Health Policy During the Great Leap Forward

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Introduction

Heretofore, analysts have argued that one characteristic of mobilization in China is to provide uniformity in policy direction. This paper sets out to demonstrate that, in at least the public health area, a diverse set of public policies was pursued even in a period as apparently " radical " as the Great Leap Forward (1958–60). The reason for this policy diversity is that different segments of health policy were made in different political arenas, or institutional settings; the pressures, perceptions and resources which characterized one of these political arenas did not necessarily characterize another.[1] The " failures " of the Leap did not simply arise from a ubiquitous " radical " assertion of power but, on the contrary, resulted from the inconsistencies in leadership and programme characteristic of diverse policy-making arenas. Because policy-making responsibility is divided among political arenas, political bargaining and conflict have characterized the allocation to them of different health issues; elaborate strategies have been devised by organizations in order to acquire and/or hold certain areas of policy and unburden themselves of others.

A four-stage analysis develops this case: (1) how diverse were Great Leap policies? (2) Which health issues were placed in which political arenas and (3) what was the political process by which these issues were allocated among policy-making arenas? (4) What were the characteristics of each political arena and what impact did these peculiarities have on subsequent policy?

The implications of this approach are several, but two points may be anticipated. First, this approach suggests that one major point of contention in Chinese politics is the battle over which organization *comes* to, or *has* to, make policy. The second implication is that if different aspects of health policy are allocated to various arenas through

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1. For an excellent theoretical treatment of political arenas, see Marc J. Swartz, *Local Level Politics* (Chicago: Aldine, 1968), pp. 1–46.

a political process, then there will be difficulties in achieving administrative co-ordination; the actions taken in one policy arena may conflict with those taken in another.[2] I will argue in this article that the difficulties of the Leap derived as much from the fragmentation of the policy-making process as from its dogmatism.

Finally, one must also ask whether medical policy-making is in some sense *sui generis*. Can concrete findings in this specific area be generally applied to all modes of policy-making in China? Some important reasons exist for thinking that health policy-making processes are not absolutely "typical," though almost all fields are "atypical" in some respect. First of all, until recently doctors in China have been somewhat independent of strict Party political control.[3] One interviewee noted:

> Doctors and nurses were left pretty much to themselves without any form of interference from their school authorities or any other outside authority. Respondent said it was like being on an island apart from everyone, and it was a strange feeling to have no one controlling them.[4]

Secondly, it is very hard to know what the actual content of political supervision in medical affairs is, or could be. How can a Party cadre prevent favouritism in drug distribution, or prevent drug waste, if he does not know about pharmaceuticals? As we shall see, there has been a consistent trend for medical doctors to dominate the Ministry of Public Health (Weishengpu). Thirdly, because so many Party cadres are entitled to " free medical care " (*kung-fei yi-liao*), they also have an interest in the maintenance of quality services; their interests as patients are not totally in conflict with the interests of physicians trained in western practices. In short, the patterns of health politics during the Great Leap are not necessarily duplicated in all other policy areas; the extent of similarity remains to be demonstrated through empirical research.

The Diversity of Great Leap Health Policy, 1958–60

Medical policy is an interesting case study to examine because it did not move in any uniform "ideological" or "mobilizational" direction as the cyclical model would lead us to expect.[5] " Health care " consists

2. Charles E. Lindblom, *The Intelligence of Democracy* (New York: Free Press, 1965). This study provides an excellent analysis of problems of policy co-ordination and discusses " hierarchical " and " partisan mutual bargaining " as two pure types of policy-making organization.

3. " Speech made by Chairman Mao at a standing committee meeting of the Central Committee " (Spring 1955). *Hsin jen wei* (*New People's Health*) (Peking: People's Health Press, 1967), p. 9.

4. Ezra Vogel, *Interview No. 12*, p. 1. I would like to thank Professor Vogel for making his unpublished interview protocols available to me. The interview numbers were assigned by me.

5. G. William Skinner and Edwin Winckler, " Compliance succession in rural Communist China: a cyclical theory," in Amitai Etzioni (ed.), *A Sociological Reader on Complex Organizations* (New York: Holt, Rinehart, and Winston, 1969), pp. 410–38.

of at least six sub-issues: medical education, medical research, the structure of the health care delivery system, health care financing, traditional medicine and mass campaigns. In addition, one could add birth control, industrial safety, environmental protection and product inspection, though these will not be discussed here.

Policy for each of the six sub-issues during the Great Leap moved in a diversity of directions, no matter which dichotomy one uses: radical/conservative, mass/elite, or urban/rural. Some policies changed dramatically and others hardly at all. During periods such as the Great Leap Forward, the mass media tend to become saturated with articles and broadcasts focussing attention on areas of substantial change. As a consequence of this focus, the outside observer often ignores the substantial degree of policy continuity which may exist in a decidedly "radical period."

Medical Education. In 1958, Chairman Mao issued a directive on education in which he said: "Education must serve proletarian politics and education must be combined with productive labor ... the period of schooling should be shortened, education should be revolutionized."[6] While the number of middle-level doctors (trained for three years) being produced annually was increased by 50–75 per cent during the Great Leap,[7] higher level medical education was lengthened from five to six years in Peking Medical College, Tientsin Medical College and Shanghai First Medical School in the first months of 1959; in China Medical University, the length of the curriculum was extended to eight years.[8] Premier Chou En-lai made this policy explicit by saying:

> Full-time regular schools at all levels should make it their constant and fundamental task to raise the quality of teaching and studying; in the first place we must devote relatively more energy to perfecting a number of *key schools* so as to train specialized personnel of higher quality for the state and bring about a rapid rise in our country's scientific and cultural level [emphasis added].[9]

In short, while the vocal thrust of the Great Leap Forward consisted in reducing the length of education, important medical schools were moving in precisely the opposite direction.

6. Cited in "Thoroughly criticize and repudiate the eight year medical education program pushed by China's Khrushchov," *China's Medicine,* No. 3 (1968), pp. 164–65.

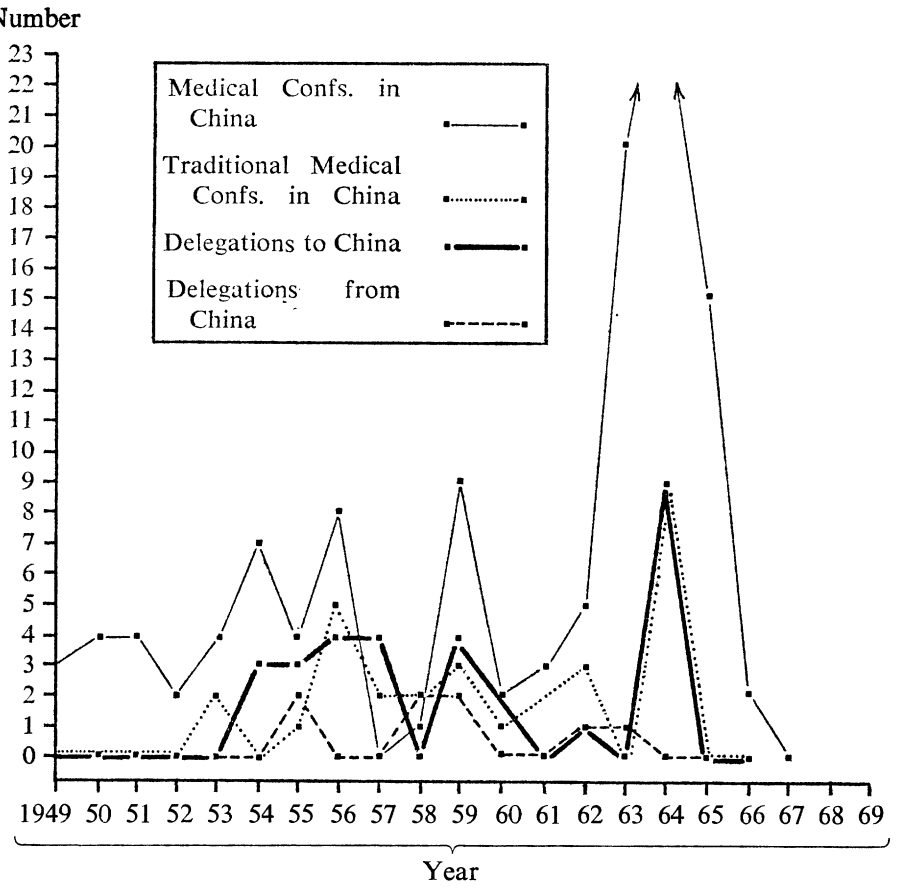
7. David M. Lampton, "The Politics of Public Health in China: 1949–1969," Stanford University Ph.D. Dissertation, 1974, pp. 159–66; also, Chu-yuan Cheng, "Health manpower in China," paper presented at the Macy Foundation Conference on Public Health in China, Ann Arbor, Michigan, May 1972.

8. "Thoroughly criticize and repudiate the eight year medical education program:" also, Maud Russell, "Medicine and public health in the People's Republic of China," *Far East Reporter* (n.d), pp. 12–13.

9. Chou En-lai, "Report on Government work," (18 April 1959), *Current Background* (*CB*), No. 559, pp. 16–17.

Medical Research. One area of medicine which Mao and Party political cadres had strenuously denounced from 1949 on was the professionalism (sectarianism) of elite medical doctors – their overemphasis on "exotic" medical research. If the actual thrust of research policy had conformed to verbal declarations, the indicators of professionalism (e.g. substantive conferences and trips abroad) would have declined and the number of "exotic" research articles appearing in major medical journals would have dropped. In reality, however, research policy appears to have been something quite different.

Chart: **Number of Medical Conferences Held and Attended by Chinese**



Note: The comprehensiveness of this chart is open to question because the Chinese authorities have provided no consolidated list of conferences either held or attended. As a result, the conferences have had to be culled from the media and this process no doubt introduces the possibility of overlooking some meetings and double-counting others.

The chart on p. 671 shows that more high level medical research conferences were attended and held by the Chinese in late 1958 and 1959 than at any time prior to those two years. Similarly, the following table, which provides a full content analysis of the *Chinese Medical Journal* for the years under discussion, shows that while radical rhetoric called for research which had a direct relationship to the masses, the number of research articles dealing with complex and rare diseases did not decline.

Content Analysis of the *Chinese Medical Journal*

Date	Colateral Event	Exotic Research		"Mass-oriented" Research
Jan.–Feb. **1955**		75		25
March–April		62·5		37·5
May–June		83·4		16·6
July–August		66·6		33·4
September–October		57·2		42·8
November–December		71·5		28·5
Jan.–Feb. **1956**	Politburo meetings on intellectuals and science	87·5		12·5
March–April		100	74%	0
May–June		91		9
July–August		100		0
September–October		87·5		12·5
November–December		87·5		12·5
January **1957**		66·6		33·4
February		57·2		42·8
March		50		50
April		50		50
May	Reversal of 100 Flowers	37·5		62·5
June		28·5		71·5
July	Tsingtao Conference	50		50
August		57·2		42·8
September	3rd Plenum	87·5	69·5%	12·5
October	3rd Plenum	56		44
November		100		0
December		66·6		33·4
January **1958**	Hangchow and Nanning Meetings	14·4		85·6
February		71·5		28·5
March	Ch'engtu Meeting	62·5		37·5
April		50		50
May	2nd Session, 8th Central	75	67·5%	25
June	Committee and 4th and 5th Plenums	91		9
July		55		45
August	Peitaiho Conference, communes	46		54

Content Analysis of the *Chinese Medical Journal—continued*

Date	Colateral Event	Exotic Research		"Mass-oriented" Research
September		66·6		33·4
October		72·8	69%	27·3
November	1st Chengchow Meeting, Wuchang Meeting and 6th Plenum	70		30
December	Mao steps down	20		80
January **1959**	Politburo Conference	30		70
February	2nd Chengchow Conference	42·8		57·2
March	2nd Chengchow Conference	75		25
April	7th Plenum	75		25
May		63·7		36·3
June		50		50
July		50	68%	50
August	8th Plenum	79		21
September–October		87·5		12·5
November		71·5		28·5
December		60		40
January **1960**		11		89
February		61		39
March		63		37
April		54	57·6%	46
May		50		50
June		60		40

Remainder of year 1960 and all of 1961 were not available.

This table demonstrates that, in the period from January 1955 to April 1957, 74 per cent of the average issue of the *Chinese Medical Journal* was devoted to articles dealing with "exotic" medical research.[10] In May and June 1957, with the reversal of the Hundred Flowers movement, the percentage of pure research articles dropped precipitously for two months and then rebounded to about the old level until the end of the year. During 1958, the percentage of pure research articles remained at the same level, except during the months when major central meetings were in progress and the future course of policy was uncertain. The amount of space allocated to exotic research articles dropped in January

10. The operational definition of "exotic" research is slippery in many cases, but "exotic" articles deal with problems that are (a) relatively rare, (b) require elaborate and costly treatment which only a few specialists can accomplish, and (c) are of greater concern to the international medical community than the immediate clinical needs of China. The usual "exotic" research article begins by stating, "While we have only seen four cases of this problem in the last ten years, it is intrinsically interesting because...." Since the categories are loose, however, the margin of "error" in the content analysis is substantial.

1958 (with the Nanning and Hangchow meetings),[11] in August 1958, with the launching of the communes, and throughout November and December 1958 (the First Chengchow meeting and the Sixth Plenum).[12] While the simultaneous occurrence of these meetings and decline in exotic research might be coincidental, the most plausible explanation seems to be that this entire period was one of great uncertainty. Chairman Mao stepped down as the head of state and he blasted the Soviet Union. Throughout the remainder of 1959, the percentage of exotic research articles stayed very near pre-Leap levels.

A possible inference from the above data is that medical research went on relatively "normally" during the Great Leap and that bureaucrats in the Ministry of Public Health and the Chinese Medical Association simply varied the rate of publication according to the fluidity of the external political environment. One seems to be seeing an insulated research apparatus trying to protect itself; this sensitizes the analyst to bureaucratic political strategies in China.

Corroborating this analysis is the fact that major advances in brain and heart surgery (along with burn research and the transplantation of severed limbs) were made during this period.[13] As the minister of health, Li Te-ch'uan, noted in April 1959: "... certain previously weak links in medical science have been strengthened. For instance, heart surgery and brain surgery have developed considerably."[14] We conclude, then, that the "ideological" tone of the Great Leap did not seriously impair high-level professional work; research activities maintained continuity with past practices.

Health Care Delivery. The discussion of the two issue areas above should only alert us to divergent policy directions during the Leap; it

11. In this discussion of the sequence of national level meetings we are fortunate in having recently acquired a compendium of Mao's speeches at these gatherings. *Mao Tse-tung ssu-hsiang wan-sui* (*Long Live the Thought of Mao Tse-tung*) (n.p., 1969). For English language data on these meetings, see Parris Chang, "Research notes on the changing loci of decision in the Chinese Communist Party," *The China Quarterly* (*CQ*), No. 44 (1970), pp. 169–94.

12. Mao Tse-tung, "Tsai pa-chieh liu-chung ch'üan-hui shang te chiang-hua" ("Speech at the Sixth Plenum of the Eighth Central Committee"), *Mao Tse-tung ssu-hsiang wan-sui*, pp. 259–69.

13. See, for example, Joshua Horn, *Away With All Pests* (New York: Monthly Review Press, 1969), Chapter 11. An ambiguity arises in our discussion of burn research and the rejoining of severed limbs. Certainly the treatment of these two traumatic problems is expensive, requires large capital investments, and the rate of recovery to the point that the individual is once again productive is low. In a society with as few resources as China a real question arises as to whether or not this is the optimal investment of each health *yüan*. On the other hand, because China is at a relatively early stage of industrialization, burns and traumatic amputations are extremely common. The Chinese argue, however, that restoring one worker to a productive life makes the costs worthwhile.

14. Li Te-ch'uan, "Placing health undertakings at the service of production," *CB*, No. 577, p. 20. Minister Li delivered this address to the first session of the Second National People's Congress, April 1959.

should not lead us to conclude that no significant departures in any aspect of health care occurred. Health delivery policy underwent substantial change. The analysis of this issue area must be broken into its rural and urban dimensions because the Ministry of Health maintained jurisdiction over the latter while the myriad of Commune Party Committees assumed control of health delivery policy below the county level.

When the communes were launched in late 1958, the expectation was that China's 50,000 " united clinics " (*lien-ho chen-suo*) would be amalgamated into collectively-run commune health centres; " united clinics " were free-for-service group practices. The new commune clinics were run by Commune Party Committees; Party cadres attempted to use free medical care as an inducement to peasants to participate in the communization movement itself.[15] The scope and quality of any given commune clinic was reflective of local conditions and decisions.[16] The enthusiasm of local cadres in the 1958–59 period produced an emphasis on the free aspects of health care. In short, the basis of the Great Leap in sub-*hsien* health facilities was increased health service availability, "free medical care" and politics in command.

The question of what the Leap really meant in terms of rural health delivery deserves more attention than it can be given here, but I must note that communes did not really change the *quality* of health care in rural areas or the people who were giving that care. United clinics, which were generally staffed by traditional doctors, were taken over by the communes and collectively financed. Unlike during the Cultural Revolution, there was no massive permanent transfer of medical personnel to rural areas. In short, commune members were being asked to share the burden of supporting largely local personnel. When economic problems arose, commune members had to ask whether the expense of these clinics was worthwhile. Many said not.[17]

In urban areas, the Ministry apparatus was in charge (down to the urban *ch'ü*) and its basic organizational form was the " sectional medical service." This programme was an attempt to reduce demand on *ch'ü* and municipal hospitals by more tightly regulating the referral of cases to them. Each urban hospital was responsible for the health conditions in all units which had health care contracts with that particular institution. The district hospital periodically sent doctors to production units to decide which cases warranted referral.[18] A major objective of this arrangement was to reduce the flow of patients to higher level health facilities: " ... rational adjustments of medical service contracts and

15. Lampton, "The Politics of Public Health," Chapters IV and V.

16. Li Teh-hua and Yang Min-ting. " The planning of Ch'ingpu *hsien* and Hung Ch'i people's commune," *CB*, No. 544, pp. 1–11.

17. " An investigation report on how the Ch'ünhsing brigade in Ch'üchiang *hsien*, Kuangtung province firmly adheres to co-operative medical service over the past eleven years," in *Selections from China Mainland Magazines* (*SCMM*) (Hong Kong), No. 642, p. 30.

18. Vogel, *Interview No. 2*, p. 1.

proper organization of the masses of the people have eased the congestion at the large hospitals and greatly developed the latent potentials of the basic-level medical set ups . . . ." [19]

To sum up, in the communes the initial thrust of Great Leap delivery policy (until 1960) was "free" medical care and equal access to that care. In contrast, the Ministry emphasized cost control and the avoidance of overcrowding.[20] In short, we see the juxtaposition of increasingly restrictive policies in urban areas and increasingly expansive ones in rural areas. Once again, the mass campaign literature is not always a good guide to what is going on in the bureaucratically administered sectors of society.

Financial Policy. Financial arrangements reflected the same lines of cleavage as health delivery policy. While financial policy was quite innovative in rural areas where policy was made by Commune Party Committees, in urban areas relatively few changes in financial arrangements were made.

In the communes, each health centre was supposed to be financially independent of higher administrative units. There were two basic types of commune financial plan. Under the first type, the production brigades were to establish a welfare fund consisting of revenues from brigade enterprises and agricultural production. In addition, each brigade received a set sum from the commune welfare fund (*pao-kan yi-liao*).[21] This brigade fund directly paid for all brigade members using health facilities. In the second type of financial plan, the commune welfare fund directly paid for all commune members.[22] As these plans were initially conceived in 1958 and 1959, no direct costs were placed on the patient. This changed in May 1960 when widespread crop difficulties washed out the financial underpinnings of this system.[23] Certainly, however, the

19. "Sectional medical service adopted in over thirty cities," *Jen-min jih-pao (People's Daily)*, 22 October 1957, in *Survey of China Mainland Press* (SCMP) (Hong Kong), No. 1645, p. 19.

20. The analysis thus far suggests a conflict which has been crucial in understanding the evolution of health care policy; the conflict of interest between the *hsien* hospital and the commune health authorities. The commune authorities find it in their interest to refer as many patients as possible to the county hospital and then balk at paying for them. The county, on the other hand, attempts to restrict access and insure payment before admittance is granted. As one interviewee said: "Communes are theoretically supposed to pay for the workers [peasants] to go to the county hospital but there has been a lot of difficulty in getting money out of the communes and county hospitals have lost a lot of money by treating commune patients." Vogel, *Interview No. 30*, p. 5.

21. "An investigation report," *SCMM*, No. 642, p. 28; also *Jen-min jih-pao*, 7 December 1968.

22. "Co-operative medical system in Honan," *Jen-min jih-pao*, 24 September 1958.

23. Hsu Yun-pei, *Chinese Medical Journal*, 80, No. 5 (1960), p. 413; also, Ho Piao, "Health units should have the aiding of agriculture as their first duty," *Hung-ch'i (Red Flag)*, No. 18 (1960), pp. 12–20.

concept of "free" medical care, of any kind, was unprecedented in the history of China's hinterland.

In urban areas financial arrangements hardly changed and a large majority of the urban population remained without comprehensive protection.[24] While full labour force and insurance statistics are unavailable for 1959, at the end of 1958, out of a total non-agricultural labour force of 56·9 million, 13·8 million persons had labour insurance and 6·9 million had health insurance [25]; about 12 per cent of China's non-agricultural work force was fully covered under industrial health programmes. The non-agricultural work force excludes children and the elderly. Offsetting some of these corrections, however, is the fact that government workers, cadres, military personnel and some students were covered for medical costs. In short, while we do not know exactly how many urban dwellers were covered under various health plans, it is hard to see how the number could have exceeded 25 per cent of the total urban population.[26]

The Chinese, even in the most frenzied moments of the Great Leap, never claimed to have greatly expanded health insurance and it must be presumed they did not. Once again, we have seen a striking contrast between financial policies as they were drawn up in rural areas by Party Committees and in urban areas administered by the bureaucratic apparatus.

Traditional Medicine. Another important area of policy concerned that of traditional medicine (*chung yi*). In rural areas Party Committees and some PLA units led the promotion and popularization of acupuncture and traditional medicinal herbs.[27] There was considerable experimentation with traditional herbs to treat schistosomiasis. Thousands of individuals allegedly acquired proficiency through short courses in the traditional arts of healing:

24. David M. Lampton, "The struggle for health: group politics in China," footnote 19. This paper was presented at Hong Kong University, 13 January 1973, at a seminar on "Ideology and Organisation." It is often asserted that health charges are so low that they do not really constitute a burden. This would seem not to be the case for the simple reason that people actually "invaded" hospitals during the Cultural Revolution demanding that they receive the same benefits as those who were insured. If a patient was not insured, he had to pay a deposit before admittance. Finally, even low daily charges add up if one is stricken with a chronic or long-term illness. While data are scarce, one article noted that when typhoid struck one man's family, its cure cost 970 *yüan*. See *SCMM*, No. 642, p. 31.

25. Audrey Donnithorne, *China's Economic System* (London: Allen and Unwin, 1967), p. 213.

26. Joyce Kallgren, "Social welfare and China's industrial workers," A. Doak Barnett (ed.), *Chinese Communist Politics in Action* (Seattle: University of Washington Press, 1969), pp. 540–73. Kallgren shows how resource constraints affected all areas of welfare policy; "need" is one of several criteria for determining who shall be given benefits.

27. *Wen-hui pao*, 10 March 1959, noted that 30,000 people had learned the art of acupuncture in a mass movement.

Still, at the height of the Great Leap this identification [of " popular culture " with folk medicine] was approached. Outright folk medicine, simple popular remedies, and unlettered rustic practitioners, were very much in vogue. Even the disappointment with the celebrated tadpole experiment in early 1958 – almost half of the women swallowing them as a test of their effectiveness in contraception became pregnant – failed to dampen their enthusiasm . . . .[28]

In fact, at the lower levels of Chinese society the popularization of *chung yi* was so extensive that one disgruntled individual said:

The Ministry's present policy with respect to *chung yi,* from the present point of view, has substituted the past " rightism " [of Wang Pin who had opposed *chung yi*] for the " leftism " of allowing those who were not previously Chinese practitioners, and who have not studied Chinese medicine, to now become Chinese doctors. . . .[29]

Policies pertaining to national level medical schools and research institutes differed substantially from rural trends. As to major medical schools, on 18 November 1958 the Party Central Committee called for a mass movement of western-style doctors to study *chung yi.*[30] Opposition to this within the Weishengpu and the medical community was great and in January 1959 the *Chinese Medical Journal* commented: " We should also call on the western-style doctors to take up part-time study, *where feasible,* on a *voluntary basis,* and on the principle of *studying their own specialties.* But, we *should not require all western doctors to study traditional medicine*" (emphasis added).[31] When policy was finally implemented, it appeared that a compromise had been worked out whereby doctors studied *chung yi* part-time, for short periods.

Policy regarding traditional medical research followed an even more divergent line in the Weishengpu and the Chinese Academy of Medical Sciences (Chung-kuo yi-hsüeh k'o-hsüeh-yüan). In January 1957 it was suggested that the Chinese Academy of Medical Sciences (CAMS) assume the Academy of Traditional Medicine's (Chung-yi yen-chiu-yüan) responsibility for research into indigenous pharmaceuticals and Chinese medical theory.[32] The reason for this suggestion concerned the alleged unwillingness, or incapacity, of traditional doctors to do quality work. In the subsequent anti-rightist campaign, this suggestion was shelved only

28. Ralph Croizier, *Traditional Medicine in Modern China* (Cambridge: Harvard Unversity Press, 1968), p. 187.

29. Huang Kuo-chang *et al.*, " A few problems in health work," *Hei-lung-chiang jih-pao* (*Hei-lung-chiang Daily*), 7 June 1957.

30. "Recent achievements in the promotion of traditional Chinese medicine," *Chinese Medical Journal,* 78, No. 2 (1959), p. 103.

31. " Earnest implementation of the Party's policy on traditional medicine," *Jen-min jih-pao,* 25 January 1959; also *Chinese Medical Journal,* 78, No. 3 (1959).

32. " A few problems in the research of Chinese medicine," *Chien-k'ang pao* (*Health Bulletin*), 29 January 1957. *Chien-k'ang pao* was published by the Ministry of Public Health and was not in circulation outside China. Union Research Institute, however, has a limited run of this periodical on microfilm covering, primarily, the year 1957.

to be resurrected and put into effect in March 1959.[33] To distil the argument, even in a "radical" period such as the Leap, the western-style research apparatus managed to insulate itself from the major excesses of the Leap and acquire additional areas of responsibility.

Mass Campaigns. The final policy area to be considered is that of mass health campaigns. One's expectations for significant policy departures are thoroughly met in this area of policy; this was because new institutions had been established almost entirely outside the health bureaucracy. In late 1955, the Central Committee, at Chairman Mao's behest, set up a special Nine Man Sub-committee on Schistosomiasis, with K'o Ch'ing-shih as its chairman and Wei Wen-po as the second in command. The sub-committee's initial responsibility was to eliminate schistosomiasis in the provinces of the Yangtse Basin.

At first, the sub-committee solicited expert opinion and, at its March 1956 meeting, a seven-year plan to eradicate schistosomiasis was unveiled.[34] The first two years of the plan were allocated for a study of the problem itself, the following three years for the elimination of the disease, with the last two years left for mopping up operations. In the two-year study phase, substantial numbers of individuals were treated by paramedics trained under Party auspices.[35] As might have been anticipated, the Weishengpu resisted this diminution of its authority: "... reactionary bourgeois authorities – and doctors deeply influenced by them – maintained that the countryside was not equipped for safe treatment and advocated that the emphasis should be on opening regular modern hospitals in the county towns. . . ." [36] Despite these jurisdictional problems, however, experts did have some impact on sub-committee decisions during the period from 1956 to early 1958; the seven-year plan represented their relatively "go slow" approach.

In May 1958, however, the decisive break with medical professionals was made.[37] Wei Wen-po called for the "basic elimination" of schistosomiasis and denounced those who were shackled to the conventional wisdom. The anti-expert crescendo was reached in November 1958 when the All China Conference on Parasitic Diseases was held in Shanghai.[38] The conference enlarged the scope of the mass anti-parasite campaign and shortened the time in which the total elimination of all

33. *Jen-min jih-pao*, 10 March 1959.

34. *Kuang-ming jih-pao* (*Bright Daily*), 14 December 1956.

35. Ch'ien Hsin-chung, "Summing up of mass technical experiences with a view to expediting eradication of the five major parasitic diseases," *Chinese Medical Journal*, 77, No. 6 (1958), p. 522. This article noted that 400,000 people were treated in 1956 and 500,000 in 1957. Originally it had been projected that 1·2 million would be treated in 1957, but this did not occur.

36. "A great victory for Mao Tse-tung's thought in the battle against schistosomiasis," *China's Medicine*, No. 10 (1968), p. 594.

37. *Jen-min jih-pao*, 16 May 1958.

38. "All China Conference on Parasitic Diseases," *Chinese Medical Journal*, 77, No. 6 (1958), pp. 519–20.

five major parasitic diseases was now to be accomplished. The five diseases to be tackled were malaria, filariasis, ancylostomiasis, kala azar and schistosomiasis: "The extent and scope of the work and the results so far achieved may be gauged from the proposal at the conference that we strive to achieve by next year basic eradication of the five major parasitic diseases."[39] Subsequently (until early 1960), the mass movement forged ahead with millions of peasants being mobilized to destroy disease vectors; the Ministry of Health and local health bureaux were largely irrelevant to this campaign.[40]

Separate aspects of health policy thus moved in quite different directions. The uniformly "radical" tone of the Leap was more an artifact of media coverage than characteristic of actual policy outputs. Furthermore, essentially three different agencies produced health policy during the Leap: the Ministry of Health and its subordinate units, the Nine Man Sub-committee on Schistosomiasis (and subordinate local Party Committees at the province, *hsien* and *ch'ü* levels),[41] and Commune Party Committees. The important consequence of this dispersion of policy-making authority is that in order to understand the shape of any given facet of policy we must understand the arena from which it emerged. Each arena affords different degrees of access to different interests, reflects different political constraints, makes particular political and social resources available, and generates policy with particular attributes. To understand the entire health policy constellation we must understand all three policy arenas (their leadership, supportive values, perceptions and resources) and the way that these arenas interacted. However, before discussing the characteristics of these agencies of health policy, I will tackle the question of how and why particular issues were "assigned" to particular arenas.

The Allocation of Health Issues

The Weishengpu. Quite simply, the Ministry of Public Health is a great residual arena. That is, it deals with all health issues unless they are appropriated from it by higher authorities and placed in an alternative arena, or unless the Ministry is faced with an issue which it finds impossible to handle (e.g. sub-*hsien* curative services). The territory under the Ministry's authority was defined in August 1950 at the First National Health Conference, and included responsibility for medical education, medical research, personnel questions, traditional medicine and health delivery. The Ministry's pre-eminence in the field was affirmed by the 1954 State Constitution. By 1955, however, the Central Party apparatus began to "lift" areas of responsibility out of the

39. *Ibid.*

40. Horn, *Away with All Pests*, pp. 94–106. Horn describes the military atmosphere of the anti-parasite campaigns.

41. Li Huei-han, "Prevention and treatment of filariasis in Shantung province," *Chinese Medical Journal*, 78, No. 1 (1959), p. 54.

bureaucracy and create new organizations to deal with tasks which it felt were being neglected (a story to which I shall soon turn). Nonetheless, it took a positive action by a higher authority to remove an issue from the Ministry.

Two considerations, however, limited this formal policy responsibility. First, many health issues involved other large agencies such as the Commercial and Chemical Ministries, the Ministry of Labour, the Ministry of Higher Education, the Chinese Academy of Sciences, and the All China Federation of Trade Unions. As a consequence, to discharge its responsibilities, the Weishengpu had to gain the co-operation of these other agencies. In short, the Ministry was not a hermetically sealed institution. The second constraint was, and is, represented by the General Line of the Party Centre and specific instructions which the Ministry periodically (and quite often) receives from Mao.[42] Both the higher Party organs and Mao represent limits on the Ministry.

In the Great Leap Forward, only two broad policy responsibilities were concretely removed from the Ministry arena: anti-parasite work and commune health care. Responsibility for medical education (at the higher level), medical research, and health financing in urban areas remained under Weishengpu jurisdiction. In fact, the Third Plenum of the Eighth Central Committee [43] explicitly acknowledged that the Ministry was to continue to administer the hospital system. Chou En-lai, a year later, instructed the Ministry to increase the attention given to higher level medical education and research.[44] In short, then, the Ministry lost control of some policy domains, but by no means all of them. My present interest is in how and when the Nine Man Sub-committee got control of mass campaign and anti-parasite work. What was the context in which Commune Party Committees were placed in charge of commune health centres?

The Nine Man Sub-committee. As in the case of many important incidents in China, a curtain obscures the process through which the Nine Man Sub-committee was created. Still, it is known that as early as June 1956 the Ministry of Public Health publicly resisted the creation of an institution divorced from its control.[45] Almost as soon as the Nine Man Sub-committee had been established, Minister Li Te-ch'uan, in a thinly veiled attack upon the Party zealots leading anti-schistosomiasis

42. The historical record is replete with specific instructions from Mao on health work. *Hsin jen wei* has a list of Mao's major statements and directives. In addition, *Translations on Communist China,* 90, *Joint Publications Research Service (JPRS)* (Washington D.C.) No. 49826, 12 February 1970, p. 24, has a complete translation of Mao's statement of 25 June condemning the Weishengpu.

43. Ho Piao, "Speech to the National Hospital Work Conference," 28 March 1958, *Hsin-hua pan-yüeh-k'an (New China Semi-monthly)*, No. 128, pp. 143–48. This summarizes Premier Chou's speech to the Third Plenum on health care.

44. Chou En-lai, "Report on government work," pp. 16–17.

45. Li Te-ch'uan, "The new tasks for the protection of public health," New China News Agency (NCNA), 16 June 1956, in *CB*, No. 405, p. 12.

work, said that " . . . there have also been many defects in this work. In some areas, there was a lack of understanding of the stupendous and complicated nature of the task, and this gave rise to a feeling of hastiness and of an inclination to belittle the enemy." [46] The belief that the Ministry fought attempts to remove mass anti-parasite work from its jurisdiction is strengthened by subsequent denunciations:

> Certain bourgeois experts were skeptic [sic] about the plan of setting a time limit for eradicating parasitic diseases. . . . They would further cite the fact that the Japanese had made a study of schistosomiasis for some twenty years and all their irrigation canals were built with cement, but even they, with their few endemic areas, had not succeeded in eradicating the disease. They did not believe in Party leadership . . . they considered the Party "unskilled" and not able to lead the "skilled." [47]

In the discussion of the Central Committee's "requisitioning" of one policy area, one needs to have the political context firmly in mind. Throughout the early 1950s, Mao had repeatedly attacked the Ministry for its lack of responsiveness to the Central Party apparatus.[48] Finally, in 1955–56, the Ministry was openly attacked and the first vice-minister, Dr Ho Ch'eng, was removed. His primary "sin" was, as he said, that "I was divorced from Party leadership" ("*t'o-li tang ling-tao*").[49] Just prior to Ho's removal, Wang Pin, the Director of the North-east Health Bureau, was purged for his opposition to *chung yi*.[50] These basic issues of institutional power (the Party apparatus in tension with Ministry authority) [51] coincided with Mao's feeling that certain areas of health care had been short-changed, especially efforts to eliminate parasitic diseases in rural areas. As a consequence, the Nine Man Sub-committee's creation served the power interests of the Party apparatus at the Centre and the ideological predilections of Mao, K'o Ch'ing-shih and Wei Wen-po.

Once the Nine Man Sub-committee had been established, it possessed an organizational momentum of its own. Anticipating a later section it had different leaders than the Weishengpu, was tied to a different implementation structure, and provided alternative interests in Chinese

46. *Ibid.*

47. Ch'ien Hsin-chung, "Summing up of mass technical experiences," p. 527.

48. Mao bitterly criticized the Weishengpu in April 1953 with "Instructions concerning the examination of leadership work of health departments of Military Committees"; in July 1954 with "National Higher Medical Education Conference"; and in the Spring of 1955 with a speech at a standing committee meeting. All statements can be found in *Hsin jen wei*, pp. 6–9.

49. Ho Ch'eng, "An Investigation of my incorrect thought in health work," *Jen-min jih-pao*, 19 November 1955.

50. *Nan-fang jih-pao* (*Southern Daily*), 19 May 1955.

51. Franz Schurmann, *Ideology and Organisation in Communist China* (Berkeley: University of California Press, 1968), p. 190. "Vertical rule reached a high point around 1954. Not only the major economic, but other Ministries as well, had created nation-wide networks of organisation."

society with access to it. As a consequence, the sub-committee's anti-parasite policy was significantly different from what it would have been had the Weishengpu been in charge. In the period 1958–59, the Nine Man Sub-committee became (as I shall discuss on p. 693) increasingly dominated by upwardly mobile political cadres whilst experts played a declining role.

To sum up, the creation of the Nine Man Sub-committee in late 1955 had as much to do with the Party Centre's desire to exercise control over an increasingly independent ministry as it did with the need to fill in the gaps in previous health policy. We may note that when the Party Centre is united in its desire to remove an issue from a ministry arena, that ministry is in a poor position to do much about it. The leverage a ministry has arises when the Centre itself is divided. In 1955–56, the Centre was not particularly divided over the issue of mass campaigns and, in fact, a multitude of leaders would have found several reasons to justify the Nine Man Sub-committee's creation. When divergences in opinion about mass campaigns became apparent in 1958 and 1959, the sub-committee was already a *fait accompli.*

The Commune Health Centres. In the above discussion, we have seen that one way in which new political arenas arise is through one sector of the political system " grabbing " an issue and constructing an apparatus to " process " it. The creation of the commune health arena was somewhat different, although any interpretation must remain tentative in the absence of complete documentation for the August 1958 Peitaiho Conference which sanctioned the widespread construction of people's communes.[52] Before probing the subject in depth, however, one can say that the Ministry did not want responsibility for sub-*hsien* (commune) curative facilities. The Ministry preferred to concentrate limited funds in the county hospitals, thinking that this would be the optimal level for maintenance of quality services and their geographic distribution. The Ministry's view was that if commune hospitals were to be built, someone else was going to have to do it. While the Weishengpu had resisted its loss of responsibility in anti-parasite work in 1955 and 1956, it felt that trying to build thousands of commune health centres was a burden it could do without.

Just as the Ministry reacted to this issue differently than it had to the 1955 decisions relating to anti-parasite work, so the Centre was less united than it had previously been. While the information on this is

52. Of course, we have the "Resolution of the Chinese Communist Party concerning the question of establishing rural People's Communes" ("Chung-kung chung-yang kuan-yü tsai nung-ts'un chien-li jen-min kung-she wen-t'i te chüeh-yi "), 20 August 1958, *Jen-min shou-ts'e 1959* (*People's Handbook*) (Peking: Ta-kung pao she, 1959), pp. 32–33. This document tells what the decision was, not what the inputs to that decision were. Also the generally comprehensive *Mao Tse-tung ssu-hsiang wan-sui* does not have Mao's speech(es) dealing with this meeting.

thin, later charges assert that Liu Shao-ch'i opposed establishing commune health centres because such a programme would create severe manpower and pharmaceutical shortages (which in fact they did).[53] Mao, on the other hand, as I shall discuss in the next section, saw commune health centres as part of the total effort to reduce rural-urban disparities. In short, while there had been unity of purpose (or at least compatability of purpose) in the 1955–56 attack upon the Ministry, now the Centre was splitting over questions of how rapidly a sub-*hsien* curative health system should be built.

While not knowing precisely how, if at all, bargains were struck and issues traded off in the Central Committee and the Politburo, all one can unambiguously say is that communes were built in late 1958 and 1959 and that health centres were to be a basic part of each commune's design.[54] Because the central budget could not support all of these centres, it was a foregone conclusion that local financing would be of primary importance. As Li Hsien-nien said: "As for general education, health and medical work ... these are public services which may be run by the masses themselves ... [they] should not become the sole financial responsibility of the State. Some works may achieve better results ... if they are run by the masses themselves." [55] Thus, Mao's views on the need for commune health centres prevailed, but economic necessity dictated that these centres be run by "the masses themselves." In the structural and organizational context of China in 1958–59, this meant that Commune Party Committees would have to run the centres and that the necessary revenues would have to be derived from the local agricultural base. If there was to be commune health care, it would have to be handled outside of the Ministry structure.

To summarize, by the later part of 1958, the three distinct health policy-making arenas were the Nine Man Sub-committee on Schistosomiasis, the Weishengpu and the approximately 24,000 Commune Party Committees.[56] The importance of these separate policy-making arenas is that each one had a different leadership composition, expressed different mixtures of social values, had different resources, and faced different sets of political and social constraints. As a consequence, the direction of policy could vary from arena to arena. My next task is to examine the leadership, values, resources and perceptions characteristic of each of these three arenas in 1958 and 1959.

53. *Ch'üan-wu-ti* (*Invincible*), No. 17. This series of newspapers is held by Union Research Institute in Hong Kong. It was published by the Chien-k'ang-pao Yenan commune in Peking during 1967.

54. Li Te-hua and Yang Min-ting, "The planning of Ch'ingpu *hsien* and Hung-ch'i people's commune," pp. 1–11.

55. Li Hsien-nien, "Speech to the 5th session of the First NPC," *CB*, No. 493, p. 13.

56. G. William Skinner, "Marketing and social structure in rural China," Part III, *Journal of Asian Studies*, 24, No. 3 (1965), p. 384.

The Characteristics of the Three Policy-Making Forums

The Weishengpu. The identity of any institution's leadership is crucial, and this is especially so in China where the political culture seems to accentuate the importance of the role of the leader,[57] and where the ideology asserts that policy is the consequence of purposive leadership action.[58] Weishengpu leaders were significantly different from the leaders of the other two political arenas. First, the Ministry's leaders (at the vice-ministerial level) were predominantly medical doctors.[59] Secondly, most of these individuals had substantial pre-Liberation PLA medical (as opposed to political or combat) experience.[60] Finally, several of the vice-ministers of public health had been in charge of regional health bureaux until the abolition of those regions in 1954.[61] All three of these career backgrounds (physician, PLA medical corps and regional medical responsibilities) reinforced in these individuals a desire to resist complete Party political domination of "professional" work. It was not a question of Party control versus ministerial independence, but a question of what type of Party members should control medical work.

The fact that these individuals were resistant to the imposition of Party political values in professional areas was demonstrated by the fact that vice-minister Tsui I-t'ien had been attacked in 1953 by the *People's Daily* for being "divorced from Party leadership" and "attempting to build an independent kingdom."[62] At the same time, Mao had attacked the entire regional Ministry structure saying: "The fact exists that there is no leadership, no politics, and no serious administration [in the Weishengpu]."[63] While the reason for the abolition

57. Richard Solomon, *Mao's Revolution and the Chinese Political Culture* (Berkeley: University of California Press, 1971).

58. John Wilson Lewis, *Leadership in Communist China* (Ithaca: Cornell University Press, 1963).

59. Of the eight vice-ministers of health, five were medical doctors: Dr Fu Lien-chang, Dr Su Ching-kuan, Dr Ch'ien Hsin-chung, Dr Ho Piao and Dr Tsui I-t'ien. Hsu Yun-pei, Chang Kai and Wu Yun-fu were not medical doctors nor did they have a medical background. While it is not a sound practice to try to measure intra-Party influence just by counting noses, the structure of the Ministry gave each vice-minister a functional area of responsibility which meant that he had a bureaucratic base of power. Also, it is clear from the kinds of policies which the Ministry proposed and carried out that the political cadres did not, in every instance, overwhelm the professionally oriented vice-ministers. For more detail on the backgrounds of each of these individuals see, Lampton, "The Politics of Public Health."

60. Drs Su Ching-kuan, Fu Lien-chang, probably Tsui I-t'ien, Ch'ien Hsin-chung and perhaps Ho Piao, had all held responsible positions in the PLA medical corps.

61. Dr Ho Piao (north-west region), Dr Tsui I-t'ien (east China region), and Ch'ien Hsin-chung (south-west region) had all been in charge of regional health bureaux before their elevation to Peking.

62. *Jen-min jih-pao*, 28 March 1953.

63. Mao Tse-tung, "Instructions concerning examination of leadership work of health departments of Military Committees," (April 1953), *Hsien jen wei*, pp. 6–7.

of the six regions in 1954 is no doubt highly complex, it was, in part, an attempt to limit the growth of regionally based professional independence. One of the possibly unanticipated by-products of bringing all these people to Peking was that they brought with them their professional predispositions and their resistances to purely political modes of operation.

Not only did the apex of the Ministry leadership consist of western-style medical personnel, but a substantial portion of bureau level administrators had medical experience. Some departments, like the Bureau of Drugs (yao-cheng-chü), the Bureau of Contagious Diseases (wei-sheng fang-yi-chü), and the Scientific Committee of Medical Sciences (yi-hsüeh k'o-hsüeh wei-yüan-hui), were almost wholly staffed by medical personnel. In speaking of the Scientific Committee of Medical Sciences one interviewee noted: "It has a chief and five staff members who are all doctors of Western medicine, mostly women. There are no Party members in the department except the chief. The important qualification for these staff members is their medical knowledge and skill." [64]

The second characteristic of the Weishengpu relates to the way in which the institution's leaders defined problems prior to the Great Leap Forward.[65] The context was the post-Hundred Flowers period when leaders in the Ministry were trying to understand and cope with the hostility which had been directed against the Weishengpu by medical professionals, staff and patients alike.[66] The internal Ministry newsletter, *Chien-k'ang pao* (*Health Bulletin*), reveals the perceptions and the central problems which gripped the Ministry leadership: how to end the alienation of the bureaucrats and professionals and how to cut waste and inefficiency in medical facilities.

The Weishengpu leadership was aware that even the mild introduction of politics into the Ministry in the 1955–56 period, and the subsequent anti-rightist campaign, had produced substantial hostility. President C. U. Lee (of China Union Medical College) had said: "The quality of the work of Union College has deteriorated. . . . The whole of Union College is in chaos; the Party Committees are simply hopeless. . . ." [67] The head of the Sian Academy of Sciences attacked the Party for its anti-research bias.[68] Nurses complained that the Party had precipitated a decline in standards for nurses.[69] Succinctly, the first major problem

64. Vogel, *Interview No. 42*, p. 14.

65. It is of course apparent that the leaders of an organization as internally complex as the Weishengpu cannot be said to share values on all issues at all times nor to order those values in the same way. However, it is equally apparent that in comparing the values of Weishengpu leaders to those of Commune Party Committee members, for instance, there is a characteristic perspective of Weishengpu leaders that derives from their roles and training.

66. Roderick MacFarquhar, *The Hundred Flowers* (London: Stevens, 1960).

67. *Jen min jih-pao*, 6 October 1956, cited in MacFarquhar, *The Hundred Flowers*, p. 127.

68. *Chien-k'ang pao*, 18 January 1957.

69. *Chien-k'ang pao*, 7 May 1957.

with which the Weishengpu leadership had to deal was the dissatisfaction of the bureaucracy and medical profession.

Below this first, outstanding problem was an entire galaxy of difficulties requiring attention. While, as we shall see, Mao believed that one of the greatest difficulties with Ministry work was the under-utilization of resources and under-supply of services, the Weishengpu believed that the pivotal problem was excess demand for services; too many people were entitled to free (*kung-fei*) or insured (*lao-pao*) medical care; people took advantage of the system. As one commentator pointed out in the *People's Daily*:

> . . . there must be revised certain existing measures which tend to encourage the rural population to infiltrate into the cities, such as subsidies for housing for workers, payment by the state of half of the medical expenses for dependents of workers, and the additional issue of food and cloth ration coupons.[70]

The Ministry also traced the origin of the financial problems to the utilization patterns of Party cadres, government workers, and others entitled to free or insured care. Because such individuals received free or cheap services they tended to waste drugs (see cartoons on pages 688–89) and to make unreasonable demands. Party cadres tended to use their Party status to gain personal and family advantages. One Shanghai Health Bureau report noted that, " . . . according to statistics from Shanghai, the great majority of those receiving free medical care are young cadres, students, and workers . . . they, on the average, visit a clinic 12 or 13 times a year." [71] While Ministry documents repeatedly refer to waste in 1957,[72] the only precise statistics which indicate the magnitude of the budgetary overruns are from 1954 and 1955. Shanghai's 1954 health budget had exceeded estimates by 2·58 million *yüan*,[73] Shantung's by 290,000 *yüan*,[74] and Tsingtao City's by 26,474 *yüan* (for the first quarter of 1955).[75] Thus, economic resources were limited and waste was high.

In short, then, one of the major limits on Weishengpu flexibility was the dearth of economic and trained manpower resources.[76] Furthermore,

70. Sun Kuang, "Urban population must be controlled," *Jen-min jih-pao*, 27 November 1957, *SCMP*, No. 1668, p. 7; see also, Ezra Vogel, *Canton under Communism* (Cambridge: Harvard University Press, 1969), p. 259. Vogel notes: "In 1958 there were 100,000 new jobs in Canton alone and over a million people migrated to urban areas of Kwangtung to take advantage of new economic opportunities."

71. *Chien-k'ang pao*, 7 May 1957.

72. *Chien-k'ang pao*, 23 April 1957.

73. "Grave waste in free medical care," *Jen-min jih-pao*, 17 April 1955.

74. *Ibid.*

75. "The phenomenon of waste is serious," *Kuang-ming jih-pao*, 22 June 1955.

76. Health expenditures were lower in 1956 than they were in 1953. The Ministry's revenue base was not expanding nearly as rapidly as its responsibilities and, in fact, the proposed health budget of 1958 was smaller than that of 1957. See Nai-ruenn Chen, *Chinese Economic Statistics* (Chicago: Aldine, 1967), p. 446.

— You see the doctor and then don't take the medicine. What a waste.
— Don't worry! It doesn't cost us a penny.

I-ch'eng wan-pao (Canton), 4 January 1964

— Father, why did you buy so many drugs? Are you going to open a hospital?
— Silly child, this is free medical care, you don't have to spend your own money.

Chekiang jih-pao, 28 *January* 1956

— To buy that many drugs must cost a lot of money.
— No, you don't have to spend your own money.

Inner Mongolia Daily, 20 January 1955

— Comrade, I haven't seen you for two days, what's wrong? Not well?
— No, No! I just went to the countryside to get some nourishment.

Chien-k'ang pao, 23 April 1957

doctors, researchers and educators unhappily perceived a decline in professional standards. The Ministry leadership, given the training of many of its members, was also distressed. The fact that physicians were unhappy and felt threatened was related to cost problems; as long as doctors were not positively motivated and felt they did not have the support of their superiors, they would not energetically reduce waste in medical facilities. Finally, the Ministry leadership could not envisage any massive expansion of its responsibilities for curative institutions until cost problems were in hand. In short, the Weishengpu was an institution which was unlikely to make bold departures on its own volition. This is not to say that the Ministry was unwilling to "serve the people" but it is clear that the Weishengpu believed that maintenance of quality, good morale and financial solvency were the best way to accomplish that objective. Without good professional morale, quality would decline and cost problems would persist. Without adequate financial resources morale would suffer and quality decline.

Mao Tse-tung and the Nine Man Sub-committee. Mao, in part, attributed public dissatisfaction with past policy to the economic policies pursued in the first Five Year Plan. As early as 1956[77] Mao began to advocate balanced development for a plethora of reasons.[78] The concentration on heavy industrial development, he claimed, hampered the rural sector in supplying light and heavy industry with raw materials. He feared that unbalanced growth slowed overall economic expansion. Mao concisely summed up his analysis of the situation in 1957 when he said:

> . . . industry must develop together with agriculture, for only thus can industry secure raw materials and a market and only thus is it possible to accumulate fairly large funds for building a powerful heavy industry. . . . As agriculture and light industry develop, heavy industry, assured of its markets and funds, will grow faster. Hence, what may seem to be a slower pace of industrialization will actually not be slow, and indeed may even be faster.[79]

Even more alarming to the Chairman was the fact that previous patterns of development had been a contributing factor to the discontent evidenced during the "bloom and contend" period. One of the most worrisome defections to Mao was the peasantry. As a New China News Agency release said:

> The peasants feel that the government is paying too much attention to the cities. As a result, the workers and the cadres are leading a good life while

77. Mao Tse-tung, "Lun shih ta kuan-hsi" ("On the ten great relationships"). *Mao Tse-tung ssu-hsiang wan-sui.*

78. "Balanced," in the present context, means balanced between light and heavy industry, between agriculture and industry, and a more even geographical dispersion of industry between the coastal and inland counties.

79. Mao Tse-tung. "On the correct handling of contradictions among the people," in *Selected Readings From the Works of Mao Tse-tung* (Peking: Foreign Languages Press, 1971), p. 476.

the life led by the peasants is a hard one. The cities are well supplied while the countryside is short of supplies. The price of manufactured goods is high.[80]

Not only had past developmental policy accentuated urban-rural inequalities, in Mao's view, but also, the previous emphasis on heavy industry had created inequalities among heavy industrial workers and the rest of the urban population. As I noted earlier, no more than 25 per cent of China's urban population was covered for medical costs.[81] These intra-urban inequalities had motivated certain workers to attack the Party in the 100 Flowers movement: "Some of the problems involving public mess halls, lavatories, medical clinics, and dormitories which could and should be solved are left unsolved. In the case of those which cannot be solved the reason is not made known to the workers. This is also a source of dissatisfaction among the workers." [82]

Another problem stemming from unbalanced economic and social welfare growth was that urban areas functioned as magnets to peasants in the countryside. In 1957 and 1958, the influx was so great that food and housing systems were strained: "The first result is the shortage of housing.... With the production of cities growing, effects are produced in the supply of goods situation.... The larger the cities grow, the greater the expenditures of the state." [83]

All these difficulties were interrelated, from the Chairman's vantage point, and their solution demanded moving towards equalizing the levels of welfare. It was hoped that such equalization could both stop the population pressures in cities from increasing and reduce the alienation which deprived groups felt. Health care was just a part, albeit an important part, of any such equalization programme:

> The scale and rate of the development of science, culture, education, public health, and so on, can no longer be entirely the same as originally intended. All must be appropriately expanded and accelerated. . . . Many of the diseases most harmful to man, such as schistosomiasis, we are now able to treat. In short, the people can see the great road open before them.[84]

The other crucial dimension of Mao's and the Nine Man Sub-committee's analysis led to a rejection of the Soviet health model which had been the basis of health work since 1949. The major resources to change health care were now said to reside in the masses of the Chinese people. Mao, at the Ch'engtu meeting of March 1958, in blasting the Soviet Union specifically mentioned health care:

80. NCNA, 14 May 1957, cited in MacFarquhar, *The Hundred Flowers*, p. 233.

81. Donnithorne, *China's Economic System*, p. 213. See also, Lampton, "The Struggle for Health," footnotes 19 and 20.

82. NCNA, 14 May 1957, cited in MacFarquhar, *The Hundred Flowers*, p. 234.

83. Sun Kuang, "Urban population must be controlled," pp. 3–7.

84. Mao Tse-tung, "Preface to the socialist upsurge in China's countryside" (27 December 1955), *SCMM (Supplement)*, No. 22, p. 10.

> After Liberation, economic and education work has given rise to dogmatism .... Dogmatism in economic work is most importantly manifested in heavy industry, planning work, banking work, statistical work, but most important is that evident in heavy industry and planning .... Statistical work is a copy of the Soviet Union's; on the education front the harm has been relatively great ... to the point of not investigating the educational experience of the liberated areas. Health work is the same, and has harmed me in that for three years I could not eat duck eggs, and could not eat duck soup, because the Soviet Union had an article which says [one] could not eat duck eggs and duck soup, and then afterwards [the Soviets] once again said that [one] could eat them. It doesn't matter whether the articles are true or false, the Chinese all abide by it, all promote it.[85]

In short, Mao did not think that the solution to China's rural health problems was to be found in the institutional context of the Weishengpu.

To sum up the perceptions and values which Mao and the Nine Man Sub-committee seem to have held, one can say that they were concerned about slow economic growth especially in the agricultural sector, the unequal development of social welfare facilities between urban and rural areas (and within urban areas), and the alienation which was resulting from both of those trends. In this context, Mao and the Nine Man Sub-committee functioned as advocates for the "have-nots" in the developmental process. The fact, however, that Mao and members of the Nine Man Sub-committee viewed the situation in the same general terms does not mean that they all ordered those priorities in the same way, though available data is inadequate to say how specific individuals ordered their objectives.

We must note the characteristics of the rest of the political arena dominated by the Nine Man Sub-committee, namely the provincial and county level Party Committees. The above analysis outlined the intellectual and bureaucratic raison d'être for the Nine Man Sub-committee, but the sub-committee needed a way to mobilize the millions of peasants; the chosen instruments were the Party Committees at the provincial and county levels. Representatives of these dispersed Party Committees periodically assembled in ad-hoc meetings at which goals were set: "Party committees of *hsien* level and above must set up leading teams composed of leading cadres from departments of agriculture, health and water conservancy."[86]

The importance of choosing this organizational structure to promote mass campaigns is substantial because the middle levels of the Party structure were the most detached from both professional and local (peasant) pressures. In a real sense they were formed by the upwardly mobile cadres who had downplayed the importance of local ties.

85. Mao Tse-tung, "Tsai Ch'eng-tu hui-yi shang te chiang-hua" ("Speech at the Ch'engtu meeting") *Mao Tse-tung ssu-hsiang wan-sui*, p. 161. Speech given on 10 March 1958.

86. "Thorough prevention and cure of schistosomiasis," *Jen-min jih-pao*, 22 January 1957, *SCMP*, No. 1473, p. 15.

. . the realm of government where the Party, as an organization, achieves its greatest power is the regional level. At the Center, the Party competes with an army of trained professionals who are in charge of the complex operations of branch agencies. At the bottom, it must reckon with the demands of the masses. However, at this middle level of government, there are fewer professionals to compete with than at the Center and the masses are not represented. . . .[87]

Initially, in 1956 and 1957, the Nine Man Sub-committee, and subordinate Party Committees at the provincial and *hsien* levels, invited experts to offer their opinions on mass health work. By 1958, however, experts were the objects of attack.[88] In the series of local and national anti-parasite meetings during 1958, *hsien* and provincial cadres competed to show how their respective units had achieved results which the " experts " had said were impossible. National anti-schistosomiasis meetings formulated even more visionary goals on the basis of these reports. In fact, Chairman Mao was so impressed by Yukiang *hsien's* claim to have eliminated schistosomiasis that he wrote a poem entitled, " Farewell to the God of Plagues " (June 1958).[89] What appears to have happened is that while the Party had created an organization to eliminate parasitic diseases, there were no persons or organizations charged with " objectively " evaluating the results which were, or were not, being achieved. As a result, the Centre became increasingly sure that willpower and manpower were transforming the face of rural China. The only effective brake on such a process was peasant alienation.

The Communes as a Political Arena. The third policy-making arena I must consider is the commune (of which there were 24,000 by 1959). Because many of the communes were extraordinarily large (in Liaoning province, which was however an exception, one commune sometimes equalled one *hsien*),[90] middle level cadres tended to dominate them; consequently, the same biases were built into commune policy-making systems as characterized the mass campaign arena.[91] Donnithorne outlines the differences between middle and lower level cadres in the commune system: " It can be seen that a significant dividing line runs between those who are state cadres and who look to higher rungs of Party and state hierarchies for the approbation which can further their

87. Schurmann, *Ideology and Organization*, pp. 193–94.

88. *Jen-min jih-pao*, 16 May 1958.

89. Mao Tse-tung, " Farewell to the God of Plagues," in Jerome Ch'en, *Mao and the Chinese Revolution* (London: Oxford University Press, 1965), p. 349.

90. Skinner, " Marketing and social structure," pp. 386 and 389. Skinner notes that the sizes of communes were highly variable. " The territory encompassed by the average commune of non-agricultural China was, therefore, immense: something in excess of 1,800 square kilometers. By contrast, the approximately 21,600 communes within agricultural China averaged less than 200 square kilometers in size."

91. Michel Oksenberg, " Chinese politics and the public health issue," John Z. Bowers and Elizabeth Purcell, *Medicine and Society in China* (New York: The Josiah Macy, Jr Foundation, 1974), pp. 149–54.

careers and the lower cadres who are first and foremost local peasants, subject to pressures from their fellows." [92] In the midst of the Great Leap euphoria, and in the absence of professional and local linkages, there was a tendency for middle level cadres to try to achieve high levels of redistribution, even though the "objective" economic situation might have suggested more caution. At this juncture, cadres were evaluated on their ability to transform the countryside and reduce rural-urban inequalities, not on their facility for articulating local peasant "conservatism." Because "free" health care was viewed as a tangible incentive for ever higher levels of collectivization, it was one of the first welfare functions initiated.[93]

The hopes that communes could support widespread health activities were not entirely fanciful, at least in late 1958, because the expectation of rapidly increasing agricultural production was confirmed by the bumper harvest of 1958 and the continually rising grain quotas of 1957 and 1958.[94] By late 1958, Party leaders at the central and middle levels believed that increased agricultural production and the new commune organization of the countryside changed the entire resources picture of rural China. In sum, then, the commune (in 1958 and 1959) was a political arena in which cadres, with inflated expectations for production and a desire to realize increasingly higher levels of collectivity, pushed for the creation of commune health facilities which would provide "free" medical care. Little thought was given to system-wide manpower and drug availability, to possible discouraging effects,[95] or to the long-term financial stability of the system. In fact, there was very little way of co-ordinating the establishment of commune clinics with the educational and pharmaceutical systems run at much higher administrative levels.

While I would like to say more about the specific characteristics of commune political arenas in 1958 and 1959, little data is available on policy processes at this level. The importance of the fact that this arena was dominated by middle level cadres with few local ties is, however, demonstrated by what happened in the 1960–62 period when the structure of the commune political arena was significantly altered.

92. Donnithorne, *China's Economic System*, pp. 66–67.

93. Li Te-hua and Yang Min-ting, "The planning of Ch'ingpu *hsien*," p. 1.

94. Vogel, *Canton under Communism*, p. 233.

95. The fact that severely discouraging effects resulted from free health care, and other welfare benefits, is demonstrated by the fact that the Sixty Articles on Agriculture specifically rejected "equalization." As one Chinese summary of the Sixty Articles said (April 1961): "We have always opposed equalization, for it denies the difference in income and distribution between teams and between commune members. And the denial of this distinction is a denial of the Socialist principle 'to each according to his work, and the more work the more pay.' If we do not exactly solve this problem, we will not be able to mobilize fully the productive positivism of the masses in general." See Chester Cheng (ed.), *Kung-tso t'ung-hsün* (*The Bulletin of Activities*) (Stanford: Hoover Institution Press, 1966), p. 527.

Changes occurred in two respects: first of all, in May 1961, new " draft regulations " were issued which cut the size of the average commune by two thirds. As the *Bulletin of Activities* noted: " The scale of the people's commune at the various levels should in every case be such as to benefit production ... and ought not to be excessively large.... In general, the people's commune should be equivalent in scale to the original *hsiang* or large *hsiang*...." [96] This meant, as Skinner has shown, that the Centre was re-establishing a rough alignment with old standard marketing areas and, in so doing, bringing the commune administration within the purview of locally based leadership.[97]

Secondly, to dislodge power further from middle level cadres and to spur production, the " basic accounting unit " was successively moved from the commune to the production brigade, and finally, to the production team. This meant that cadres lower in the administrative and geographic hierarchies gained more power; these were cadres who were much more dependent on their village co-inhabitants than the commune cadres of 1958 and 1959 had been. Once administrative and fiscal power had been decentralized, the number of rural health centres declined and those centres which remained (most of which were the " united clinics " that had existed before 1958) were not, for the most part, collectively financed (or free).[98]

This slight digression into the 1961–62 period demonstrates that the composition of commune leadership, and the level at which such leadership is exercised, is a crucial determinant of policy. Chinese, at all levels, recognize this fact and much of the struggle over rural health policy has centred around the question of who, with what resources, is to make commune policy. Should it be the commune, the brigade, or the production team? [99] Essentially the same arguments have raged over the control of commune industries and over the allocation of labour.[100]

Conclusion

I have argued in this article that there was no uniformly " radical," " mobilizational " or " mass-orientated " direction to health policy in all of its varied dimensions during the Great Leap Forward. My approach

96. Cited in Skinner, " Marketing and social structure," p. 397.

97. *Ibid.*

98. " The Mao-Liu controversy over rural public health," *Current Scene*, 7, No. 2 (1969); see also, Lampton " The Politics of Public Health," Chapter IV.

99. " The commune or the production brigade?," *Jen-min jih-pao*, 4 January 1969, *CB*, No. 872, p. 31. This article describes the conflict in one commune over the question of at which level health centres should be run.

100. " An investigation on how Ch'ünhsing brigade in Ch'üchiang *hsien* Kuangtung province firmly adheres to co-operative medical service over the past eleven years," *Hung-ch'i*, No. 1 (1969), *SCMM*, No. 642, p. 31.This article details the argument between brigades and teams over who should control brigade enterprises. As one person in one production team said, " If the enterprises aren't turned over [to the production teams] it means that brigade cadres are corrupt."

is intended to sensitize the reader to the fact that not all dimensions of any given policy area are made in the same institutional context, by the same leaders, subject to the same constraints, with identical resources. From this proposal, that different issues were " processed " by alternative structures, I went on to discuss whether political bargaining and conflict occurred over the allocation of sub-issues and to examine the strategies by which organizations have sought to acquire and/or hold certain areas of policy responsibility.

As the above propositions would suggest, struggle between organizations has been a continuing feature of health politics in China. The Weishengpu resisted Party usurpation of anti-parasite work in 1955 and 1956, by arguing that untoward results would occur without thorough research and administration. In these years the argument did not carry much weight because the Party Centre was united in its desire to reduce autonomous Ministry-based power. In 1958 and 1959, Ministry arguments for longer medical education at the higher levels, and emphasis upon research, were successful because the Centre itself was split over these questions.[101] In retrospect, Chou En-lai, Liu Shao-ch'i and Lu Ting-i all apparently argued for insulation of certain areas of health policy within the Ministry.[102] Experience would suggest, then, that a major strategy which the Ministry of Health can employ is to find supporters for its position at the Centre; this involves the cultivation of personal and bureaucratic ties. In contrast, during the Leap (and in the Cultural Revolution), Mao has shown a propensity to employ the strategy of setting up alternative policy-making arenas (e.g. the Nine Man Sub-committee).

Organizational conflict has occurred not only vertically, that is between the Ministry and the Centre, but also horizontally, that is between the Ministry and equivalent agencies. While much of this conflict is submerged in a sea of rhetoric about unity, occasionally it comes to the surface. One of the recurring conflicts has concerned the level of drug prices. The Ministry has claimed that the level at which the Commercial and Chemical Ministries set drug prices is crucial to its own financial well-being. Quite predictably, the Ministry and subordinate bureaux wanted to keep drug prices as low as possible while, on the other hand, the Chemical and Commercial Ministries argued that drug prices have to be relatively high so that capital accumulation can occur and demand for drugs will stay within tolerable bounds. As one Ministry representative said: " . . . if the Commercial Ministry can qualitatively and quantitatively help, by giving the *hsien* [health department] aid, this would solve the Health Ministry's previous difficulty of capital insufficiency and then [we] can make a Great Leap Forward in the speed of development of medical work. . . ." [103]

101. *Ch'üan-wu-ti*, No. 14, p. 2.
102. Chou En-lai, "Report on government work," pp. 16–17.
103. *Kuei-chou jih-pao*, 29 July 1956.

Organizations not only fight about who is to make policy, but they also fight about who must make policy in certain other areas. The Weishengpu has continually tried to get the industrial ministries to assume some responsibility for industrial health and safety, often to no avail.[104] In short, then, some policy issues are fought for and others are avoided. Although we can only see this game dimly, researchers would do well to explore it.

This intra-governmental competition for control of issues results, at any given time, in a certain distribution of issues throughout the policy-making system. I am arguing that the distribution of these issues in 1958 and 1959 explains the particular divergences in policy direction which I noted in the first section. Because higher level medical education and medical research policy was kept in an arena dominated by medical professionals, policy change in these areas was different in tone and direction than in the case of commune health care and mass campaigns where middle level political cadres were in charge. Post-Leap policy change occurred because the resources and constraints in the commune and mass campaign arenas changed.

I have described how health policy responsibility resided in several arenas. In administrative terms, we could call this a "divided policy-making system"; functionally related policies were not all made in the same institutional context. In the Nine Man Sub-committee and the 1958–59 commune arenas, the perceptions of middle level cadres were conditioned towards action and producing dramatic results through reliance upon the masses. The major resources were seen as the masses and the Party mobilization structure. Subsequent policies reflected their institutional origin.

In the Weishengpu, a different situation prevailed. Medical doctors (albeit Party members also) were heavily represented at the vice-ministerial and bureau levels. Within the institutional framework of the Ministry of Public Health, each bureau had its own functional area of responsibility and this encouraged specialization and institutional division of labour. The very structure of the Ministry gave urban and professional inputs more weight than rural inputs. Furthermore, the Weishengpu's evaluation of resources reflected its urban location and technical composition.

Various types of policy-making systems have various advantages and disadvantages, and the "divided" system is no exception. The great

104. "Do a good job in industrial health work," *Nan-fang jih-pao* (*Southern Daily*), 28 November 1955. This article promotes the idea that all the organizations related to industrial and labour work have a responsibility for industrial safety. Recent visitors to China have noted the apparently high rate of industrial accidents. The great interest in burn research and the rejoining of severed limbs would tend to confirm this. If this is the case, it would indicate that efforts to get inter-Ministry co-operation have been less than totally successful and that the need for increased production is in conflict with the expenditure of resources on industrial safety and health; see also, David M. Lampton, *Interview File 21K* (unpublished).

advantage of this multi-arena system was that it made health policy as a whole more responsive to a broader range of social inputs than the previous Ministry-centred system had been. In the 1958–60 period, provincial, local and commune cadres had substantial influence over anti-parasite policy. In the Weishengpu arena, doctors and researchers had a role in policy formulation. If we are speaking in system "capability" terms, as Almond does,[105] we would say that the "responsive capacity" of this kind of policy-making system was relatively high.

On the other hand, the "divided policy-making system" had a considerable number of drawbacks, the most important being an inability to co-ordinate. In some senses, the left hand did not know what the right hand was doing. If policy in each arena was to be successful it had to be co-ordinated with policies generated in each of the other policy-making forums. By the very nature of the institutional divisions, however, no regularized channels for co-ordination were operative and the divergent premises, values and leadership of each arena aggravated "natural" institutional divisions. This inability to co-ordinate was most evident in the fact that 24,000 communes were established and yet relatively few planned provisions for increased high level manpower were made, and the drug industry was totally unprepared for the rapid increase in demand for pharmaceuticals. In addition, no regularized procedures were established which would link the mass health campaigns with local health bureaux.

In sum, the "divided policy-making" system maximized inputs into the health policy-making system and minimized the ability to co-ordinate. I have tried to demonstrate that the "failures" of the Leap did not just arise from a ubiquitous "radical" take-over but, on the contrary, resulted from the very inconsistencies in leadership and programme characteristic of diverse policy-making arenas.

105. Gabriel Almond and Bingham Powell, *Comparative Politics: A Developmental Approach* (Boston: Little, Brown, 1966), pp. 201–203.