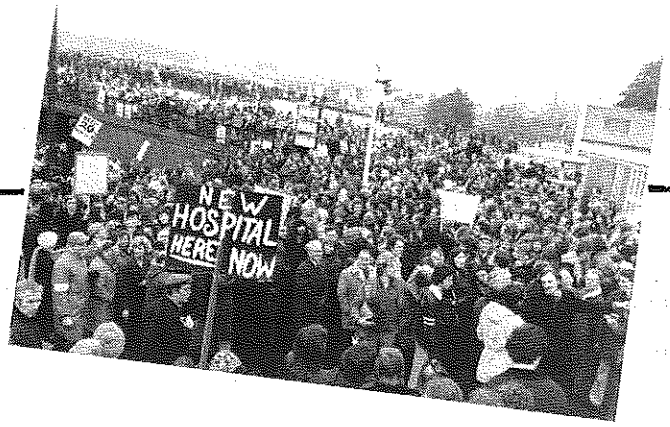
Health

Introduction

Sarah Martin



The following articles are about alternative views of health care. The first is an assessment of how China is coping with its immense health problems. The other article is a description of a health project in south east London, an inner city area in this country with extensive health problems, which it is trying to overcome in a new and co-operative way.

Health is one of the most important political issues confronting the socialist movement. The class you are born into determines not just your wealth, but how long you live and the kind of health you will enjoy during your life. And – as the women's movement has shown – the power of the medical profession is important because control over our bodies is ultimately one of the pre-requisites by which we will be able to take control of our own lives.

The assessment of health work in China was written after a visit to China in 1978 organised by the Socialist Medical Association and the Society for Anglo-Chinese Understanding. Western style health care is in an acute crisis in both developed and less well developed capitalist countries. Doctors trained in Western medicine, who are an elite group within capitalist society, take for granted the emphasis on curative rather than preventive medicine and the pressure for increased specialisation and restriction of medical knowledge. However, ever-increasing costs and the manifest failure to deal with current health problems, particularly cancer and cardio-vascular disease, and infant mortality in the Third World, has led many doctors to turn towards China for alternative models of health care. It quickly becomes clear that it is not just a question of a different organisation, but of a system of health care based on totally different values.

Much of this report covers familiar ground. We have included it because of its remarkable clarity in delineating the structure of health care in China. However, it also has very clear criteria for this structure which are important in our own assessment of alternative ways of providing health care. The key concepts are prevention, accessibility, integration, and decentralisation.

Under *prevention* is included such projects as mass health education, early screening for developing conditions, mass campaigns to stamp out infectious epidemics and pest-borne diseases, control over reporoduction. *Accessibility* talks about the spread of clinics to reach every factory and rural commune, and more importantly, enough barefoot doctors and health workers to be present and familiar in every street and workshop and school. *Integration* refers to involvement with everyday life, so that there is no disjuncture between production and health care. *Decentralisation*, probably the concept most familiar to us, is used in China as a way of responding to local needs.

The article begs many questions over real political control, both of resources, priorities and pace. But both the obvious improvement in health care and the doubts over the extent of people's control of their health and reproduction illuminate the pitfalls for our own attempts at alternative health care in Britain.

The problems are illustrated by the work of the *Health Project*, described in two interviews with two of the original workers. One is a G.P. and the other a community health worker. They have been involved over the last three years in a health group, based on the catchment area of a new health centre, which is trying to build people's confidence and control over their own health care. The first interview describes in some detail the workings of this project and some of the fundamental questions that are posed by this kind of work. The second takes place after two events. The first was an Open Day held by the project with other groups doing the same kind of work. The second was the absence, for three months, of the interviewees and the resultant increase in responsibility of the 'non-professional' workers in the group.

The changes that are described are slow and small, but they are fundamental to a confrontation over health in a class society. The emphasis is on collectivity; a collective unearthing of the conditions in which people become ill, and what needs to be done to change people's vulnerability. This is no simple programme of individual fitness, as propagated by the Health Education Council, but recognition of the need to change people's living and working conditions and to demystify knowledge and skill so that they can begin to feel at one with their bodies.

The more people understand their own health care the more the present emphasis on community care can be turned to our own advantage rather than used as an excuse for cuts. Community care will become a class confrontation over health and illness, not yet another burden on women at home, which they are expected to cope with without complaint.

Fighting for health has to become integrated into everyday life. Capitalism creates a contradication for the working class, whereby it becomes impossible to work in safe conditions and earn a living. Increased overtime, productivity schemes, pollution, overcrowded housing, unemployment . . . all of these wear out members of the working class who have no control over these factors and make a mockery of the media message 'Look after yourself'.

The inbuilt sexism has to be challenged as well which puts all the responsibility for the health of the family on women, and then denies them any knowledge, so that they become reliant on the doctor as authority. Men can learn to feel that it is not a sign of weakness to worry about your health. The sexist assumption that housework is a safe and cushy number also has to be dispelled, in the face of the enormous number of accidents in the home.

Such projects are not a diversion from fighting the cuts. They can begin to show us – despite the contradictions they face – how we might combine fighting against the cuts with the struggle for a radically different kind of health service. For example, hospital occupation committees might want to think about introducing some of the lessons of the Health Project on a wider scale. In such a way we would be moving onto the offensive: restructuring the health service so that all the people who work in it and use it are involved in determining the way it operates. A health system where workers assist users to define their own health needs. Even though at the moment such experiments reflect existing hierarchical patterns by depending on the goodwill of radical doctors, they might in the long run foreshadow how these might be transcended.

Popular Health

an interview with two community health workers

Robin MacCartney

Sarah: How did you both get involved with this type of work?

Sue: Briefly from my side of it, I started work at the Community Settlement, which is a small settlement in south east London, nearly four years ago, and for me there were various reasons why I wanted to get involved in health. One was that I had a personal interest in health through the women's movement, but I suppose the main thing that made me realise immediately it would be part of my job was that a health centre was being built on the estate where we were working. It was a large anonymous building that nobody had been consulted about. We felt that it would be very unlikely that people would be able to gain access to the centre. So we were initially thinking about how we could make it more of a community resource.

The second thing for me was that when I started working on the estates, I became involved with working with women and children, and I felt that there was quite a large amount of time spent talking about being ill. I immediately began to feel that that was the way that people were able respectably to ask for help. That being ill was quite acceptable and so people were ill quite a lot, especially if you had a number of other problems. Therefore in terms of community work and bringing people together around certain issues it might well be a catalyst for bringing people together.

John: I come from the standard medical education and I've been interested in politics for many years. I'd chosen general practice because it seemed a much more political area. People were actually living, and working in the community and that's where you had contact with them. First of all, I wanted patients to be more informed about their bodies and their illnesses. I wanted to break down the rift between professionals and patients and I wanted to get a degree of patient participation and control in our local health centre and our local health services. I wanted people to start asking for things that they wanted. But the first step seemed to be in just straightforward education, so I was interested in starting a patient group. Sue knew of group on a local estate, a mother and toddler group, so we went there and asked if they wanted to have a few sessions on health. They said yes and we just haven't stopped since. That was three years ago. The response was immediate. They were just desperate for information and what astonished me was there was also a level of dissatisfaction with doctors and dissatisfaction with the health service which came across very quickly. I had 'theoretically' realised it must be there because the health service doesn't give people what they need. Not only doesn't it give them what they need, it gives it to them in a way that they don't like either.

Health

Sue: When I started thinking about the health service it became quite clear that the health service more than any other area of our lives has become quite out of people's control, and there are certain differences in what people feel about health and what they feel about other things that affect their lives. For a start, people feel quite OK about getting angry about bad housing, about the fact that the school isn't doing what they want for their kids or the fact that social security doesn't treat you the way it should. The big problem about the health service is that even though people feel very angry about the way they're treated, they feel they shouldn't be because of what 'wonderful people' doctors are – how much they're prepared to give. It's not even realised that there's such a dependency. People have been so taken over by professional health workers. We don't even realise it.

Sarah: What kind of work has been covered by the health group?

John: It's quite an important list – kids' illnesses, the doctor's bag, vaginal discharges, cystitis, breast cancer, an overview of cancer in general, we've had long discussions about sex and violence in the home, menopause, smoking, positive health and diet. We've done some stuff on environmental health in terms of who gets sick and why people get sick.

Sue: There were a few things that came out of that. In the early stages, we found that somehow whatever we started talking about we would end up talking about depression and anxiety which was quite a constant feature in the first few months. And it was quite clear that by using a topic that people were interested in, actually having information, people were then able to discuss that and use it to talk about the things that actually worried them. The discussions in the first year were at quite an amazing level. Most of those women if you'd said, 'Do you realise this is the sort of discussion that goes on in women's consciousness raising groups?' would have been amazed, but it was.

John: The development has very slowly gone from talking about specific issues like cystitis to generalising about doctor-patient relationships. We're beginning to think about service delivery and the way the health service in the region operates.

Sue: Also to look at the health service in general, how it should be more accessible at a neighbourhood level in our particular area. And to question the whole thing about illness, and what illness is, and why we get it, and how we could be thinking more positively about health. I'm surprised at just how difficult it is to get people interested in health rather than illness.

Sarah: How has the project developed?

Sue: We found that though both John and the Health Visitor accepted that people could take control in terms of wanting people to, they were frightened that medical mistakes might be made. I've had to work quite hard at saying that it's quite positive for people to make mistakes. That we aren't going to be talking about life and death issues, that it doesn't matter if people make mistakes.

Over the three years the health group has also written two pamphlets. one on children's illnesses, and one on breast or bottle feeding. Three public meetings have been held – one on the menopause, one on cystitis and one on smoking. We've also now made a video-tape about doctor-patient relationships.

We talked about the menopause in the group and we decided that it was something that was relevant to all women and nobody knew anything about it. That idea grew to having a public meeting. John and I then started developing that idea with the steering group to being another strand of the health project, holding public meetings which might then develop into groups around a particular subject. Hopefully it would mean that some people within those specific interest groups would get a wider interest in health and would want to link in with the project in an area which would be thinking about health in all its sides. And so the menopause meeting was held, and a group did form from that, which met for a few months.

The menopause meeting was very interesting in that we had 60 middle-aged women turn up to it, which was staggering because it was on a November evening and it was wet and cold and dark and the middle of an estate. A cystitis meeting was also held and a a group has been meeting since then. The smoking group started about May 1978. That's an area of the project we would like to develop further, starting other special interest groups. The next stage will be having a day's session on health at the clinic.

Sarah: What about men in the health project?

John: That's very difficult because most of the things we do are held during the day. I think we will be getting into special interest groups that attract men more than women, things like heart disease and high blood pressure, and the smoking group has got a smattering of men in it. But on the whole, men feel very differently about their health. They're not willing to see themselves as ill or potentially ill and think that it's not really very virile to talk about yourself beyond the keep-fit weight-lifting stage.

Sue: I think women have been conditioned to feel that it's more acceptable that they are ill. Childcare in our society, in the main, is down to women and a very large percentage of people who use the health service use it for their children so it's quite natural the first links would be made with women. I don't think we need to shy away from that because I think women are important and I think women's needs in the health service are important. They are the people who have to face up to hospital births and men don't have to face up to that sort of institutionalized experience.

Another area I'm optimistic about is our group taking out the video tape to other mother and toddler groups to talk about health. With one group that we went to the problem that came out was not so much what happened when you saw the doctor but what happened in the waiting room. You always had to wait for ages, there was nothing for your kids to do and you were really anxious about your kids getting on everybody's nerves, so by the time you got into the doctor's you were so hassled about that, there was no way you were going to talk to the doctor about what you really came about. Out of the discussion about that, one or two people said they wanted to do something about it. That for me is a step forward – from talking about health to talking about creche provision and other decisions about the way the health centre is run.

I think for things to be spreading at that level, for people to see that, with some information, (a) you need to use the service less and (b) you feel a lot better about looking after yourself, we can share those sorts of ideas. The problem about that is, if you just base a project around consciousness raising, when do people start to take action to make changes and that's the whole dilemma that we're in.

One of the things that happened because of the health project was that we were able to stop the local Family Planning Association clinic from closing. The women from the group got the information and went along to the CHC meeting and managed to persuade people against closing the clinic.

John: The cuts affect us in other ways, like health visitors. The allocations are too low and this kind of thing affects us across the board. The number of beds that they think are correct are clearly too few to be effective. The cuts have affected us in terms of district nursing staff, which is much lower than it should be, and in the difficulty of providing small, but vital things like aids in the home and the fact that the local hospital is full a lot of the time. You can't actually get patients in there because there just aren't enough beds. The throughput of patients has increased – I don't really know whether that's led to poorer patient care, but it's certainly put a greater strain on community resources and greater stress on women, and indeed men, at home too.

I think what we're trying to provide is a framework whereby the whole gamut of health issues can be explored. There is a potential for us to tackle in an organised way, both questions that relate to the way an individual patient relates to his or her individual doctor at the health centre and also we will be able to tackle

Robin MacCartney

questions about where money is going in our health region. We're starting that from where people are at, what they're thinking about. At this stage, they are thinking about their illnesses and the way they relate to doctors, but all those are just beginning questions.

Sarah: How do you see the link between health work and general political change?

John: Health is such a political area – it embraces so many aspects of life. As soon as you scratch any statement about health, you come immediately across some political issue. As soon as you start looking into things like using penicillin for sore throats and why people get ill you immediately start talking about housing and diet and attitudes to going to the doctor and who makes antibiotics.

Sarah: But there is a difference between health being a political issue and how you organize to change the relations of power around health care.

John: I'm not sure how those two questions link up. At the moment there aren't many organisations that will help us to do that linking. Personally, I'd like to see stronger links with the trades council and local trade unions. We'd have to do a lot more groundwork with local unions.

Sue: I think the work we can do best is to create structures so that when we go, other people can carry on the work.

Looking at my politics in a general way, I suppose the main thing I think is wrong is that people don't have power, that they're not involved politically because they feel it's all so hopeless. Therefore any area that I work in will always be about personal struggle to regain power and thereby make change. It's crucial that people start taking control of their own health care. I think, very generally, it's that simple.

The second part of the interview took place after an absence of three months.

Sarah: What is actually happening at the Project now? It was a collection of separate groups.

Sue: First there was the influence of the open Health Day. People involved in the project saw that there were other groups. They began wanting to involve other people. In fact, they've become almost 'evangelistic' with a particular point of view to pass on to others.

The most successful groups on that day were the practical ones, like eating a meal of health food together, doing exercises, looking in ears, taking blood pressures. These started ideas for new groups. For instance, there was a relaxation and exercise groups that started while we were away, and will start again in September. There's also going to be a self-defence group for women and girls, and a blood-pressure screening group that people will do themselves.

People's perspective changed from cut and dried ideas of illness to more positive ideas about preventive health.

Secondly, much more use was made of the video on the doctor/patient relationship. The group was invited to a Labour branch day on women, and also to a day conference in East London where they met doctors and health visitors. Going out like that on their own broke their reliance on us.

They've also been taking the video on a regular 8-weekly basis to medical students at the local hospital, which hasn't made an awful lot of difference to the students, but has broken a lot of myths about future doctors. The group has also been taking the video to schools.

The groups that are going at the moment are the stop-smoking group, the original health group that goes out with the video, and a new planning group. In the autumn, we hope there will be a women's health group, arising out of the cystitis and menopause groups, and the other groups we mentioned before.

The health group took initiatives in inviting outside speakers while we were away, so it turned out to be a good thing that we went. The planning group has developed out of that independence, as people have realised that they can take initiatives and decisions as well as us. The planning group is open to anyone who wants to look at the project from a wider perspective, while the other groups remain for people who just want to look at particular aspects of health.

Sarah: Do you think that the project is moving outwards?

John: We found there is a need to identify the health needs and services in the area. But we have to be careful. We want to identify problems that people have, not pick out and label groups of people like 'the handicapped', 'the blacks', 'one-parent families'. We've started on various ways of doing this.

1. We've produced a leaflet with very general questions about health, which we're going to use to leaflet an estate, and then go door-knocking. There are worries about whether we're doing the social services work for them, but our attitude is very different. We aim, firstly, to get new people involved, secondly perhaps to set up a new group on this estate which contains the health centre, and thirdly to get some practical ideas for new approaches.
2. We're also doing the usual work of finding out the statistics on health needs and services, although this is actually bloody hard work!
3. We now have a representative on the Community Health Council, which is very useful for contact with the Area Health Authority. *[This is the Lewisham, Lambeth and Southwark AHA which has rebelled against the government directive to cut their spending.]*
4. Sue is now on the women's committee of the trades council with a particular emphasis on health. This is one way of making contact with the wider labour movement.
5. There's much more contact with health visitors. This began when the health group invited the health visitors to come and see them. The women were getting very resentful that the health visitors weren't taking any interest in this project that was taking place within their working area. Now the women from the health group are going to a mother and baby clinic at the health visitors' request to talk to the mothers there. The health

group's aim is to get suggestions for improvements and to get the women there to ask questions themselves. The health group don't want to be seen as an 'expert' or 'informed' group – and they also don't want to make life easy for the health visitors!

However, this work with the health visitors has opened up work at the health centre itself, and the job of winning over 'professional' health workers. It's become imperative to confront the other doctors at the health centre and we're going to begin by showing them the video and seeing what happens.

Sue: I'm very cautious about the response of health workers: I don't want it just to be an opportunistic reliance on patient support for health workers while cuts are threatened. The dynamic of the doctor-patient relationship has got to change as well.

Sarah: With all these new perspectives there's obviously a strain on women in the project who are being asked to do more and more work, but who aren't paid workers.

John: In this case, there is a question of what will happen to the funding for Sue's job, in that there should be local control of the money so that someone with experience of the project can take over the job. However, we're in danger of falling into the urban aid trap, which is that just as local people are getting the confidence to do these jobs, cash is being cut off from STEP, Urban Aid etc.

In general, the effect of the cuts is going to hit us harder than people think. The local hospital is definitely going to be closed. Questions about the cuts are beginning to be asked. We can go on helping people manipulate the systme but eventually people get fed up with tinkering.

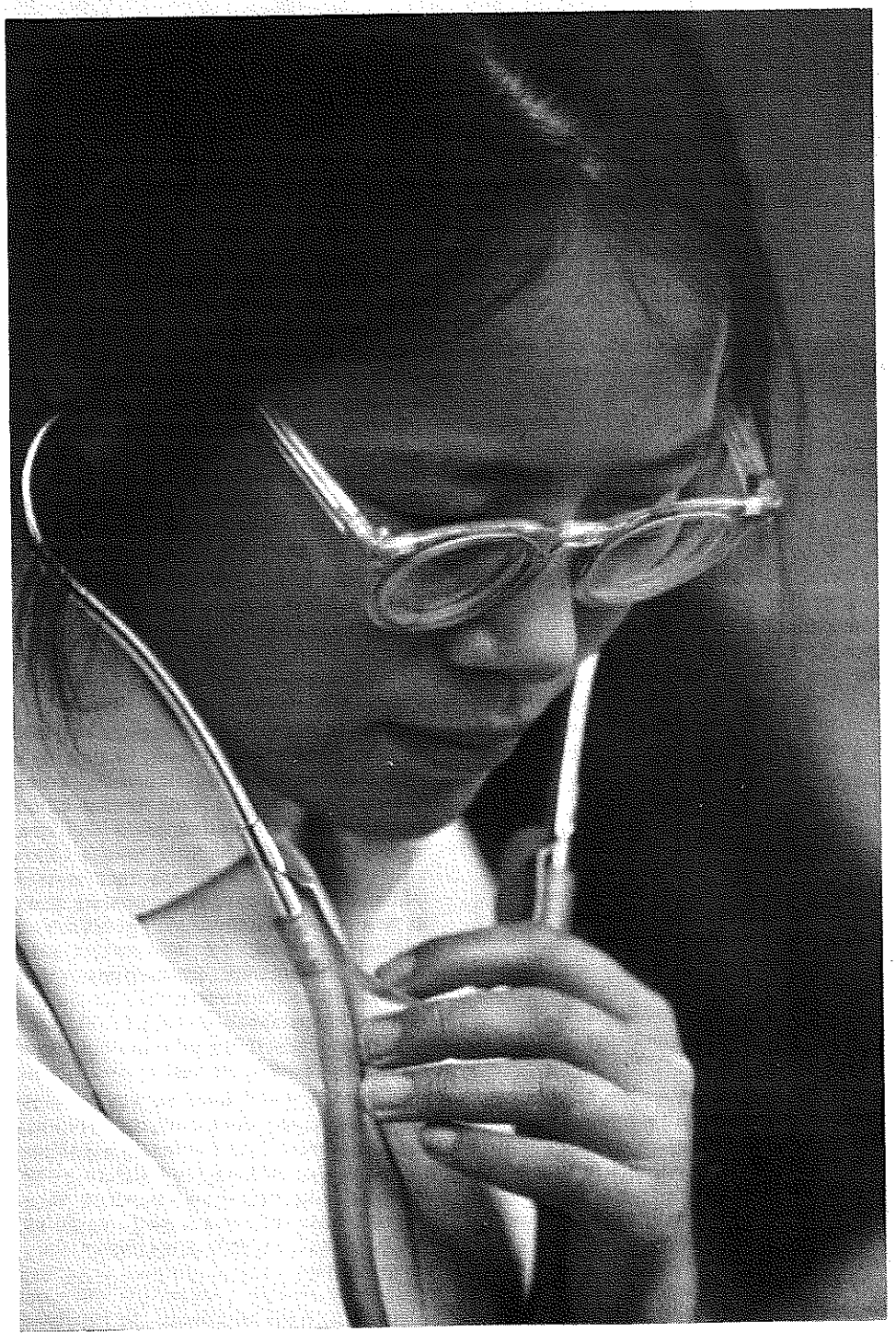
The question of the creche at the health centre shows some of the contradictory problems. What do we do if the Area Health Authority says there is no money but people still want a creche and want to run it themselves. This falls into the Tory ideology of self-help at no expense to the state. We've got no answers, but we are prepared to ask direct questions now about the implications of the cuts, and not just let people build up expectations. In general, we need to push for more money to go into projects like ours.

Sarah: What do you think the work of the project has meant in relation to your strength to face the cuts?

John: I feel quite freaked out that after three years the base still does not seem very strong, which is why the link with the trade union movement must be strengthened through the trades council.

Sue: I feel more optimistic. I think the groups will rise in response to the crisis. There's a lot of potential in friends and neighbours who haven't been active before

Health in Chin



Care

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Sheila Hillier

Part one

1. Characteristics of western systems of health care

The health care systems of late capitalist countries are characterised by a number of features. They are increasingly costly; they emphasize curative medicine at the expense of prevention; the concentration on curative medicine encourages the growth of specialisation, and the restriction of basic medical knowledge to the few; as a consequence, doctors themselves form a social elite who are repaid for specialised services with high fees, status, or both. The availability of medical care tends to vary inversely with the need for it in the population served, facilities being concentrated in the wealthy suburbs of urban areas, and utilised more effectively by members of the middle class. Control is increasingly centralised in the health care bureaucracy, in the drug, insurance and medical equipment companies, and in the elite institutions which produce medical manpower.

2. Characteristics of health care systems in less developed countries

In less developed countries where two thirds of the world's population live, the grosser features of the Western model are often reproduced, partly because these form new markets for the export of Western medical technology and drugs which are accompanied by a philosophy of health organisation and model of medical training. The problems of less developed countries, such as shortages of financial and skilled manpower, huge burdens of infectious and parasitic disease, nutritional deficiencies, and the absence of basic necessities like clean drinking water remain generally undealt with. In 1964 a World Health Organisation study found Chile and Sri Lanka devoted 94.4% of the health budget not to environmental medicine but to personal health care.

3. Problems of less developed countries

The inadequacy of the health care systems of many of the less developed countries is evidenced by the low life expectancy of the population and the high rates of infant mortality. In India, for every thousand children born, 136 die. In these countries as a whole, children, who comprise 40% of the population, suffer most. Of those under four, 48,000 die out of every million every year, compared to 625/million in developed countries. The failure of third world 'health care' is fairly spectacular.

4. Problems of Western health care systems

a) cost

What is less acknowledged is the crisis of capitalist systems of health care. Expenditure on health now takes a growing share of GNP in Europe and the USA. Those systems which propagate a lucrative system of private practice, like the USA, where 74% of the 136 billion dollars spent annually is private money, only a third of which is from prepaid insurance, promote health as a commodity. It is a commodity which is increasingly in demand as a health care/medibusiness seeks new consumers and promotes high technology 'luxury' items. The victims are not just the poor, the blacks, the Puerto Ricans who can neither afford nor utilise the health industries' products, but increasingly millions of working class people, and members of the middle class with chronic, rather than acute conditions, who try to obtain adequate health services.

In the United Kingdom, successive governments have striven to reduce the modest amount of expenditure on the NHS. Although in this country medical inflation has not reached USA standards, and the resources we do devote to health are spent relatively economically (though not fairly) the reorganisation of the health service in 1974 had as one of its main objectives the attempt to impose cost cuts effectively and dampen opposition to them in a welter of bureaucratic plans and so-called consultation mechanisms.

b) effectiveness

Perhaps a more important question than cost, however, is 'How effective is it?'. Medical science under western capitalism has produced some spectacular technological advances — life support machines, kidney machines, transplant surgery, prenatal screening, contraceptive pills, insulin and many excellent surgical techniques. As in the past however, the overall impact of medical intervention on the disease patterns of developed countries has been small. In the 19th century the provisions of decent drains saved more lives than all the efforts of doctors. In the 20th century, the same could be said of the Clean Air Act.

The health care systems have done little to increase life expectancy, especially that of working class people, and have failed to combat the two major health problems of developed countries — cancer and heart disease. In addition, mental and psychosomatic diseases, addictions to alcohol and tobacco, venereal disease, and occupational illness, are endemic and epidemic in capitalist societies.

In fact the system 'blames the victim', and continues to expose workers and their families to an enormous variety of environmental carcinogens.

This review of the health care systems of the developed capitalist countries and the less developed countries leads us to certain inevitable conclusions. Although the Western health care systems vary, the most important difference being the degree to which parts of the system are nationalised, capitalism either dominates or significantly invades them, to a degree which renders them less useful to the mass of people in these countries. The lack of relevance of the Western model for developing countries is clear. It is a new type of imperialism. It sets for developing countries health care styles which are completely ill-suited to their medical, economic and social systems, and happily profits from supplying the needs it creates.

Part two

Health care in the People's Republic of China

In its thirty years of existence, the People's Republic of China has developed a model of health care which has produced visible success. This poor and populous country has developed an alternative way of delivering health care which seriously challenges that of other poor countries, and which offers many lessons to the rich ones. Accounts of the Chinese health care system have either tended to uncritically admire everything that was presented as evidence, or have concentrated on reproducing the myriads of out-of-context statistics which Chinese sources have made available. However

enough evidence is appearing for some evaluation to take place.

Briefly, the chief features of the Chinese health care system are these — it places an emphasis on care for the rural areas; it seeks to make the health service accessible to all; it emphasises prevention; it is organised decentrally; it has initiated new styles of health worker; it has used the existing knowledge and manpower resources of traditional practitioners and tried to integrate Chinese and Western medicine; it encourages mass participation in health activities. It is clear that these general features, even allowing for the local differences and conflicts that exist, contrast sharply with the other systems described in the first section.

Antecedents of the present system

1. Traditional Chinese health care

Traditional Chinese medicine influenced the future development of health care in three ways; it represented a coherent world view, which saw health as something to be continually maintained in the ordinary structures of daily life; prevention was part of this. It was accepted that there should be state regulation of medical practice and state responsibility for health care provision. It emphasised the efficacy of locally grown plants and herbs and animal materials, compiling a vast pharmacopeia which could be utilised without a large pharmaceutical industry.

2. Western medicine

Western medicine made little impact in China until the nineteenth century, when medical missionaries visited the country, using their medical knowledge as a means of establishing themselves. The missionaries established several medical schools, the most famous of which was the Peking Union Medical College which trained an elite of medical practitioners, many of whom though now in their seventies, are still practising in China. Rockefeller money built the College as a vehicle for conveying a 'scientific rational philosophy' to China.

The Western influence produced a modest public health programme and a hospital system, a conflict between those doctors of the traditional school and those trained in Western medicine which still exists today and periodically surfaces in the Chinese press, and an elite who were reluctant to abandon their positions of power in the health service when the communists took over in 1949.

3. Red base medicine

In the 1930's and 40's, during the setting up of the Jiangsi Soviet and the subsequent Long March to Yenan, the Communist Party itself evolved specific methods of dealing with sickness, disease, and the wounded. In the anti-Japanese base areas short basic training of doctors, environmental hygiene (maintainted by mobilising all personnel) and the use of cheap, readily available traditional remedies produced a model of health care which would be extolled by Mao Zedong until his death.

4. The legacy of disease

Many observers have described in horrifying detail the state of health of the population in towns and cities during the years before 1949. Although comprehensive health care statistics in the pre-Revolutionary period are difficult to come by, what figures there are suggest a terrible burden of infectious and parasitic disease. By the 1940's the situation had worsened and by 1949 was worse still. 30% of children died before the age of 5, and 11 out of every thousand mothers died in childbirth.

At the time of the 1948 revolution there were an estimated 16,000 qualified medical doctors in China, of whom 75% were concentrated in the main towns of the six coastal provinces; this meant about one doctor for every 25,000-50,000 people. Hospital facilities outside the main towns were virtually non-existent. The antecedents described above have played an important role in the present form of the system.

Characteristics of the present health care system

1. Prevention

The philosophy of prevention was spelled out at the first National Health Conference in 1950. It was stated as being the major health objective, and mass participation of the population to bring it about was stressed. At the same time it was stated that the principle aim of health work is to ensure agricultural and industrial production. The link between health and industrial production has received varying emphasis over the last 30 years. Until about the early 1960's it was prominent, but during the period prior to the Cultural Revolution it was played down. It re-appeared occasionally during the years 1967-9, usually emphasising the importance of health care to the peasantry engaged in agricultural production, but disappeared until firmly restated at the 1978 Health conference when it was reasserted as an important factor in achieving the 'four modernisations'.

It was suggested that co-operative work on projects helped to raise socialist consciousness, and prepared the way for the rural cooperatives and commune formation. The Communist Party organisation demonstrated its ability to mobilise large numbers of people without forcible coercion, using discussion, propaganda and grassroots activists.

The 'mass line' was less successful with doctors. The medical profession in China was not interested in preventive work on a mass scale. Indeed, the whole responsibility for the eradication of schistosomiasis was transferred from the Ministry of Health to a lay group with direct responsibility to the Politburo. In general university trained doctors preferred to work in urban hospitals, and indeed there was plenty to keep them busy. In 1960 Canton's general hospitals pioneered a 24 hour service and there have been many struggles since to get the profession to extend their working hours. Only the political upheavals of the Cultural Revolution forced doctors to move from the cities to play an important role in preventive and curative work in the countryside.

As well as the difficulty of involving professionals, there were other problems. Many cadres, wishing to fulfill production plans and quotas, found the additional burden of organising health campaigns too much to cope with. Peasants themselves were sometimes inclined to see the snail clearing exercises as interfering with co-operative agricultural production or work on their private plots. During periods of political upheaval, the prevention targets were not reached. It proved more difficult to mobilise people after the Great Leap Forward (1958-1962), and during the Cultural Revolution (1966-69). During the mid-seventies, health campaigns (supposed to be held bi- or tri-annually) lapsed. Indeed one of the charges against the Gang of Four was that they interfered with public health work.

a) Parasitic and infectious disease control

i) medical activities

During the 1950's doctors and medical assistants set up an intensive programme of inoculation and tuberculosis prevention. As a result of an impressive organisation of health work, smallpox plague and cholera were virtually eliminated by 1960. Mass chest X-ray campaigns for the early detection of TB were designed as part of a preventive system. In these diseases, control followed the conventional Western model, expanded to deal with enormous numbers. By 1958, the mortality rate for TB was 46/100,000 compared with 230/100,000 in 1948. Soviet doctors often formed part of the teams which toured the countryside.

ii) mass activity

The Chinese innovation in health care was the mass activities which were the basis of the Patriotic Health Campaign of the fifties. These still continue today, especially in the big cities and coastal provinces. Using the people's fears about the effects of US germ warfare in Korea, water supplies and sanitation were improved, and methods of composting night soil (human faeces, the traditional manure in Chinese agriculture), to remove parasitic eggs, were instituted. The campaign against the 'four pests' (rats, flies, mosquitoes and bedbugs) began. 'Adult flies were pursued with fly swatters wielded with zeal, while unsanitary places where eggs might be laid and hatched into larvae were cleaned.' Millions of people were mobilised in these campaigns. Led by local cadres and reinforced by the Army, each lane, street and courtyard in every town would compete to produce enormous quantities of dead flies and rats, to fumigate premises for mosquitoes and clear the filthy ditch water that was their breeding ground.

The involvement of manpower was impressive. In Anhui province 1.5 million people devoted 20 million work days to the removal and slaughter of the snail which carries the parasite that causes schistosomiasis (snail fever). The entire working population of communes took part in 'shock' attacks to 'clean up' and rebuild.

iii) integration

The other main aspect of prevention was that it should be integrated as far as possible with production. Thus peasants engaged in massive irrigation schemes were also killing and burying the snails; they dug away infected earth from river banks and buried the snails six inches deep to kill them.

iv) health education

At the same time, extensive programmes of health education were launched; these taught people the germ theory of disease. Slide shows, pictures, songs and folk tales were all used to underline the importance of hygienic practices, and the need to eradicate pests.

v) evaluation

There is no doubt that the health campaigns, made possible by mass activity had, and continue to have, an effect. The labour-intensive model, with its ideology of the 'mass line' has many economic advantages in a poor country. Human labour — China's largest natural resource — produced widespread environmental changes at little financial cost.

Labour-intensive programmes require a degree of political stability, detailed organisation and propaganda support that have not always been present over the last thirty years in China. It is interesting to note that the campaigns have undergone a change, and the more recent ones stress the involvement of those in service industries and non-productive sectors of the economy. Teachers, schoolchildren, students, and office workers are more likely to be called on to kill rats and fumigate buildings than factory workers. The PLA and Peoples Militia do much cleaning and rebuilding, and the basic force of 3 million 'sanitarians' (part time health workers) coordinate local activities rather than cadres. Preventive injections and immunisations are now administered by barefoot doctors of whom there are 2.8 million. This and the care of mothers and children is now their main task, which they have taken over from the small numbers of university-trained doctors.

b) Other preventive services

The care of women and children has always been a priority. Maternal mortality rates have declined steadily and perinatal and infant mortality rates in large cities like Peking and Shanghai are often superior to those of Western countries.

Low perinatal mortality (a better index of medical care than infant mortality which is a combination of medical care plus social standards) is due to: few illegitimate births, which reflects the strong sanctions on premarital sexual experience, few births to women under 20 and over 40 (the promoted 'ideal age' for women to marry is 25), fewer multiple pregnancies (because of the highly organised birth control programme), and spaced births.

Antenatal care is well organised and given routinely in a neighbourhood clinic (in town) or in the brigade health station (in the commune). Women are visited during pregnancy, by barefoot doctors, and the aim is to take antenatal care to the woman either in her factory or neighbourhood, rathert than requiring her to seek out care at a clinic, as in the UK.

c) Population control

The population policy has undergone changes since the days of the Great Leap Forward when population growth was encouraged. The present population is estimated at just under one billion. All forms of contraceptive are used and they are free and easily available to married people. Low dosage pills, which have less risk of side effects are preferred, and abortion by vacuum extraction (the safest method of abortion) is readily given in cases of unwanted pregnancy. Couples are encouraged to marry late and have two or one child. A strict check is kept on contraceptive practice, and many Westerners are scandalised to see the records of contraceptive use in the locality publicly displayed in the neighbourhood clinic. The

aim has been to reduce the burth rate to 1%. 8 million fewer babies were born in 1978 compared with 1971. In the big cities the birth rate is down to 1%, but the rural areas still have more births. 1977 saw the transference of responsibility for family planning move from the Ministry of Health to the Politburo; the Minister was sacked, and there are signs that a switch in policy has been envisaged. In the past the positive economic and health benefits of two children were emphasised. The latest pronouncements describe sanctions against those couples having a third child and very strong benefit incentives for those who only have one. A 'male pill' has been tested, and numbers of portable aspirators for use in the countryside have been produced.

There are signs too of a backlash against the population policy, with wallposters accusing Deng Xiaping of coercive methods, 'married men are being forced to take drugs which damage their physical functions, pregnant women are being forced to have abortions'. These suggest that the drive to

d) Cancer screening

Apart from infectious disease, cancer is the main killing disease in China. A central programme to discover the cause was set up as a national priority in 1978, and reinstated university doctors were given this as one of the main research tasks. Cancers of the nose and throat, gullet, stomach, liver and cervix are major causes of death. Where epidemiology has shown a concentration of these cases, mass screening programmes have been set up. Whole populations are screened using simple, cheap diagnostic techniques which can be administered by medical auxiliaries (the barefoot doctors). Over the past 15 years in Shanghai the entire married female population under 45 has been screened for cervical cancer. These screening programmes, particularly that for liver cancer which identified minute growths, have been most important in the early detection of the disease, with impressive cure rates from early surgery.

It is important to stress that mass discussion and education programmes have been instrumental in overcoming fear and reluctance to be screened. In Western countries, cervical screening is very much an individual decision which middle class women are more likely to take, and in general cancer screening programmes are not undertaken because of their cost, and the fear of discovering fatal disease, although studies have shown the benefits of mass screening for cervical cancer.

Accessibility and decentralisation

a) Organisation

The basis of all preventive and curative programmes in China is accessibility. Every factory has a rudimentary clinic, every workshop a volunteer health worker. Responsibility for primary care lies in the hands of part time volunteers and barefoot doctors, who staff factory workshops and sections, and production brigade health stations. There will usually be 10 of these at this level, caring for about 200 households of 1500 people. At production team level (20-40 households) there will be 3 or 4 barefoot doctors.

Each of China's 50,000 communes has a hospital or clinic, which can be a simple affair, with a couple of beds and rudimentary equipment, or on richer communes a 20-bedded hospital offering a wide range of services. The health care on the communes is financed by the co-operative medical fund, towards which each person pays 1 or 2 yuan a year (a Yuan equals about 35 pence, but rural incomes average 150Y per annum). County hospitals, where more complex cases are sent, are state financed. Every one of the 2000 counties has one. In the cities, the local level of health care is at the street or lane clinic and cases are referred upwards for treatment to district hospitals. Big teaching hospitals in Peking, Shanghai and Canton resemble their Western counterparts both in the kind of care they give and the level of trained staff, equipment and technology they possess.

b) Decentralisation

Decentralisation implies making local levels self-financing and self-reliant as far as possible, and reducing the need for referrals to large city hospitals. It implies a degree of autonomy at the local level to allocate resources as it wishes, but there has been a trend towards requests by communes for greater handouts from regional funds to keep their services going.

An examination of evidence shows that some major policies were initiated and directed by the centre — the training of barefoot doctors, the initiation of the co-operative medical service, the war on schistosomiasis, the birth control programme.

c) The Cultural Revolution in health care

Perhaps the major assault on the policy-making process in health care came from Mao Zedong himself. After bureaucratic retrenchment in the early 60's, he saw radical innovations in health care vanishing with the growth of the party bureaucracy. Western medicine was being promoted at the expense of traditional medicine, rural health care programmes folded, 'middle-level' medical schools collapsed. 80% of the health care budget went on the towns. The medical schools were staffed with the children of the bourgeoisie. He summed up the discontent of the rural disadvantaged in his famous directive of June 26th 1965.

'Tell the Ministry of Public Health that it only works for 15% of the total population of the country and that 15% is composed mainly of gentlemen, while the broad masses do not get any medical treatment. The Ministry of Public Health is not a Ministry of Health for the People so why not change its name to the Ministry of Urban Health or the Ministry of Gentlemen's Health. In medical and health work put the stress on rural areas'.

i) mobile medical teams

In the upheavals of the Cultural Revolution, mobile medical teams of urban doctors were sent to the countryside. Medical schools were closed, and students graduated after only a few months and were sent to work in the rural areas. The Ministry of Health was attacked by Red Guards and all its ministers dismissed.

ii) 'barefoot' doctors

The major innovation in health care of the Cultural Revolution was the wholesale training of 'barefoot' doctors. These were peasants or middle-school graduates who, after a short 3 or 6 month training, formed the backbone of health care in the rural clinics, and at primary level in the towns. Their exploits and superior diagnostic efforts were much praised by the media up to the early 70's when a more sanguine view suggested that many needed to improve their skills. Deng Xiaoping was among those suggesting that the barefoot doctors needed to move from 'being barefoot to straw sandals, cloth shoes and leather shoes', suggesting an improved level of training standards. This view was often shared by the peasantry, who paid barefoot doctors by crediting them with work points and wanted value for money. Some barefoot doctors themselves often found the combination of agricultural and medical work arduous; others fell victim to 'wanting to be city doctors in white coats. They bought large volumes costing 9 or 10 yuan and walked round the village showing off'.

Despite some problems, however, the barefoot doctors have proved a good solution to the problem of cheap, accessible health care. Problems of quality of care are being rectified. Barefoot doctors now receive priority in admission to medical school, and it is clear that they will be of major importance in health care provision for the foreseeable future. Barefoot doctors practise the techniques of traditional medicine using acupuncture and low-cost plant drugs, usually manufactured locally. The Barefoot Doctors' Handbook shows the degree to which primary health care, at least, is dominated by traditional medicine.

d) The fall of the Gang of Four

Recent political changes in the Peoples Republic of China have meant changes in the health care system, although the fundamental objectives remain unaltered. A more strongly directive element has crept into health care policy and two Ministers of Health have been sacked in the last two years. Population planning is now subject to stronger Party controls, and university medical education has been extended to five years, dispensing with the 3 year curriculum of the early seventies. Fundamentally, however, a strong infrastructure of health care has been built and stabilised. Inequalities exist between rural and urban areas, but what looks like a devolution of responsibility from the centre to the Regions in the provision of health care means that decisions about resources can be made at this level, ensuring that the disparity between Peking and the rich coastal cities and the rest of the country can be debated at the Regional level as a quasi-federalism emerges.

3. Conclusion

This review of the Chinese health care system has attempted to describe the ways it differs from that of the West and of less developed countries and to explain some of the political and historical reasons for this contrast. Despite certain disadvantages, on a number of criteria, the system measures up very well.

a) Efficiency

The shifting nature of the Chinese political system makes long-term planning difficult, but on the other hand, the health care system is inexpensive and local financing makes for local monitoring and control of resources. Scarce medical resources are used well and the labour-intensive model, along with the preventive health campaigns, has provided a low-cost solution to the problem of environmental hygiene.

b) Effectiveness

Major infections and parasitic diseases, with the exception of schistosomiasis, have been eradicated, or brought under control. Mortality rates have lowered dramatically, and life expectancy has increased. Infant mortality rates have dropped and in the large cities compare and occasionally surpass those of advanced countries. Inequalities exist between the health status of the major coastal cities and the rural hinterland, but these appear to be narrowing. Surgical techniques like limb re-attachment, and screening techniques for cancer prevention have enabled the treatment of patients, who in the West would have been given up as hopeless.

c) Acceptability

The use of deprofessionalised health workers, and the involvement of lay workers in the management and delivery of their own health care has meant a high level of acceptability of the service. The use of ordinary men and women has meant that screening programmes, which often arouse resistance in groups at risk, have been possible. The use of traditional medicine and attempts to combine it with Western medicine have been welcomed by most people, although there are reports of the rejection of the former, especially by Western-trained doctors, and indulgence in 'superstitious practices' for profit by lay healers. Barefoot doctors have also been criticised for their youth and lack of skill

d) Accessibility

An admirable level of accessibility has been achieved by decentralisation thus making rudimentary health care available in the school, college, workshop or field. The problem is therefore one of keeping the system coing at the local level. A few bad harvests can wipe out the funds of the co-operative medical service; standards of care may vary, although it is argued that the standard of local care can be maintained by local financing.

What one sees in China is still far from perfect; it is an evolving system, with variable progress, which has enabled 'the masses to rise and free themselves from illiteracy, superstition and unhygenic habits' and to live longer and healthier lives.

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