organized by the production brigades, which pooled contributions from their constituent production teams. Sometimes groups of contiguous brigades pooled funds on a slightly larger scale, and in some localities communes pooled funds across the brigades within them, but the schemes were always in the hands of sub-county collectives.[19] Barefoot doctors,

13 It did have antecedents in the 1940s CCP-controlled areas. See Jun Han and Dan Luo, *Zhongguo nongcun weisheng diaocha* (*China Rural Health Survey*) (Shanghai: Shanghai yuandong chubanshe, 2007).
14 Xinzhong Qian, *Zhongguo weisheng shiye fazhan yu juece* (*Development and Decisions in China's Health Work*) (Beijing: Zhongguo yiyao keji chubanshe, 1992).
15 David Lampton, *The Politics of Medicine in China: The Policy Process, 1949–77* (Boulder: Westview Press, 1977).
16 Xinzhong Qian, *Development and Decisions*.
17 Feng *et al.*, "Cooperative medical schemes"; Xuegai Kan, "Village health workers in China."
18 Ministry of Health (ed.), *Zhongguo weisheng nianjian 1983* (*China Health Yearbook 1983*) (Beijing: Renmin weisheng chubanshe, 1983), p. 206.
19 Lampton, *The Politics of Medicine*.

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who delivered health services through brigade clinics, were paramedics also expected to do agricultural work and paid in work points, the standard commune system of remuneration. Rural dwellers usually sought treatment at the brigade clinic, but depending on the generosity of their local scheme, might also attend their commune health centre or county hospital.

During the Cultural Revolution CMS was strongly promoted as an initiative to "guarantee" poor rural dwellers access to health care.[20] It helped them pay for treatment and medicines and reduced their direct "out-of-pocket" payments.[21] But because it was funded at the sub-county level, it was very often under-resourced. County government budgetary subsidies, which differed substantially from locality to locality, provided mainly for preventive programmes (vaccines, contraception and health campaign materials), training doctors, and paying county health workers' salaries and medical equipment.[22] CMS schemes therefore funded medicines and curative care provided through the brigade clinics and commune health centres. Given the widespread rural poverty in the 1970s, however, finance in most localities was extremely limited. This meant that CMS provided only very basic health care and relied heavily on locally grown herbal medicines. Local schemes were often bankrupted or suspended, particularly when harvests were poor.[23] Accounts of problems, particularly with shortages of finance, were common even when they were being promoted most heavily, during the late 1960s.[24]

Decollectivization Policy and its Impact on CMS

Although information on the prevalence of CMS schemes across China in the 1960s and 1970s is patchy, they seem to have been at their most extensive in the late 1970s, and they were abandoned mainly between 1982 and 1984.[25] While reliable accounts of the numbers of people participating in CMS during this period are unavailable, numerous accounts from within and outside China

20 See e.g. "Fully accept the cooperative medical system welcomed by poor, lower and middle peasants," *Renmin ribao* (*People's Daily*), 5 December 1968, p. 1.

21 It did not eliminate out-of-pocket payments. There are no reliable data for the 1970s, but data for 1980, when CMS was still relatively widespread, show patient fees to be 23% of total health spending. See Shaikh I. Hossain, "Tackling health transition in China" (Washington, DC: The World Bank, 1997).

22 Asian Development Bank, *People's Republic of China: Toward Establishing and Rural Health Protection System* (Manila: Asian Development Bank, 2002).

23 David Lampton, "The roots of interprovincial inequality in education and health services in China," *American Political Science Review*, No. 73 (1979).

24 See e.g. "Huangcun, liangxiang gongshe dui leyuan gongshe shixing hezuo yiliao zhidu de yijian" ("The opinions of Huang village, Liang commune, on Leyuan commune's implementation of the cooperative medical system"), *Renmin ribao*, 5 December 1968, p. 1.

25 Xinzhong Qian, *Development and Decisions*. The total amount of rural collective health fund spending halved between 1982 and 1983, from just over two billion yuan to just over one billion. See Hossain, "Tackling health transition."

indicate that by 1984 around only 5 per cent of villages had CMS, a dramatic fall from the much more widespread provision in the late 1970s.[26]

Where CMS schemes ceased operating in the early 1980s, some localities – encouraged by the Ministry of Health – experimented with "medical treatment contracts" (*yiliao chengbao hetong* 医疗承包合同).[27] But in other areas health service providers often simply charged fees that villagers had to pay directly out of their own pockets. This removal of health risk protection was explained away with remarkable sanguinity in the official Party newspaper *People's Daily* in 1981:

> To suit rural economic system reform, the rural health system currently is also undergoing some changes. In some localities where the economic conditions are a little lacking and the brigade runs a health clinic, they are implementing [a system in which] those who seek medical treatment pay the money (*shui kan bing shui jiao qian* 谁看病谁交钱).[28]

Official explanations like this, which portray health system changes as a consequence or requirement of economic reform, have been taken up by others within and outside China. Some for example have argued that the "socio-economic base of the co-operative medical scheme was initially the agricultural collective. When this was transformed into the household responsibility system at the end of the 1970s, most of the co-operative medical schemes collapsed."[29] More recently, others have stated that "the government suddenly and completely dismantled communes to privatize the agricultural economy. A side effect was to rip apart the health care safety net for most of rural China,"[30] and that "the abolition of collective farming and communes after 1982 resulted in the collapse of the co-operative medical system."[31] Studies that go into a little more detail tend to argue that CMS collapsed primarily because decollectivization removed collective funding for it, though they do not elaborate on the mechanisms through which this happened. Although some do mention other factors, including weakened administrative capacity,[32] "financial, political and managerial problems"[33] and the "problem of ideology,"[34] they are not fully explored.

26 It is not unusual to see estimates of around 90% of villages in China with CMS schemes in the 1970s, but David Lampton has shown pattern of CMS implementation to have varied enormously that decade. See Lampton, "The roots of interprovincial inequality," pp. 459–77. CMS participation rates remained low after 1984 until a "new" rural CMS was promoted from 2005.

27 *China Health Yearbook 1983*.

28 Zhenpeng Xu and Bingguang Chen, "Jiaqiang hezuo yiliao caiwu guanli de changshi" ("Strengthen attempts to manage co-operative medicine financial affairs"), *Renmin ribao*, 17 February 1981.

29 Gu and Tang, "Reform of the Chinese health care financing system," p. 186.

30 Blumenthal and Hsiao, "Privatization and its discontents," p. 1167.

31 Sukhan Jackson, Adrian C. Sleigh, Peng Li and Xi-Li Liu, "Health finance in rural Henan: low premium insurance compared to the out-of-pocket system," *The China Quarterly*, No. 181 (2005), pp. 137–57 at p. 137.

32 Victor C.W. Wong and Sammy W.S. Chiu, "Health care reforms in the People's Republic of China: strategies and social implications," *Journal of Management in Medicine*, Vol. 12, No. 4/5 (1998), pp. 270–86.

33 Gu and Tang, "Reform of the Chinese health care financing system," p. 186.

34 Xingzhu Liu and Huajie Cao, "China's cooperative medical system: its historical transformations and the trend of development," *Journal of Public Health Policy*, Vol. 13, No. 4 (1992), pp. 501–11 at p. 505.

It is understandable that post-Mao economic policy has been seized on as the main explanatory factor in CMS's collapse. Not only has the economic reform paradigm established the parameters and premises of the field, but the 1982–84 collapse is contemporaneous with the widespread introduction of household farming and the dismantling of the communes through which collective farming had been organized.[35] Moreover, decollectivization did remove sources of funding for CMS and incomes for barefoot doctors. Household farming meant farmers selling their produce directly to the state, and communes (now transformed into townships as set out in the 1982 State Constitution) and production brigades (now villages) no longer organized farming and controlled its revenues. The impact was three-fold. First, the significant agricultural income for commune (township) or brigade (village) collective funds that contributed to CMS came to an end. This was particularly important where the local economy was dominated by agriculture; the effects may have been mitigated in localities with collectively owned industry. Second, although rural dwellers had supposedly made voluntary contributions to CMS under collectivization, in fact these "contributions" were not paid directly by them, but were deducted from a production team's income before the end-of-year allocation of that income to its members.[36] The collective's capacity to gather these contributions was therefore also weakened by household farming that put revenues directly in farmers' pockets. Third, now that brigades and communes no longer managed production and its revenues, they abolished the work point system through which barefoot doctors had been paid to deliver health services, and this also effectively defunded CMS.

But explaining CMS collapse as a simple by-product of decollectivization is unsatisfactory for two reasons. First, it depoliticizes a highly political issue: the withdrawal of an important programme of public provision aimed at guaranteeing access to health services. CMS collapse increased the vulnerability of the rural population to the financial costs of ill-health and thereby to impoverishment, and economic policy does not explain why alternative sources of funding were not found. While brigades and communes lost income because of decollectivization, farmers were now required to pay agricultural taxes. CMS could have been funded from the new county government tax revenues, perhaps alongside mandatory individual contributions.

Second, decollectivization is not plausible as the main causal factor behind the collapse because CMS was a programme under the responsibility not of the Ministry of Agriculture but of the Ministry of Health. Under Chinese government norms CMS could not be abandoned nationally without Ministry of Health permission. China's political system in the early 1980s remained tightly controlled, and local health officials would be unlikely to abandon a national

35 According to Carl Riskin, the household responsibility system was in place in most parts of the country between mid-1982 and 1983. Carl Riskin, *China's Political Economy: The Quest for Development since 1949* (Oxford: Oxford University Press, 1987).

36 Han and Luo, *China Rural Health Survey*.

programme so quickly without approval from higher levels. For this reason, if we are to understand the real causes of the collapse we must examine the Ministry of Health's policy towards CMS.[37]

The Ministry of Health's CMS Policy Reversal

The Ministry of Health had been charged with establishing and overseeing CMS since before the Cultural Revolution, and in the early post-Mao period it restated its commitment to guaranteeing rural dwellers' access to health care. From late 1979, however, it became more ambivalent and began to permit some localities to charge fees. Then in 1981 the Ministry completely reversed its initial post-Mao policy stance, labelling attempts to extend CMS a "leftist error" and abandoning it. This shift from commitment to abandonment is set out in more detail below.

Continued commitment, 1977–79

In the immediate post-Mao period, the Ministry of Health retained its commitment to CMS. In 1977, it reaffirmed its pro-rural focus in health policy and announced plans to develop it.[38] CMS was even mentioned in the new 1978 State Constitution.[39] And in March 1979, at a national meeting of health bureau leaders, the Ministry of Health defended CMS, reclaiming it as a 1950s initiative associated with the co-operativization of agriculture and the creation of the communes.[40] Deng Xiaoping's presence at this meeting seems to indicate that CMS retained support right at the apex of the new, reform-oriented party-state leadership.

The Ministry's commitment to CMS was apparently consolidated in December 1979 when it promulgated jointly with several other government bodies a CMS "constitution."[41] This document described CMS as a form of "welfare" and an important part of health department work. It also stipulated that communes and brigades experiencing difficulties with their schemes should receive state assistance. And it made clear that CMS-funded village health services should

37 I do not intend to imply here that the Ministry of Health was powerful within central government. Indeed the discussion below shows how it was constrained by the wider central government commitment to economic growth and decollectivization. However, the Ministry still did have considerable influence over health policies, particularly those that were congruent with the post-Mao modernization agenda and did not impinge on other ministries' interests.

38 "Yingming lingxiu Hua zhuxi zhichu: zhunque de wanzheng de guanche zhixing Mao zhuxi geming weisheng luxian" ("Wise leader Chairman Hua points out: accurately and completely carry out the implementation of Chairman Mao's revolutionary health line"), *Renmin ribao*, 20 August 1977.

39 Han and Luo, *China Rural Health Survey*.

40 See Xinzhong Qian, "Woguo weisheng shiye shengli fazhan de huigu" ("A retrospective on the victorious development of health work in our country"), in *China Health Yearbook 1983*.

41 Ministry of Health, Ministry of Agriculture, Ministry of Finance, State Administration for Medicine Management and the National Supply and Marketing Co-operative, "Nongcun hezuo yiliao gongcheng, shixing cao'an" ("Rural co-operative medicine constitution, draft programme for implementation"), issued on 15 December 1979.

be provided though non-profit seeking clinics.[42] That same month, Minister Qian Xinzhong 钱信忠 put rural health work first on his list of priorities for 1980, reiterating its importance as "socialist welfare work."[43] He argued that mutual help should be preserved and said that CMS's importance was in "guaranteeing 800 million rural dwellers' access to health services and medicine" (*baozhang ba yi nongmin kanbing chiyao* 保障八亿农民看病吃药). Thus he retained its Cultural Revolution goals, albeit stripped of the Maoist class rhetoric of "poor, lower and middle peasants."

Qian's December 1979 speech and the CMS constitution did, however, for the first time permit rural governments to implement schemes according to local circumstances. Most significantly, the Ministry specifically allowed variation in the collection of co-operative funds and the proportions of medicine costs that could be reimbursed. Crucially, it also permitted patients to be charged wholesale prices where funds were temporarily insufficient to finance reimbursements or where CMS was not favoured locally.[44] Although this fee charging would have been common practice, it appears to be the first time that the Ministry officially allowed it, and it marks a shift from the Cultural Revolution policy of insisting on nationwide implementation.

Ambivalence, 1980

In 1980 the Ministry of Health's position on CMS became increasingly ambivalent. In a speech in January that year, Qian, while noting its importance for rural dwellers' health, again gave permission for local variation. Although he apparently anticipated CMS developing in line with the collective economy so that "the proportions of medical fees that are reimbursed should gradually be raised,"[45] he warned against prematurely reimbursing too high a proportion of farmers' medical costs for fear of bankrupting the schemes. And he also noted CMS should not increase the economic burden on farmers, an important issue at the time because it had led rural dwellers to protest in Beijing.[46]

Through the year, the Ministry's calls for taking into account local economic conditions became more prominent. In March 1980, Qian, while still making CMS a priority, encouraged flexibility based on local conditions when deciding on methods for gathering funds and the proportions of medical expenses to be reimbursed. He also stressed the need for health work to serve national

42 Note, however, that the CMS constitution envisaged CMS developing along with the collective economy. Perhaps at this stage it was supported by pro-collective forces within the Ministry of Health against whom the tide was about to turn.

43 Xinzhong Qian, "Zai quanguo weishengjuzhang huiyi shang de jianghua (zhaiyao)" ("Speech at a national health bureau chief meeting (extract)"), 29 December 1979, in *China Health Yearbook 1983*.

44 *Ibid*. p. 33.

45 Xinzhong Qian, "Zai quanguo weisheng juzhang huiyi shang de zongjie jianghua (zhaiyao)" ("Concluding speech at a National Health Bureau Chief Meeting (extract)"), 5 January 1980, in *China Health Yearbook 1983*.

46 Thomas P. Bernstein and Xiaobo Lü, *Taxation without Representation in Contemporary Rural China* (Cambridge: Cambridge University Press, 2003).

modernization.[47] By May, *People's Daily* was arguing that some localities had encountered problems with CMS because they had not "set out from economic conditions."[48]

Abandonment, 1981

The year 1981 was the watershed for CMS as the Ministry of Health linked it to Cultural Revolution leftism and abandoned it. In January 1981, the Ministry began by further reducing its commitment. It emphasized funding, the delivery of health services and the availability of doctors rather than the access to services that CMS afforded villagers. At the national health bureau leaders' meeting that month, Qian gave two speeches. In the first, he repeated that localities could temporarily suspend CMS and charge fees for medical treatment, but he did not mention the need to charge wholesale prices. He also indicated that priority should be given to ensuring that "production brigades have doctors, medicine and health service providers, and people responsible for preventive health construction and birth planning work," arguing that barefoot doctors were crucial to CMS.[49]

But in his closing speech to the January 1981 meeting, Qian went further. He stated that it was a "leftist error to stress raising the reimbursable proportions and scope of CMS without considering the objective economic situation and the masses' wishes."[50] This marked a reversal and a clear attempt to associate CMS with the Cultural Revolution.[51] Subsequent accounts of the January 1981 health meeting indicate that it had taken a decisive turn away from core Cultural Revolution policies on health, including CMS. Reportedly, the meeting was critical of "the mistaken view, influenced by leftist thinking" that "health work is social welfare work, that if there is more and more state protection, more and more free preventive care, and fees for treatment and medicine prices are continually lowered, then this will embody the superiority of socialism."[52] This is a clear reversal of the position taken by the Ministry less than two years earlier in March 1979 when Qian had stated that "our country's medical and health work is social welfare work."[53] From late January 1981 onwards,

47 "Weisheng gongzuo yao geng hao de wei sihua fuwu" ("Health work must better serve the four modernizations"), *Renmin ribao*, 7 March 1980.

48 Haolin Du, "Nongcun hezuo yiliao zhidu de gaige" ("Rural co-operative medical system reform"), in Ministry of Health (ed.), *Zhongguo weisheng nianjian 1984* (*China Health Yearbook 1984*) (Beijing: Renmin weisheng chubanshe, 1984).

49 Xinzhong Qian, "Zai quanguo weisheng tingjuzhang huiyi shang de jianghua (zhaiyao)" ("Speech at a national meeting of health bureau chiefs (extract)"), 16 January 1981, in *China Health Yearbook 1983*.

50 Xinzhong Qian, "Guanche tiaozheng fangzhen, jiaqiang weisheng shiye jianshe" ("Grasp the adjustment line, strengthen the construction of health work"), concluding speech at a meeting of national health bureau chiefs, 24 January 1981, in *China Health Yearbook 1983*.

51 Qian himself has also since argued that CMS was allowed to "disintegrate" in part due to an "anti-'leftist' wave." Xinzhong Qian, *Development and Decisions*, p. 96.

52 Xinzhong Qian, "Woguo weisheng shiye shengli fazhan de huigu" ("A retrospective on the victorious development of health work in our country"), in *China Health Yearbook 1983*, p. 14.

53 Xinzhong Qian, "Ba weisheng bumen de gongzuo zhongdian zhuanyi dao yiyao weisheng xiandaihua jianshe shang lai (zhaiyao)" ("Shift the emphasis in health department work to the construction of medicine and health modernisation (extract)"), in *China Health Yearbook 1983*.

CMS is rarely mentioned in Ministry of Health policy statements and work reports.[54] Instead, the Ministry moved to supporting contracts between barefoot doctors and local collectives (whether communes, brigades or "organizations of rural dwellers"), and permitted private out-of-pocket payments (*zifei yiliao* 自费医疗 or *kan bing shou fei* 看病收费).[55]

The central policy shift was soon picked up in the localities. Many began experimenting with contracts in health in the early 1980s, perhaps as early as 1981 and certainly by 1983, while in other areas there was a direct shift to villagers paying for their medical costs themselves.[56] The widespread local response reflects local government officials' sensitivity to political changes at the centre in the early 1980s. Previous swings in ideology and the political purges that had often accompanied them since the founding of the People's Republic in 1949 meant that by the 1980s local leaders are likely to have felt that they needed to demonstrate they were not themselves "leftists." Once it was clear that the Cultural Revolution was to be thoroughly repudiated, and once CMS was associated with that period, local leaders were often afraid to defend it.[57] Given the problems there had evidently been with the long underfunded schemes in many localities and the further decline in co-operative funds with the switch from collective to household farming, it is not surprising that local government officials abandoned programmes. Indeed officials in localities that had *not* abandoned CMS reported in the early 1980s that they were afraid that they would be punished.[58]

Elite Politics and Ministry of Health Priorities

What, though, explains the Ministry of Health's change in policy? First, it was influenced by leadership appointments as Deng Xiaoping began to emerge as China's pre-eminent leader in the late 1970s. Central and local leaders who had been criticized and removed from governmental posts in the Cultural Revolution were reinstated, including Qian Xinzhong, purged from his post as Minister of Health in June 1968 and again made Minister in March 1979. Ji Zongquan 季宗权, another key reformer who worked closely with Qian, was made Vice-Minister in February the same year.[59] Both leaders, but especially

54 There are few references to it until the end of the 1980s when it came back on to the policy agenda.

55 Haolin Du, "Rural co-operative medical system reform"; Haolin Du, "Nongcun zhong duozhong xingshi de yiliao zhidu" ("The multi-form medical system in the countryside"), in *China Health Yearbook 1983*.

56 Du reports that "In recent years … many localities have implemented medical contracts … and others have implemented a system of self medical self payment, that is [a system in which] the person going to the doctor pays the money." Haolin Du, "The multi-form medical system," p. 206.

57 Also noted by Feng *et al.*, "Cooperative medical schemes."

58 Reported by Xinzhong Qian, *Development and Decisions*.

59 Haidong Cao and Jianfeng Fu, "Zhongguo yigai 20 nian" ("20 years of health reform in China"), *Nanfang zhoumo* (*Southern Weekend*), 4 August 2005, at http://news.sina.com.cn/h/2005-08-04/10427410736.shtml, accessed 6 August 2007. This newspaper article was written during the publicity

Qian, who was trained in medicine, are associated with a range of post-Mao policies to extend "socialist modernization" – the stated goal of the Dengist reformers – to health. At the same time, the Ministry of Health benefited from the reform strategy's focus on science and technology, one of the "four modernizations" and something the new Ministry leadership was keen to develop.[60] It also benefited from the reformers' support for expertise and training that had been opposed during the Cultural Revolution when educated "intellectuals," including medical professionals, were vilified.[61]

Second, as Deng Xiaoping consolidated his power there was an ideological swing against egalitarian "leftism" as the reformers engaged in a vituperative criticism of the Cultural Revolution, its leaders and its policies.[62] It was in this context that CMS, a prominent Maoist initiative from 1968, was labelled a "leftist product," became "thoroughly discredited" and had to be "reformed out" (*gaigediao* 改革掉).[63] The timing of the Ministry's abandonment of CMS, in early to mid-1981, corresponds to the events that year that saw the Cultural Revolution formally repudiated by the CCP leadership in its June 1981 "Resolution on certain questions in the history of our Party."[64]

But resources were also an important factor. Crucially, the Ministry of Health did not have a real stake in CMS because it did not bring the Ministry or its subordinate health departments control over a significant budget item. CMS institutions from at least the late 1960s (and probably earlier) gave control over funds to production brigades rather than to county (or higher level) health departments. And because schemes were only financed by brigades and communes, they were usually under-resourced. Thus when agricultural decollectivization removed local collective funding for CMS, it impacted only indirectly on health departments' resources by reducing income to the brigade clinics they oversaw. In any case the Ministry was able to turn to other mechanisms for funding the lowest tier of rural health service provision: in addition to supporting contracts between barefoot doctors and local collectives, and permitting out-of pocket payments, it also sought – and received – from the State Council permission for small-scale private practice to "supplement" state and collective health service

footnote continued

following a very critical report on China's health reforms published by the Development Research Centre in 2005.

60 Xinzhong Qian, "Shift the emphasis in health department work."

61 See e.g. "The opinions of Huang village, Liang commune." This article refers to doctors "losing their smell" when they go down to the countryside, a reference to the Cultural Revolution classification of intellectuals as the "stinking ninth category" inferior to the peasant and worker classes.

62 Stuart R. Schram, "'Economics in command?' Ideology and policy since the Third Plenum, 1978–84," *The China Quarterly*, No. 99 (1984), pp. 417–61.

63 Xinzhong Qian, *Development and Decisions*, p. 102. This book was written by the 1979–82 Minister of Health.

64 "Resolution on certain questions in the history of our Party since the founding of the People's Republic of China," adopted by the Sixth Plenum of the 11th Central Committee on 27 June 1981.

provision.[65] This enabled doctors to practise medicine even where there was no CMS funding or collectively run clinic.[66]

After the State Council granted permission for private practice, the Ministry of Health began to encourage it at the expense of CMS.[67] By 1983, it was portraying CMS as simply a source of finance for rural health services alongside contracts and fee-for-service, and had dropped all references to guaranteeing rural dwellers' access to doctors and medicine.[68] The result was that by 1983, 32 per cent of rural health service providers were small-scale private practices and by 1985 the proportion was 44 per cent.[69] The Ministry's prioritization of financing services over guaranteeing farmers access to them reflects its long-established primary responsibility for health service providers. It also stems from its poor understanding of insurance and risk protection: discussing the Ministry's abandonment of CMS in favour of private practice, former Minister Qian has said that "in retrospect health department leadership levels had had a rather vague understanding of the theory and practice of CMS" in the early 1980s.[70]

Overall, then, without a direct stake in CMS, and with other funding mechanisms now possible, Ministry of Health leaders may have calculated that the programme was not worth defending, particularly given the underfunding and problems many localities had experienced even before decollectivization. Instead, the Ministry focused on promoting private practice in particular,[71] but also other policies, such as developing medical science and technology and improving medical professionals' education, training and skills, that were more likely to win support and resources because they were congruent with the Dengist reformers' wider modernization programme.[72]

65 Small-scale private practices across the country had been severely criticized as capitalist during the Cultural Revolution and 44,000 of them were eradicated. See Ministry of Health, "Weisheng bu guanyu yunxu geti kaiye xingyi wenti de qingshi baogao" ("Ministry of Health report asking for instructions concerning the question of permission for individual health practices"), 20 August 1980, in Ministry of Health Office (ed.), *Zhonghua renmin gongheguo weisheng fagui huibian 1978 nian–1980 nian* (*Collected Health Laws and Regulations of the People's Republic of China, 1978–1980*) (Beijing: Falü chubanshe, 1982).

66 In its report asking for permission, however, the Ministry's arguments for CMS were ones that would appeal to top leaders: private practice was already emerging spontaneously and that permitting it would enable it to be managed; it would provide work for unemployed medical practitioners; it would make visiting a doctor more convenient for "the masses"; and it would "serve the four modernizations." *Ibid*.

67 Argued by Qian Xinzhong. See *Development and Decisions*.

68 Xinzhong Qian, "Wo guo weisheng shiye shengli fazhan de huigu" ("A retrospective on the victorious development of our national health work"), in *China Health Yearbook 1983*. Qian cited the guarantee in his 16 January 1981 speech, but did not mention it in his anti-leftist speech on 24 January 1981 and it does not appear in Ministry documents thereafter.

69 Xinzhong Qian, *Development and Decisions*; Haolin Du, "Dadui (cun) weisheng jigou de gaige" ("Brigade (village) health service provider reform"), in *China Health Yearbook 1984*.

70 Xinzhong Qian, *Development and Decisions*.

71 Qian reports that although there had also been good examples of good practice, CMS was abandoned in the rush to private practice. See *ibid*.

72 "Health modernization" is the focus of the Minister's annual work report in March 1979, where it is seen as the key to all health work. See Xinzhong Qian, "Shift the emphasis in health department work." Here, the health sector's "concrete tasks for 1979," which are conventionally in order of priority, were set out as: reorganizing the management of health service providers; strengthening medical science

Absence of Opposition from Societal Interests

But it was not just that there was there no bureaucratic stakeholder to defend CMS. There also appears to have been limited opposition to its collapse among societal stakeholders: the barefoot doctors who worked within the system and the rural dwellers protected, albeit patchily, by it. The barefoot doctor policy had been promoted alongside CMS during the Cultural Revolution and these rural paramedics were the key deliverers of rural collectively funded health services. They may not, however, have been motivated to defend CMS. Centrally, this is because when CMS was abandoned they had other options. Because they had been part-time practitioners who also worked in the fields in the 1970s, they were easily able to return full-time to the now more lucrative agricultural work.[73] Alternatively they could move into private practice: although the September 1980 State Council approval for private medical practice stipulated that barefoot doctors should not usually practise privately, it gave permission for them to do so in poor areas.

There also appears to have been little opposition to the collapse of CMS from among China's rural dwellers, the main beneficiaries of the programme. One late 1970s account argued that it would be hard to take CMS away because farmers had become accustomed to having the curative care that it helped fund.[74] But this anticipated opposition apparently did not materialize. Of course, farmers had few formal channels for expressing dissatisfaction with central policy to roll-back CMS. Notably, they were unable to form independent associations through which to articulate their interests collectively. But farmers did organize public protests over other issues in the early 1980s, and they apparently did not did not do so over CMS.[75]

There are three key reasons for this absence of public protest. First, CMS often provided low-quality medical care. A report in 1978 (when the programme was still officially in favour) noted for example that commune members who had made contributions to CMS schemes were sometimes unhappy with the quality of treatment they received.[76] Second, CMS may have become associated by

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research; strengthening medical education; continuing to focus on prevention; combining traditional and western medicine; pharmaceuticals management; birth control; and foreign affairs.

73 Lampton, *The Politics of Medicine in China*. Barefoot doctors' incomes began to decline relative to those of farmers as agricultural incomes rose. Note that the Ministry of Health did argue that barefoot doctors' wages should be increased. See State Council, "Guanyu nongcun geti gongshangye de ruogan guiding" ("Some regulations concerning rural individual industrial and commercial business"), 27 February, 1984.

74 Lampton, *The Politics of Medicine in China*, pp. 241–42.

75 Bernstein and Lü, *Taxation without Representation*. I have found no accounts of protests in defence of CMS.

76 Changlu Huang, "Chijiao yisheng xuyao tigao: canjia Qinghaisheng weisheng gongzuo huiyide ganbu he chijiao yisheng lianxi shiji, pipan 'Sirenbang' fandui, pohuai chijiao yisheng tigao yiliao jishu de fangeming zuixing" ("Barefoot doctors must improve: cadres and barefoot doctors participating in Qinghai provincial health work meeting connect with reality and criticize the 'Gang of Four's'

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villagers with the sometimes predatory and corrupt behaviour of local officials and the so-called "farmer's burden" created by many non-tax charges, some of them illegal, that officials levied on rural dwellers. Certainly, in the late 1970s, accounts of the "peasant burden" problem did mention CMS contributions.[77] And the fact that the Ministry of Health at times felt it necessary to challenge such accounts indicates it was a significant problem.[78] Finally, farmers, like officials, may have feared retribution for supporting leftist policies, and so may not have articulated their opposition to the collapse of CMS.[79]

Conclusion

Health policy and the politics surrounding it, including feedback from pre-reform policies, were central to the early 1980s collapse of CMS. This shows the limits of explanations based on post-1978 economic policy and thus of the economic reform paradigm in social security and health research. But this article also shows that research on social security, health policy and politics can enhance our understanding of China's post-Mao reforms. First, health policy was not simply reactive in the early post-Mao period; it also contributed to the reform project. Rehabilitated health officials were part of the reformist national leadership and they not only abandoned collectivist CMS and promoted pro-professional, scientific and technological modernization, they were also at the forefront of reform,[80] adopting some health policies that preceded and may have paved the way for reformist economic policies. An example is the Ministry's request for State Council approval of private medical practice in 1980. It followed very quickly on 1979 CCP Central Committee and State Council permission for small-scale private economic activity (*geti jingji* 个体经济) in repairs and handicraft work,[81] and it preceded the 1981 permission for urban small-scale private trade and commercial businesses (*geti gongshanghu*

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counterrevolutionary crime of opposing and damaging barefoot doctor improvement and medical technology"), *Renmin ribao*, 9 June 1978. See also Xuegai Kan, "Village health workers in China."

77 Jingcun Yang, Yongnian Jiao and Aihong Wang. "Ni chou ta chou sheyuan fachou" ("You gather, he gathers, commune members worry"), *Renmin ribao*, 8 December 1979.

78 Xinzhong Qian, "Concluding speech," 5 January 1980.

79 The 5% of villages that retained CMS are likely to have had schemes that worked reasonably well. They may have been localities where rural industry brought in collective revenues that allowed CMS to be relatively generously funded, or where local officials and their superiors were promoted in the Cultural Revolution and prepared to risk retaining schemes.

80 Cao and Fu, "20 years of health reform." These authors argue that the Ministry took a lead in the reforms with health policy initiatives to introduce material incentives.

81 "Guanyu quanguo gongshang xingzheng guanlijuzhang huiyi de baogao" ("Report concerning a national meeting of industrial and commercial administration bureau chiefs"), approved by the State Council. The meeting was held in February 1979 and approval was reportedly given soon after. See "Guojia gongzhangzongju juzhang Zhou Bohua tan gongshang xingzheng guanli jiguan 30 nian de gaige fazhan" ("State administration for industry and commerce bureau chief Zhou Bohua discusses 30 years of industrial and commercial administration department reform and development"), Xinhua, 24 September 2008.

个体工商户), the 1982 State Constitution's inclusion of small-scale private economy, and 1984 permission for rural small-scale industrial and commercial businesses.[82]

Second, health policy and the politics surrounding it also contribute to our understanding of some of the more fundamental political transformations of the post-Mao period. For example they show more clearly than economic policy the values and ideological underpinnings of the reformist strategy. That strategy, when seen simply as an economic one, may seem "pragmatic" even though it values wealth creation over equity. It has certainly been portrayed that way by international scholars perhaps influenced by the fact that marketization was a move toward doing things "our way."[83] But the Ministry of Health's decision to abandon CMS[84] – and the fact that it was not blocked elsewhere in the central government – at a time when economic policies were beginning to produce (indeed encourage) income inequalities, reveals a clear rightward shift in political values and ideology.[85] It serves also to remind us that economic reform policies are not value-neutral or without ideological foundation.

Given their ability to shed light on these important ideological issues, it is surprising that the field of Chinese politics has neglected health and social policy. But political science research, too, has been preoccupied with economic reform and its consequences. It has focused predominantly on outcomes such as the emergence of a middle class, the rise of the private sector and the development of civil society. And its core questions have centred on their implications for state–society relations and their potential to catalyse democratization. But the big political issues in China's transformation – who gets what, when and how[86] – are not only those that result from economic policy. As this study of CMS collapse has shown, social and health policies also have enormous redistributive consequences. In changing entitlements to state provision and reshaping or removing safety nets, they contribute to the wealth of some and may plunge others into poverty; and by significantly shifting the balance of state resources across the population, they create powerful new stakeholders and transform state–society relations in ways that tell us much about Chinese politics today and the forces likely to shape them in the future.

82 State Council, "Guanyu chengzhen feinongye geti jingji ruogan zhengcexing guiding" ("Some policy-type regulations concerning urban and town non-agricultural individual economy"), 7 July 1981; National People's Congress, *The Constitution of the People's Republic of China* (Beijing: Foreign Languages Press, 1982); State Council, "Some regulations concerning rural individual industrial and commercial business."

83 Susan Shirk and others have shown economic reforms to have had political motivations but not more right wing ideological ones. See Susan Shirk, *The Political Logic of Economic Reform in China* (Berkeley: University of California Press, 1993).

84 Even if CMS had not been as successful as it is often portrayed, and did not in the 1970s guarantee access to health services, there had been a commitment to expanding and improving it.

85 Minister Qian himself has noted this in relation to health policy in the early 1980s: "the socialist direction in health work was not clear enough" (*shehui zhuyi ban yi fangxiang bu gou mingque*). Xinzhong Qian, *Development and Decisions*, p. 96.

86 The classic definition of the subject of politics as set out in Harold D. Lasswell, *Politics: Who Gets What, When and How* (Gloucester, MA: Peter Smith (1950 ed), 1935).