45

COMMUNIST MEDICINE

The emergence of TCM and barefoot doctors, leading to contemporary medical markets

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When the Chinese Communist Party (CCP) overcame the Nationalists and established a new regime in October 1949, it inherited a dire medical situation. Medical resources were deplorably scarce and health indicators were extremely low, as were the administrative blueprint and experimental practices for improving the health of the people (Lucas 1982: 461–89; Yip 2009a: 105). The Communist regime incorporated its political ideology and social mobilisation strategies into its medical and health work in order to overcome resource and personnel constraints (Oksenberg 1974: 375–408; Perry 2007: 15; Thornton 2009: 93). In 1951–52, the government established its four general principles of health work at the National Health Work Meeting, namely 'prevention first; serve workers, peasants, and soldiers; unite Chinese and Western medicine; and combine health work and mass movements' (Wilenski, 1976: 7). These principles underlay the priorities, objectives, and organisational strategies for Communist health work, including strategies regarding Chinese and Western medicine. Throughout the state-building and modernisation processes of the second half of the twentieth century, specific features emerged for Communist medicine, notably the definition of Traditional Chinese Medicine, the promotion of barefoot doctor programmes in rural China, and the rise of national medical markets.

The emergence of traditional Chinese medicine (TCM)

Prior to the nineteenth century, the term 'medicine' (*yi* 医) could refer to any form of medicine from different medical schools and social strata in China. It also encompassed a wide range of practices, including oracular therapy; demonic medicine; religious healing; pragmatic drug therapy; Buddhist medicine and the medicine of systematic correspondence in a broad sense (Unschuld 1985: 5). In 1834, American missionary doctors arrived in Canton, which marked the beginning of Western medicine in China (Barnes 2005: 288–90; Taylor 2005: 79; Yang 2013: 24; Andrews 2014: 53). It was only at this point that the term 'Chinese medicine' (*zhongyi* 中医) first appeared, as a way of distinguishing local practices from those of the missionaries.

The advent of Western medicine in China gave rise to new ideas about 'the presence, nature, and causation of disease; appropriate therapies; and the legitimacy of native, foreign, and foreign-trained healers; the imposition of policing measures in the name of public

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health; the need for a particular institutional infrastructure; and the intellectual presuppositions themselves of Western medicine' (Cunningham and Andrews 1997: 14). From the early twentieth century onwards, Western medicine started to challenge the legitimacy of Chinese medicine. In 1929, the proposal for 'Abolishing Old-Style Medicine in Order to Clear Away the Obstacles to Medicine and Public Health' was passed by the first National Public Health Conference of the Nationalist government. It became the hallmark event of the legitimacy crisis for Chinese medicine in the first half of the twentieth century.

Throughout the Republican period, reform-minded Chinese medicine practitioners attempted to bring about profound institutional; epistemological and material changes in their field. These reformers strove to launch a national medicine movement, 'scientificize' Chinese medicine, and establish schools and associations (Zhao 1991: 21–37; Farquhar 1994b: 12; Xu 1997: 847–77; Lynteris 2013: 66; Yang 2013: 354; Andrews 2014: 145–84; Lei 2014:101–5). On the one hand, though Chinese medicine doctors were not deprived of their status and their legal right to practise medicine, the state was reluctant to legitimise them, and their position was precarious and continually challenged throughout the Republican period (Croizier 1968: 234). On the other hand, Chinese medicine still enjoyed great practical legitimacy. As a 1935 survey indicated, 1,182 Western-style medicine doctors were practising in Shanghai, while there were 5,477 licenced Chinese medicine physicians, not counting those who were unlicenced (Xu 1997: 847–77). In rural areas, villagers usually resorted to folk healers and professional Chinese medical practitioners (Fang 2012: 20–2).

Ironically, the situation did not change much until the mid-1950s. Though 'the unification of Chinese and Western medicine' was adopted in 1950 as one of the three health work principles at the First National Health Work Meeting with a goal of creating a single 'new medicine', the Communist government gave Chinese medicine very little administrative power within the higher echelons of the party structure (Unschuld 1985: 247; Taylor 2005: 30–1). According to *The Provisional Regulations Governing Doctors of Traditional Chinese Medicine* implemented on May 1, 1951, a Traditional Chinese Medicine doctor was not allowed to prescribe chemically compounded medicines or give injections unless he had received scientific training in medical treatment, and under no circumstances could he induce an abortion (Fang 2012: 45). In the meantime, Chinese medicine was viewed as a 'feudal society's feudal medicine that… needed to be transformed through strict controls on medical practice and reeducation of its practitioners' (Scheid 2002: 69).

According to the new licencing regulations, Chinese medicine doctors had to pass qualification examinations, which required extensive Western medical knowledge. Chinese medicine improvement schools were also established to improve Chinese medicine practitioners' political understanding and scientific techniques and disseminate theoretical and practical knowledge of Western medicine among them as part of the programme of 'Chinese medicine studying Western medicine' (Scheid 2002: 69). Lecturers at these schools were usually doctors of Western medicine who offered a strong, condensed regimen of basic biomedicine, including anatomic physiology, pathology, germs, medical history, and pharmacology (Taylor 2005: 47). Students also studied social sciences, and preventive medicine (infectious medicine and public health), and were encouraged to gradually develop towards preventive medicine and the 'scientificizing' of Chinese medicine (Scheid 2002: 69–70).

However, Chinese medicine gradually acquired legitimacy under the Communist regime. In late 1953, the Ministry of Health was criticised for its policies on Chinese medicine because the licencing and recruitment regulations for Chinese medicine doctors seriously restricted their medical practice. In July 1954, Mao put forward the idea of 'Western medicine studying Chinese medicine' in order to eradicate the boundaries between Chinese and

Western medicine and form a unified Chinese medicine. Soon various training classes of 'Western medicine studying Chinese medicine' were established throughout China. The term 'Traditional Chinese Medicine' (TCM) first appeared in 1955 (Taylor 2005: 84), but it is found only in Western-language literature. No equivalent term is applied in China, where 'Chinese medicine' (*zhongyi* 中医) remains the more proper term (Scheid 2002: 3). Meanwhile, the previous regulations on Chinese medicine doctors were abolished, the China Academy of Traditional Chinese Medicine and Chinese medicine hospitals were founded, and Chinese medicine was integrated into Westernised medical universities, colleges, schools, hospitals, and so on.

In 1956, the 'integration of Chinese and Western medicine' was first proposed by Mao and became the guiding principle from then onwards. During the Cultural Revolution, the integration of Chinese pharmaceuticals and treatment methods with Western diagnostic techniques, treatment, and pharmaceuticals was further promoted and advocated (Lampton 1977: 112; Scheid 2002: 65–88; Taylor 2005: 30–150).

In this way, Chinese medicine, now known as traditional Chinese medicine (hereafter TCM), was transformed from the marginal, sidelined medical practice it had been in the early twentieth century to an essential and high-profile aspect of the national healthcare system. The institutionalisation and standardisation of Chinese medicine in Communist China was completed by 1963, by which time it had begun to be admitted into the primary health care system (Taylor 2005: 12). During the 1960s, TCM was practised in hospitals and clinics and taught in schools. Knowledge of it was systematically recorded in textbooks, and it was divided into categories which parallel those of Western medicine (Scheid 2002: 65; Taylor 2005: 147). By the 1980s, C. C. Chen, who led a rural medical experiment in Ding County, Hebei Province, under the leadership of James Yen in the 1930s and was opposed to TCM, reluctantly admitted that 'each system has its own representation in the central government, as well as its own nationally or provincially administered urban clinics, hospitals, and medical schools… as of 1987, organisational conflict had almost entirely disappeared' (Chen, 1989: 147).

Since the 1970s, TCM has undergone four major tendencies: Westernisation; standardisation; urbanisation and globalisation. The Westernisation process was formally recognised after 1980, when the Ministry of Health listed Chinese medicine, Western medicine, and the integration of the two as the three great pillars of the Chinese medical system. The integration of TCM and Western medicine is usually regarded as a branch within TCM. However, practitioners of both TCM in general and the integration of this with Western medicine usually resort to Western medicine diagnostic techniques and prescribe Western pharmaceuticals.

Second, influenced by the Chinese Herbal Medicine Campaign and Western pharmaceuticals, Chinese patent medicine developed rapidly during the 1970s. To overcome the inconvenience of decoction of Chinese *materia medica*, raw herbal medicines became much more commonly made up into pills, liquids, syrups, and powders than before, and new forms such as granules, instant teas and capsules also came into use. Chinese medicinal products have been further standardised in terms of these extraction and production processes, packaging, dosages, and ingredients.

Third, as barefoot doctors brought new healing styles and a host of Western medicines to rural China from the 1960s onwards, villagers, in turn, developed a preference for Western medicine. Interestingly, as Farquhar found in the early 1990s, urban Chinese 'are these days much more enthusiastic users of Chinese medicine than rural people' (Farquhar 1994a: 476). Her findings were been increasingly verified during the first decade of the twenty-first century.

Last but not least, TCM, represented by acupuncture, massage and herbs, is going beyond China and is now practised in an increasing number of different settings across various continents (Zhan 2009). As Volker Scheid points out (2002: 268–9), 'after a century of struggle against domination by Western medicine, of modernisation and revolution, Chinese medicine now stands at the threshold of emergence as a truly global medicine'. However, this does not mean that Chinese medicine has a dominant position outside China, where it is still an 'alternative medicine'.

The promotion of the barefoot doctor programmes

The establishment of the state medical system in rural areas was highly significant as China had a largely rural population. The rural medical system was proposed and implemented experimentally in the 1930s by the Nanjing-based Nationalist government and the Rural Construction Movement, which was represented by C. C. Chen in Ding County, north China. In both the governmental and non-governmental blueprints and practices, at the lowest level of the organisation were village health workers. The Communist regime basically inherited these practices (Lucas 1982: 479; Chen 1989: 423; Yip 1995: 76–7; Andrews 2014: 108–11). With the beginning of agricultural collectivisation in 1952, villagers were selected to become health workers within mutual aid teams and cooperatives as part of the programme of enhancing agricultural productivity. The selection criteria for these initiatives were the possession of both basic primary educational qualifications and the right political credentials. Selected candidates were required to follow an informal training programme entailing the 'Four Principles of Health Work', which pertained to basic first aid and preventive medical treatment (Fang 2012: 27).

Starting in 1965, the Communist government launched the Socialist Education Campaign targeting the inequality in the distribution of healthcare resources, as well as rural politics and other social issues, including education. Plans were put forward to organise mobile medical service teams for rural areas and to train rural health workers in order to improve the rural medical situation. Under this programme, each production brigade was required to have two 'half-peasant, half-doctors (*bannong banyi* 半农半医)', one of whom was to be a woman who would be in charge of delivering babies. Youths with primary and middle-school education and 'good' family origins; 'correct' political thoughts and 'love for the countryside' were selected after being nominated by the masses; recommended by the association of poor peasants; approved by a party branch or commune and interviewed by a training unit. After receiving training, they returned to their own brigades where they were required to diagnose and treat a number of common diseases using their basic pharmaceutical knowledge, as well as conduct the Patriotic Health Campaigns, while participating in agricultural production (Fang 2012: 29–30). In Shanghai suburban areas, local people usually called these new health workers 'barefoot doctors' (*chijiao yisheng* 赤脚医生) as, in addition to providing villagers with basic healthcare, they also laboured barefoot in the rice paddy fields.

On September 14, 1968, an investigative report entitled 'Fostering a Revolution in Medical Education through the Growth of the Barefoot Doctors' was published in the *People's Daily*, an organ of the Central Committee of the CCP. It described the work of barefoot doctors in Jiangzhen Commune, Chuansha County, Shanghai Municipality. The concept of barefoot doctors was first introduced to the public through newspaper pieces (*Renmin ribao*, 1968a). On December 5, 1968, the same newspaper carried a report with the headline 'Cooperative Medical Service Warmly Welcomed by Poor and Lower-Middle Peasants'. This article introduced the new cooperative medical service of Leyuan Commune, Changyang County, Hubei province (*Renmin ribao*, 1968b).

As one of the 'newly emerged things' that reflected the political ideologies and rural development strategies of the Cultural Revolution, the barefoot doctors were rapidly popularised, and cooperative medical stations were set up in villages nationwide with revolutionary zeal (Sidel 1972). Villagers paid fees to form local 'cooperative medical services' to cover the costs of establishing these medical service stations, which would be presided over by barefoot doctors. When villagers sought treatment at cooperative medical stations, they were given certain services and medicines free of charge. Soon every village had at least one barefoot doctor to provide basic medical care, creating a national network of healthcare services for the very first time. Barefoot doctors formed the lowest level of a three-tiered state medical system that comprised the county, commune, and brigade levels. The health implications of the advent of the barefoot doctors lie in that they carried out the social transformation of rural medicine through the introduction of Western medicine and the marginalisation of TCM in Chinese villages across the spheres of knowledge; pharmaceuticals; healing; institutionalisation and professionalisation.

The barefoot doctor programmes changed the traditional family and apprenticeship-based forms of knowledge transmission in the villages and led to a Western-influenced medical knowledge structure among barefoot doctors themselves and those living in their villages because of the selection criteria, the appearance of unified medical textbooks, and the presence of instructors teaching Western medicine. Through barefoot doctors, Western pharmaceuticals were introduced into Chinese villages on a large scale. Meanwhile, TCM was given official legitimacy due to economic factors, though it was promoted in the name of political discourse and ideology (Fang 2012: 42–93).

Barefoot doctors developed a healing style which was also more oriented towards Western medicine from the start, due to the nature of the knowledge structure, the medical proficiency and the availability of medicines. Their practices included the use of basic modern medical instruments and the prescription of Western medicine as tablets. Villagers also formed comparative medical beliefs about Chinese and Western medicine, such as 'western medicine works quickly, Chinese medicine slowly' and 'western medicine treats (only) symptoms, Chinese medicine treats the root of the disease' and also applied different medicines to different diseases. The interactions of healing styles and medical beliefs completely changed pharmaceutical consumption in Chinese villages, a process in which TCM pharmaceuticals were quickly marginalised (Ibid.: 94–124).

The setting up of medical stations presided over by barefoot doctors not only strengthened the medical community based in each commune, but also completed a mechanism for coordinating a hierarchical medical system for the first time in rural China. Depending on the referral system, barefoot doctors extended and stratified medical encounters in villages, communes and county hospitals. During this process, medical stations and county hospitals grew, while commune clinics – the middle level of the three-tier medical system – experienced a dramatic decline. The pyramidal three-tier medical system evolved towards a dumbbell-shaped structure, with barefoot doctors replacing commune clinics and gaining dominance in the local community (Ibid.: 125–50).

Barefoot doctors gradually developed a group identity from the late 1960s by setting themselves apart from 'competitors' in the local community, including folk healers (legitimate or illegitimate) and other medical practitioners, while forging links with medical station colleagues and barefoot doctor peers. The barefoot doctors' status and respect rose steadily in part as a result of their daily interactions with patients and in part because of the rapid effects of Western medicine. The state contributed to the formation of group identity among barefoot doctors and facilitated their rise in community power relationships over villagers (Ibid.: 151–66).

In 1978, Deng Xiaoping developed the rural socioeconomic reform policies of the household responsibility system following the end of the Cultural Revolution. Their implementation included the dismantling of the people's commune system, which led to the gradual disintegration of the barefoot doctor programme. On January 24, 1985, the health minister Chen Minzhang 陈敏章 announced that the term 'barefoot doctor' would no longer be used in China: 'From now on, those barefoot doctors who reach the proficiency level of secondary technical school (*yishi* 医士) shall be called "village doctors" (*xiangcun yisheng* 乡村医生), while those who cannot reach the *yishi* level shall be called "health workers" (*weishengyuan* 卫生员)' (Chen 1985: 137).

During the changeover, medical examinations and group differentiation re-defined the medical legitimacy of barefoot doctors, and medical proficiency became a key requirement. In this sense, the disintegration had a positive impact on rural health because of the increasing professionalisation of former barefoot doctors. From then on, barefoot doctors effectively became private medical practitioners with their own clinics, though they still undertook public health work in villages. The reforms also resulted in a remarkable continuity in the provision of medical care and public health, even though rural Chinese people faced serious challenges in their efforts to access healthcare services (Rosenthal and Greiner 1982; Fang 2012: 166–76).

The basic structure of the rural medical and health system did not undergo much change from the 1980s until the implementation of the 'integrated management of rural health' medical reforms in 2008–10. County governments established new health service stations and abolished extant village clinics or merged these into health service stations. The regulations specify that these centres and stations must provide 'six-in-one' services to villagers, which encompass prevention; treatment; promotion of health and wellbeing; rehabilitation; health education and family planning advice. Meanwhile, given that the majority of current village doctors began work under the barefoot doctor programme, many will be retiring soon, so county governments started training rural community doctors to fill these forthcoming vacancies in 2009. Senior middle-school students were selected and sent to study clinical medicine for three years at medical college, and will be assigned to health service stations after graduation. As such, in the near future, the barefoot doctors of the Cultural Revolution era will completely disappear from the medical world of China's villages.

The path to the contemporary medical market

The medical market includes doctors and pharmacies. For thousands of years, China's doctors and pharmacies operated separately from one another, with the exception of the 'doctors who sit in the pharmacy (*zuotangyi* 坐堂医)', who used the premises as consulting rooms. Medical practitioners would suggest which pharmacy patient families should buy medicine from, a practice which, to some extent, exerted pressure on the pharmacy (Leung 2002: 354). The owners of these pharmacies usually had some basic medical knowledge and dispensed medicines themselves, since they did not usually hire staff or only had one or two apprentices. The shops were generally small and were usually located inside owners' homes (Zhu 2006: 243). These private Chinese medicine shops had their own medicine supply sources and limited networks, which were confined to certain geographic scopes because of transport issues (Cochran 2006: 4–8). Nonetheless, Chinese consumption of pharmaceuticals (Chinese *materia medica* and patent medicines) was quite limited. The medicine that patients bought was usually *xingjunsan* (行军散 for treatment of heatstroke, diarrhoea, stomach ache and internal heat), *biwendan* (避瘟丹 for treatment of heatstroke, acute gastroenteritis and diarrhoea), and *shayao* (痧药 for treatment of heatstroke) (Qiao 1992: 308–9).

Western medicine shops started appearing in urban and metropolitan areas of China after the late nineteenth century, while transnational pharmaceutical companies moved into the Chinese medical market and competed with newly emerged pharmaceutical companies run by Chinese. Though Chinese people could access Western medicine, especially after the Second World War, supplies were still quite limited and prices were high. For example, a bottle of penicillin was worth the equivalent of 50 kg of rice before 1949 (Shi 1992: 648). As a result, Chinese medicine shops still dominated the Chinese medical market (Fang 2012: 74).

After 1949, the Chinese medical market underwent two significant changes: the integration of doctors and pharmacies at hospitals and the formation of a new state pharmaceutical network based on the pharmaceutical networks and private medicine shops already in existence. The main purposes of these initiatives were to allocate, supply and sell both Western and Chinese pharmaceuticals to customers efficiently and economically, while meeting the growing demands of various medical and health campaigns (Ibid.: 74–7).

The establishment of the state medical system and the pharmaceutical sales system, which were supported by the development of the medical educational system and pharmaceutical industries, contributed to the rise of the Chinese medical market nationwide. In rural areas, the formation of the three-tier medical system made villager patients move from seeking treatment in the broad, mixed sector of folk remedies and healing by exorcism, divination and prayer, to local and regional hospitals. In urban areas, the implementation of free medical services and labour insurance medical services provided the state medical system with a reliable source of patients. These two factors contributed to the rise of a huge medical market in China.

As China is an agricultural country where the population is predominantly rural, the rural medical market is especially significant. County pharmaceutical companies were first set up in the early 1950s, with the aims of managing the wholesale supply of medicines within the county through rural clinic pharmacies; supply and marketing cooperatives and medicine shops, as well as some medicine peddlers. In the mid-1950s, rural pharmacies were incorporated into clinics or rural supply and marketing cooperatives. In this way, a pharmaceutical sales network was gradually established in rural areas.

After 1968, cooperative medical stations were established with the popularisation of barefoot doctors in rural China. Each was presided over by a barefoot doctor with a medical kit. The medical stations and kits extended the pharmaceutical sales network throughout rural China at a rapid pace, and were thus highly significant in the social history of medicine in Chinese villages. Meanwhile, the wholesale pharmaceutical network was further extended to the commune level. Each county's people's disease prevention and treatment hospital (formerly known as the county people's hospital) commissioned commune clinics to serve as medicine wholesalers.

Through these initiatives, prices were radically reduced, which was a crucial factor for villagers. For example, on August 1, 1969, prices for 1,230 kinds of antibiotics, sulphanilamides, fever-reducing medicines, pain-relieving medicines and other medicines were reduced by 37.2%. These products constituted about 72.1% of the total pharmaceuticals available at the time. By 1971, medicine retail prices were only one-fifth of what they had been in 1949 (*Zhongguo yiyao gongsi* 1990: 273). Antibiotics including tetracycline and terramycin became common pharmaceuticals prescribed by doctors and consumed by patients during the 1970s. These medicines were particularly effective for treating common diseases.

Because of the rise of the national medical market, pharmaceutical consumption and medicine expenditure per capita increased steadily throughout the 1970s (Fang 2012: 111–20).

The improvement in basic health indicators was very impressive, and China was promoted as model for developing countries by the World Health Organisation (WHO 1978). From the late 1970s onwards, China's economic reform had a huge impact on the medical system, pharmaceutical sales network and medical market, in both positive and negative ways as the state retreated from medicine and healthcare provision (Duckett 2010). In rural areas, the dismantling of the people's commune system in the early 1980s resulted in the disintegration of cooperative medical service stations presided over by barefoot doctors, which affected public health and medical service to different extents (White 1998; Blumenthal and Hsiao 2005: 1165–9). In urban areas, one consequence of the economic reform, especially the state-owned enterprise reform in the late 1990s, was that workers and employees lost the basic medical welfare they had enjoyed in the socialist era.

Meanwhile, the medical market was becoming increasingly commercialised. On the one hand, because of this commercialisation and marketisation, patients were able to obtain cheaper, more convenient and more effective medical services than before. Alternative medical markets also flourished, including *qigong* 气功, acupuncture, massage and *yangsheng* 养生 (nourishing life) (Farquhar 1996; Hsu 1999; Chen 2003; Farquhar and Zhang 2012). However, the pursuit of profit resulted in over-commercialisation and marketisation, which further led to a further series of problems, such as wide gaps in access to healthcare between rural and urban areas, inter-regional gaps, the over-concentration of medical resources, unaffordable prices for medical attention and a worsening of relationships between doctors and patients.

Among these problems, the overuse of pharmaceuticals and medical technologies is the most serious as the sale of pharmaceuticals as a revenue source for doctors (known as 'supporting doctors by selling medicines', *yiyao yangyi* 以药养医) became the main profit-making mode in the medical market (Farquhar 1996: 244; Fang 2012: 121). Pharmaceuticals account for 45% of China's healthcare expenditure, or 1.6% of its GDP, far above other countries, where pharmaceuticals usually account for one-quarter of total health-related spending (Organisation for Economic Cooperation and Development 2010: 272). This overuse is particularly common among village doctors, who have an incentive to overprescribe, given that they rely on medicine sales for part of their income. For nearly three-quarters of the patients surveyed, the medicine prescribed was an antibiotic, while one-fifth were prescribed two or more drugs (Ibid.: 225). Similarly, this commercialisation and marketisation also resulted in the overuse of medical technologies. The high caesarean section rates at Chinese hospitals is a typical example of this.

In view of these problems, the Chinese government has been making efforts to tackle these shortcomings of the medical market, such as by implementing the National Basic Pharmaceutical Catalogue in the New Rural Cooperative Medical Services and Basic Medical Insurance for Urban Residents to curb the overuse of pharmaceuticals. However, it remains a challenging task for the government, such as 'medical disputes' (*yi'nao* 医闹) over the recent years. Patient families physically attacked and assaulted medical doctors and hospitals due to their mistrust and suspicion towards the medical market and their reluctance to accept the results of medical treatments (Hesketh 2012).

Conclusion

As the key components of the Communist medicine, the emergence of TCM, the promotion of the barefoot doctors programme, and the rise of the national medical market were the landmark events in the social transformation of medicine in China guided and dominated by the state after 1949. During this process, the recognition of the legitimacy

of TCM in the 1950s and the launching of the Chinese herbal medicine campaign in the 1960s demonstrated the state's realistic strategies and tactics towards TCM when faced with constraints on resources and personnel. This process also indicated the decisive role of the state in improving health and medicine, including the integration of doctors and medicines in the late 1950s; the implementation of the national barefoot doctor programme after 1968 and the large-scale decrease in pharmaceutical prices from the 1950s onwards.

The social transformation of medicine in China also reveals a dynamic relationship between the state and the local governments. In the post-socialist era, after 1978, the state retreated from health and medicine in terms of investment and allocation of funding, resources and personnel, as well as administrative intervention, which were relegated to local governments (Huang 2004). With the initiation of the economic reform, the Chinese medical market has been greatly commercialised, which is further complicated by the medical technology, services, and management strategies brought by globalisation. The commercialisation of the medical market not only provides Chinese with good, convenient, and effective medical services, but also brings serious challenges to the government, such as the worsening patient-doctor relationships.

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