

## Chapter 17

# A Risk Society

“Risk society” is a concept that was first framed by the German sociologist Ulrich Beck in *Risk Society* in 1986. In Beck’s view, the modern society had deviated from (Karl Marx’s) class society or (Max Weber’s) industrial society and had developed into a social form that is highly modern, known as the “risk society.” Social theories based on unequal distribution of wealth (the functional theory, Marxism, and various kinds of postindustrial or postmodern theories that derived from it) have lost their interpretability when it comes to the crisis and inequality in the distribution of risks. Therefore, there needs to be a turn in social theories, that is to say, “risk sociology” needs to be advanced with problem awareness being “how to avoid, minimize, and direct risks or hazards systematically created as a part of modernization.”

Beck’s concept of a “risk society” demonstrated his worries about and vigilance against “the faith in the progress of capitalism” (Zhou Guitian 1998). When the belief is embedded in the political decision-making mechanism of the modern state, and becomes the normal practice in social order, it will lead to “linear rationality” and, consequently, a “world ungoverned.” The vast rural areas of China, threatened by ubiquitous diseases, had been actually thrust into a “risk society.”

### 17.1 Small Peasant Economy Versus Big Market

Small peasant economy constitutes a basic feature of the traditional agricultural country of China. Such a small peasant economy is generally organized by the household, “with the husband tilling the fields and the wife weaving,” assisted by the elderly and the young. Every family member depends on each other, each carrying out their own duties. When it comes to time for harvesting or seeding, a time when labor force is needed the most, every member will do their utmost to contribute their share. The objective of domestic economic activity is usually to “get a mere subsistence out of the soil” rather than the pursuit of profit. As He Bingdi once said,

the most prominent feature of China's agriculture is "autarky."<sup>1</sup> The surplus produced in the small peasant economy was extremely small with the small scale of the economy and the pressure from increasing population. It was vividly termed as the "subsistence economy."

The subsistent nature of the small peasant economy had its effect on politics. From the perspective of Weber's "political finance," the peasants in the traditional society had to complete two tasks assigned by the state: taxes and corvée. As larger surplus could not be obtained from the small peasant economy, forced labor became an important way for the state to exploit the peasants. In addition, the small peasant economy shaped the governance model and structure of the traditional country: It was difficult for such a small surplus to support a complex state apparatus, thus impeding the expansion of state power, forming the political philosophy of "no rule is the best rule"<sup>2</sup> and a governance tradition of "the emperor's reign stops at the county level," in addition to a dual governance pattern. Moreover, the emphasis on agriculture and the exclusion of commerce, or the orders of "warning against luxury" issued by various dynasties were all connected with the small peasant economy.

The state wholeheartedly lent support to the small peasant economy, despite the fact that the small peasant economy constrained the state in various ways. "Smallholders, after all, were a more accessible source of tax revenue than the powerful big estate owners. From the point of view of the central government, they were also far less politically threatening. The success of the Qin state, for example, had very much to do with a small peasant economy... Through much of imperial history, therefore, the beginnings of new dynasties were associated with renewed assertions of the small peasant economy. It is in the periods of dynastic decline that one witnesses the rise of big powerful estates to challenge the central government's authority" (Huang 2000). In consequence, the support for small peasant economy became a basic state policy in many dynasties. Many examples exist, such as the "equal field" system of small cultivators that was installed in Tang Dynasty, while smallholders were supported by the Ming Dynasty.

In the delicate interplay between the small peasant economy and the traditional country, small peasant economy became the standard practice in dynasties. The society and the country used to be extremely stable, sometimes reaching the state of "stagnancy."

In modern times, confronted with the suppression of Western colonizers with armed forces, and faced with the influx of modern industrial and agricultural

---

<sup>1</sup>See Hu Zhihong (2002).

<sup>2</sup>As the "subsistent" small peasant economy was extremely fragile, "active" politics would not do. As a result, "if the ambitious imperial power had wanted to break new ground, built a river, it should have been regarded as an investment actually, just as what Roosevelt had done in the Tennessee Project, but it would be called tyranny in China." The result would be that "cries of discontent arose all around, and protests against the imperial reign rose everywhere" (See Fei Xiaotong 1985). In this sense, Emperor Shihuang of Qin (the first emperor in Qin Dynasty), who built the Great Wall, and Emperor Sui Yangdi, who built the Beijing-Hangzhou Canal, dug their own grave by being too "active."

products, the small peasant economy was placed under enormous pressure and was at the brink of collapse. Small peasant economy and small peasant society still played a dominant role in China, however, with China's crippled modern industry. Even after the industrialization process began after the founding of New China and the transition of the traditional agriculture to modern industry had begun, small peasant economy was a fact so commonplace in the grassroots society that it could not afford to be overlooked. The complicated development pattern of the rural China in modern times was shaped accordingly.

The history of New China's economic development was "abnormal" in a sense. A very special pattern and development path was optioned by the PRC under immense foreign pressure. Priority was taken to develop the defense industry and heavy industry, which were both intimately related to national security. Light industry and civil industry were somewhat marginalized, as a result. Domestic or internal accumulation became the only choice since there were no possibilities for foreign sources of accumulation. However, rendered destitute by the long-term plunder and prolonged war, the state had to create social or political discourses of thrift, hard work, and plain living to complete this Herculean task of developing industry. Individual consumption was reduced to a minimum subsistence level; meanwhile, the process of "equal distribution of poverty" began.

Agriculture made a substantial contribution to the completion of the industrial construction process. Small and dispersed surplus was efficiently and continuously gathered by such grassroots organizations as the people's communes to be used to develop modern industry; the large amount of agricultural produce was also frequently found on their way to the cities as important industrial raw materials. At the same time, constantly increasing efforts were paid to the collection and taxation of grain and other agricultural produce as provisions for the growing urban population to develop industry. In order to maintain a basic level of agricultural growth and the number of agricultural labor force during this process, the state strived to improve conditions and technology for agricultural production. On the other hand, peasants were confined to the rural areas by the household registration system (*hukou*) and other special means to prevent them from swarming into the cities and intensifying pressure on the cities. Special institutional arrangements of the segregation of the urban and the rural were made, and a dual social structure of the segregated urban and the rural areas came into being.

This unconventionality in industrial construction after the founding of the PRC not only resulted in the dual urban-rural social structure, but also shaped a unique social scene during the process of industrialization. There is usually a trend toward the reduction of agricultural population with the development of modern industry, but this was not the case in China, since the overwhelming majority of the agricultural labor force remained agricultural by the time when the industrialization process had been largely completed. By 1980, 80 % of the one billion people in China were still rural residents. That is to say, when the state had accomplished its construction of modern industrialization and had become an industrialized state, the grassroots society still retained the mode of small peasant economy and small peasant social status.

After the household contract responsibility system was generally adopted in rural China, the household resumed its place as the basic accounting unit. A dramatic turn occurred from collective economy to a modern small peasant economy in the rural areas. With fertilizer and with better strains of seeds, agricultural production rose and larger surplus was produced in agriculture. In the meantime, the taxation of the state lessened when it had basically accomplished the industrialization process. The dream of “enough food and clothing” that had long been cherished by the Chinese was finally turned into reality.

The pleasure of having “enough food and clothing” did last long, however, when the market began to involve the rural residents.

The dual institutional arrangements still segregated the urban and rural areas in space and restrict the peasants’ access to the level of social security and social welfare the state has granted the urban areas. With its powerful “philosophy of money,” however, the market broke down the barriers erected by space and the institutions, integrated the rural with the urban, and turned into an immense exchange mechanism. In this exchange mechanism, the differences between the urban and the rural, between the advanced and the backward, or differences in space and time are all totally ignored, as the cardinal principle of “universal equivalent” is applied everywhere. In the free exchange of equivalents, money has become the basic currency, and prices are set in a larger production system.

Involved in the whirlwind of the modern market, the weaknesses of the rural areas were quickly exposed: The juxtaposition of the products of simple labor and the industrial products of complex labor would soon reveal the primitiveness of the former and the sophistication of the latter. Furthermore, natural economy is too dependent on the weather, which makes it unstable. Additionally, the small surplus can never be expected to keep pace with the ever-increasing prices in the pricing system of demand. Therefore, growing valuable resources are departing from the rural areas and are being allocated to better places automatically.

The market mechanism, following the dual structure, swept over the country and thrust the rural areas into a nondiscriminatory exchange system. In consequence, another deep-cut “rupture” arose between the rural and the urban and between demand and payment, in which it became the practice that the peasants “have enough to eat, but with no money to spend.” A dilemma presented itself when the development needs (such as education) and security needs (such as medical treatment) must be satisfied by means of payment in cash.

## 17.2 A Disrupted Medical Care Network

Article 8 of “Provisions of the CPC Central Committee and State Council on Further Strengthening Rural Health Work” (issued on October 19, 2002) specifically prescribed the respective functions of the components of the three-tier rural preventive health care network: The government-run county health care institutions are the guidance center of the operation of rural disease prevention and health care,

assuming the responsibilities of disease prevention, health care, medical service, referral from lower-level hospitals, first aid, and training and guidance for grassroots health personnel. District (or town) health care centers should improve the service model and deliver disease prevention, health care, and basic medical service directly to the rural communities, households, and schools. These health care centers should not follow the hospital model. The village health care centers should shoulder the preventive health care tasks entrusted by its administrative health care departments to provide primary diagnosis and treatment of injuries or diseases. Professional service institutions for family planning are an integral part of rural health care resources. In accordance with the provisions of relevant laws and regulations, health care institutions and family planning professional service institutions should have clearly defined functions, play their respective roles in the rural health care work, help each other with their respective advantages, and share their resources. In summation, in this network, the county health care institutions (the county hospitals, county hospitals of TCM, epidemic-prevention centers, schistosomiasis control centers, maternity and child-care centers, and family planning professional service centers) are at the top, while the township-level health care centers are the body and the village clinics are the base.

The three-tier rural network of disease prevention and health care once played a vital role in protecting the health of rural residents and was one of the so-called three open sesame to construct China's rural health care. It received universal international acclaim as well. However, when the health care system gradually turned into a market-oriented system since the 1980s, the three-tier rural health care network was at the brink of insolvency for the following three reasons.

**Insufficient Investment:** First, the national health input was actually continually in decline from 1990 to 2000 (except in 1993 and in 1998 when there were catastrophic floods), when compared with the annual 16 % increase in financial expenses since 1993. In addition, the financial resources were extremely unreasonably distributed between the urban and the rural. The government's rural health budget expenditure from 1991 to 2000 was merely 69 billion yuan, accounting for only 15.9 % of total government health budget expenditure. Although there was an increase of 50.67 billion yuan in government health expenditure, only 6.008 billion yuan or 12.4 % of the increased sum was spent on rural areas during this period.<sup>3</sup> In the WTO assessment of the performance of national health systems of 191 WTO member countries in June 2000, it was found out that China ranked 188 (before Brazil, Myanmar, and Sierra Leone in the ranking) in terms of the "fairness of financial burden." On the other hand, as rural health care investment is largely financed locally (the local government is responsible for the finance of the cities, counties, or villages, respectively, under its jurisdiction) since the introduction of the tax sharing system in 1994, there necessarily arose the divergence of health care investment among different places in terms of local health investment. Only 2 % of the local health expenditure is backed by the Central Government, whereas 55–60 % is financed by the county governments or township governments. But the local sanitation investment fully

---

<sup>3</sup>"Research on the Policy Orientation of the Investment in Public Health in Rural Areas," *Shanxi Finance and Taxation*, 2005 (9).

**Table 17.1** China's investment (I) in public (P) health (H) (1990–2000)<sup>a</sup>

Year	I in PH: I in H care (%)	I in the operation of hygiene care (billion)	I in H care operation: fiscal expenditure (%)	I in H care operation: I in science, education, and culture (%)
1978		2.242	2.02	19.90
1990	19.03	7.95	2.58	12.88
1991	17.09	8.646	2.55	12.21
1992	15.44	9.609	2.19	12.12
1993	14.09	10.785	2.32	11.26
1994	13.93	14.697	2.54	11.50
1995	11.99	16.326	2.39	11.13
1996	11.39	18.757	2.36	11.01
1997	10.70	20.92	2.27	10.99
1998	10.87	28.28	2.62	13.13
1999		23.56	1.79	9.78
2000		27.22	1.71	

<sup>a</sup>Cited in Chen Qiulin (2003)

rely on the local economic development and fiscal revenue, while they differ greatly from place to place (taking 1998, for example, gross product of Shanghai was 368.82 billion yuan, while in Ningxia the figure of 22.75 billion yuan was less than 10 % of that of Shanghai). What rural public health service can exploit from the local financial resources is limited where the local fiscal revenue is limited. In some cases, the salaries of the health workers cannot be paid in such areas. If they were to survive under such circumstances, the health institutions would have no other choice than to resort to business income or income from selling drugs. As it was put by some people, we “sell drugs to support medicine,” to “provide medical service with charge to support the health care center.” According to a survey, 67 % of the county health funds come from business income, among which 51.2 % of the revenue comes from the outpatient department, 38 % from in-hospitalization, and 3.4 % from charged maternity and child-care service (Table 17.1).

**Lack of Health Personnel:** A WTO expert paid a visit to China during his inspection of the SARS epidemic in 2003 and discovered that the shortage of professional public health personnel and no accessibility to professional training on the part of the rural public health care personnel were two of the four major problems in China's public health care and epidemic-prevention system. In addition to the inadequacy of medical professionals, the low educational level of the health workers was also a problem. Among the 32,000 health care personnel in the township health care centers of Yunnan Province, only 9.5 % of them claim a medical college education. Among the 32,100 village health personnel, only 13 % of them have secondary education (Chen Huiyang and Tan Zhonggui 2003). Across China, 1.4 % of the health professional staff in township hospitals have a college education, 53 % of them have a secondary education, and 36.4 % of them have a high school (or below) education.<sup>4</sup>

<sup>4</sup>See Health Minister Zhang Wenkang's report at the National Rural Health Conference on October 29, 2002.

**Backward Equipment:** According to an investigation by Jiangxi provincial health departments in 2000 on the 39 kinds of medical equipment in township health care centers as required by the “Standards for Township Health Care Centers” (formulated by the Ministry of Health in 1992), only 5 % of the township health care centers own birth process monitors and 7–25 % possess first-aid equipment such as ventilators, gastric lavage machines, suctioning machines, tracheotomy packages, and phlebotomy packages. Over 50 % of the centers have equipment necessary in obstetrics and pediatrics, such as the fetal head extractor, abortion suction apparatus, gynecological examination bed, and neonatal weight meter. Although more than 70 % of the centers are equipped with X-ray machines, B ultrasonic machines, and high-pressure antiseptic equipment, they are generally very old, and 41, 35, and 57 % of them (respectively) could not operate normally. Many a township health care center still heavily relies on stethoscopes, sphygmomanometers, and thermometers to diagnose diseases.<sup>5</sup> Among the 1,526 township health care centers in 1,539 towns, and the 12,991 village health rooms of the 13,555 villages in Yunnan Province, 48 % have no housing, equipment, or personnel, and 7,011 of the village health rooms do not have a specific room to practice medicine (Chen Huiyang and Tan Zhonggui 2003). Currently, 13.2 % have no blood pressure meter and 40.5 % do not have a sterilizer.<sup>6</sup> Such facilities proved inadequate once a public health crisis occurred. Prevention and treatment of SARS was a case in point. When the first case of SARS was reported in Jingle County, Shanxi Province in early April 2003, it was discovered that there was no ambulance in the entire county. With a mobile surgical vehicle borrowed from the County Family Planning Commission, the patient was finally sent to Taiyuan to receive treatment. When the epidemic struck Chezhan Town (in Suiping County, Henan Province), the health care center there was on the verge of bankruptcy. Only with 50,000 yuan borrowed from all possible resources, and an X-ray machine borrowed from Suiping County Medical School, was a clinic for fever diagnosis, with the glass panels of the head office all broken, able to be set up there. It shows the poor fundamental instrument which bring a lot of difficulties for Rural Public Health Service.

As a result of the disrupted health network, a variety of endemic or infectious diseases revived or even became rampant for a while in some places. Tuberculosis, once put under effective control, saw resurgence and claimed five million patients in China or one quarter of the world tuberculosis cases. Hepatitis B remains a serious communicable disease in China, with 120 million virus carriers in China or 1/3 of the world total. Occurrences of AIDS have seen a substantial annual increase, and it is estimated that approximately one million people have been infected; endemic diseases such as Kashin-Beck disease, endemic fluorosis poisoning, or schistosomiasis are still widely spread, mainly in those ancient, minority, frontier, or poverty-stricken regions, claiming 51 million patients. In rural areas, in the poor

---

<sup>5</sup> Li Li, “Management System and Operation Mechanism of Township Hospitals” (Unpublished).

<sup>6</sup> See Health Minister Zhang Wenkang’s report at the National Rural Health Conference on October 29, 2002.

regions especially, health indicators of the rural residents ceased improving or even fell. The gap between the health level between the rural and the urban residents widens. While in 1994 the rural maternal mortality rates and infant mortality rates were 1.9 and 2.9 times that of the city, the figures were increased to 3 times and 3.4 times, respectively, of those in the city in 2000.<sup>7</sup>

### 17.3 From “the Benevolent Medicine” to the “Formula for Money-Making”

In the long history of Chinese culture, “to pay attention to human beings” is a very important tradition. Xunzi said in *Xunzi* that “human beings have breath, awareness, and spirit, so they are the most noble ones in the world.” In *Suwen* (*Noinclude*, a part of *The Yellow Emperor’s Canon of Internal Medicine*), “there is nothing nobler than a human being, who is born with the breath of the heaven and the earth, and who grows up with the laws of the seasons.” In this awareness that human beings are the noblest and the most valuable, it naturally follows that “life” is emphasized. Confucius “never discussed strange phenomena, physical exploits, disorder, or ghost stories” because “while you do not know life, how can you know about death?” Xunzi once said that “what the human beings desire most is life; what the human beings hate most is death” (in *Xunzi*). In the living world, “benevolence” becomes the highest principle, as Yuan Mei, a well-known scholar in the Qing Dynasty, said, “There is nothing more important than being benevolent in the sayings of the saints.”

The nobleness and the uniqueness of human beings decide that “life” is noble and health is important. And “benevolence” served as the basic principle for the maintenance of “life.” In such a culture, medicine, which enables the patients to do away with pain or sometimes the threat of death, becomes a “technique for achieving benevolence.” “To show benevolence to people and to prevent people from dying young or dying from plagues” so that “the commonalty could be protected,” “the common people could be relieved or saved.” The practice of the physicians had been upgraded above the general social behavior and became a sort of “virtue.” “The *Tao* of medicine is to prolong one’s life, to help virtue arising from the interactions of the heaven and the earth to live on” (written by Wang Haogu of Yuan Dynasty). “The human life is the most valuable thing; it is even more valuable than a thousand *liang* gold. If we give the patient a formula to save his life, we shall possess virtue” (Sun Simiao of Tang Dynasty: *A Thousand Liang Gold Worth of Recipes* or *Qianjinfang*).

---

<sup>7</sup> See Health Minister Zhang Wenkang’s report at the National Rural Health Conference on October 29, 2002.

While medicine was equivalent to “benevolence,” the practice of medicine was equivalent to “virtue.” Therefore, some requirements were imposed on the medical practitioners, such as, “if you know neither the ancient history nor today’s society, if you were not knowledgeable, if you were not highly talented, or if you were not Bodhisattva-hearted, you might as well make a living by tilling the fields or by weaving clothing instead of practicing medicine and cheating the world! Medicine is sacred and not something that you pursue when you fail in your studies and have nothing else to do to make a living. So one cannot be a physician before he has talents and professional knowledge, knows the rules of this world and the other world, has reflections on the books ancient and of today” (Pei Yizhong of Ming Dynasty: “Preface,” *On Medicine*). Sun Simiao imposed some more specific requirements on the behavior of a physician in his book *Dayijingcheng (The Essence of Being a Great Physician)*: “If a patient resorts to you, do not care whether he is rich or poor, young or old, beautiful or ugly, be a relative or a friend, a Han or a minority; physicians should regard the patients as equal human beings, and as the most endeared ones. They should not hesitate and consider their own luck and protect their own life first. Instead, they should regard others’ pain as their own pain, have deep sympathy, and not delay. Saving the patient should take priority even when it is at the dangerous moment, in the small hours, or when the physicians are hungry or thirsty. Great physicians should be saviors of the common folks; bad physicians are the thief of the common folks.” If a physician practices medicine only to “court reputation” and to “accumulate wealth,” then “it is not a benevolent behavior,” and “it is disdained by humans and gods and those good people won’t do it.”

The tradition of “benevolent” medicine and health care continued to be carried out in the process of medical and health care construction in the PRC. The guideline of “to cater for the needs of workers, peasants, and soldiers” determined for whom the health care service was provided and what were the correspondent professional requirements. Under such requirements, to wear a gauze mask would be blamed by Mao Zedong, while “the socialist neo-tradition” imposed requirements of “benevolence” on the medical and health workers at another level; “to serve the people wholeheartedly” is a modern expression of being benevolent, while “being selfless and serving others’ interests only” are the behavioral requirements. In combining modern politics and traditional thoughts, medical treatment became a “benevolent” means of saving the patients and saving the people.

The secularization of the market, however, had swept away the rich cultural, political, and other connotations contained in the word “benevolence,” and medicine has degraded into being merely an occupation. Just like all the other occupations in modern society, this occupation also obeys the law of overall social division, undergoes the tests and complies with requirements of the specialized knowledge in its specific space of the profession, and is subjected to the specific constraints and management of the specific regulations imposed by the profession. This is the first step from the “benevolent medicine” toward “formula for money-making.” Then the market transcended the limitations imposed by time and space as well as boundaries among the walks of life, involving medicine in an exchange system with unparallel force. At this time, survival is of the utmost importance for the medical and health

care departments, and growth is the fundamental requirement. Under such pressures of survival and growth, terms like cost accounting, input-output, and economic efficiency act as the inherent constraints of health care activities. Medicine was unable to retain its characteristic of “benevolence” and eventually became a “formula for money-making.”

**From a Welfare Provider to Profit Maker:** In the initial health care management system in the PRC, the medical and health care sectors were state apparatus and agencies of social welfare. The state was responsible for the appropriation of all their funds (the majority of the funds were from the state financial budget, although the actual business income may differ from one unit to another). Since the 1980s, however, the reform to the managerial system of the health care sector was carried out as efficiency, and profit-making became the general requirement or the goal model. The medical and health care sector turned corporate: “High quality, high efficiency, and low cost” frequently appeared in the internal standard set by the medical and health care units. The state threatened to “wean” the appropriation of all or most of the funds, triggering the pressing survival crisis of the health sector. Yongfeng County People’s Hospital can serve as a good example. In 2003, the constant fiscal appropriation decreased from 655,000 to 400,000 yuan. An average of 40,000 yuan each month and 480,000 yuan each year had to be spent on the 60 retired staff of the hospital if each had a salary of, say, 650 yuan. Then, how about the salaries of the 87 registered staff and 220 other staff? Such a dilemma forced the health care sector acclaim profit-making as the highest standard.

**The Negative Effects of Cost Accounting:** Medical and health personnel, who were once compared to “angels in white,” once won universal social respect for their special role of “healing the wounded and rescuing the dying.” However, profit-making and cost accounting later posed as the requirement and usual practice of the so-called internal management. The purported cost accounting is, in turn, simplified as such a rule: The unit must be responsible for and defray its patients’ unpaid medical fees. Under such circumstances, how could the medical and health personnel help being “cold-hearted killers”? After all, a medical worker is just an ordinary human being who has to make a living. In addition, there are simply too many patients in poverty. The unpaid fees would likely swallow the annual revenue of the unit like an insatiable monster, if one was not careful. No wonder social ills frequently arise: “No measures are taken (by the medical staff) to save the dying (for the medical fees have not been paid),” or “patients who cannot afford the medical fees are not welcomed.” What has turned the “angels in white” into “cold-hearted killers”?

**A Heavy Heart After Life Saving:** According to Article 24 of “Law on Medical Practitioners,” doctors cannot refuse to treat a patient in an emergency; they are required to provide the patient with their medical treatment. It is all very well that emergency medical treatment is thus ensured, but who will defray the bill for the unpaid medical fees and for the medication for such patients? This is not mentioned in the law. While such unpaid fees could be reported to higher authority for compensation, this will no longer suffice today. Therefore, the joy of the doctors who have saved the patients from the brink of death might turn sour.

Thus the “benevolent medicine” has finally undergone the metamorphosis to “a formula for money-making” with the pressure from profit-making standards, cost-accounting regulations, and the requirements of law. In addition, medical service is indeed developing into something very expensive.

## 17.4 One's Life or Death Is Utterly Dependent on One's Fate

With diseases looming large on the horizon and with the disbanding of the CMS, a vast number of peasants found themselves in an awkward situation in which “whoever can afford the fee will get medical treatment” and in which the market-oriented medical service proved to be beyond their purchasing power.

In his book *Krankheit als Krise und Chance*, Edgar Heim states: “In the course of a fifty-year lifespan, the average adult suffers one case of life-threatening illness, twenty serious illnesses, and around two hundred fairly serious illnesses” (Dethlefsen and Dahlke 1999). When medical service proved to be beyond the peasants’ affordability, what can they do to cope with the diseases that some would inevitably catch from time to time?

Escape: According to a 2003 investigation carried out by Economics Research Center and Center for Health Care Policies and Management of Peking University on the expenses of a SARS patient using the data of Peking University Hospital, the People’s Hospital, the Third Hospital of Beijing Medical University, and other hospitals in Beijing before April 20, 2003, 1,090 yuan was spent on every suspected SARS patient during his/her 3-day observation; for the diagnosed SARS patient, approximately 1,100 yuan (for a mild case) or 3,220 yuan (for a critically ill patient) was spent every day in his/her 21-day treatment. So the total expense on mild and critically ill SARS patients was 23,000 and 67,000 yuan, respectively. What should we make of the figures? As Premier Wen Jiabao revealed to the reporters of Hong Kong Phoenix TV at the Press Conference after the Tenth National People’s Congress in March 2003, “In China, 900 million of the 1.3 billion people are peasants. Among them, 30 million peasants have not been upgraded above the poverty line according to the standard of 625 yuan annual per capita income.” “If the standard of 825 yuan is used, then the number of the peasants below the poverty line is 90 million.” Using Wen’s statistics, and assuming that these poor peasants must finance their own medical treatments, we will discover that, if the patient were a critically ill SARS patient, even if he has been working from 18 to 68 years old and does not spend a penny on anything, he would still be 27,000 short:  $67,000 \text{ yuan} - (800 \text{ yuan} \times 50 \text{ years}) = 27,000 \text{ yuan}$ . That is to say, if a peasant became a critically ill SARS patient, he would have to work until he was 103 years old to pay off his medical fees. As a matter of fact, 170,000 yuan (excluding human capital) was spent on the case of imported SARS in Jiangxi Province. No wonder peasants were severely frightened and resorted to fleeing the area when SARS struck (Xu Yong 2003). Fortunately, the state exerted all its powers under the guideline that “nothing should be left undone to control the epidemic.” Faced with the

**Table 17.2** Peasants' top ten diseases for hospitalization and the corresponding expenses for each hospitalization (Unit: Yuan)

Injury of chest, abdomen, or brain	3,108.13	Pesticide poisoning	2,614.80
Traumatic brain infarct (hemorrhage)	4,032.03	Natural birth	1,861.50
Fracture	3,761.35	Coronary heart diseases or myocardial infarction	3,789.33
Bleeding or perforated alimentary canal	3,453.90	Chronic bronchitis or chronic cor pulmonale	2,078.50
Acute appendicitis	2,380.11	Caesarean birth	1,949.00

epidemic of SARS, Deputy Minister of the Ministry of Health Gao Qiang announced on April 20, 2003 that “medical fee subsidy system should be implemented for the urban SARS patients in economic difficulties and all the peasant patients.” Three days later, two billion yuan was allocated by the Central Government for the founding of a SARS Prevention Fund. On April 29, the Ministry of Finance and the Ministry of Health issued a document, in which it was prescribed that free treatment be provided for those urban SARS patients in economic difficulties and peasant patients, and all the costs be reimbursed by the government. On May 1, the Ministry of Health, Ministry of Finance, Labor and Social Security Ministry, and Ministry of Civil Affairs jointly issued “Notice about the Medical Expenses of Atypical Pneumonia Patients and Suspected SARS Patients,” emphasizing the principle of “treatment first, fees later.” All patients with fever will receive treatment and be hospitalized with neither registration fee nor deposit (prepayment); all the peasants and the poor people in the cities belonged to this category. Only with such state arrangement was the escape of the frantic peasants prevented and conditions conducive to the triumph over the spreading of SARS were created.

While the SARS peasant patients could use the specially allotted funds of the state, how about those peasant patients who face the threat from other diseases (such as schistosomiasis and Kashin-Beck disease) neither internationally influential nor reimbursed by the state? Could they stay calm? With the resurgence of communicable diseases and endemic diseases such as schistosomiasis, maybe to escape from the epidemics or the endemics was the most “rational choice” of these “rational smallholders.”

Delay: First we can see some data collected in an investigation conducted by the School of Public Health of Harbin Medical University in 2000 on the top ten diseases because of which peasants were hospitalized and the correspondent expenses for medical treatment in each hospitalization (see Table 17.2).

Let us now have a look at a case (F/Yuan/2004/H/3/yhw) of the author's investigation on a person with the surname Yuan, 47 years old, with four family members, the eldest daughter being a migrant worker in Guangdong and the little son studying in the Yuanzhou District Senior Middle School. Yuan tilled 4.2 *mu* fields (among which 1.4 *mu* was rented) for rice. This was his expenses and receipts in 2003: (1) Gross income. With the average annual produce being 750 kg/*mu*, the

total produce was 3,150 kg. As the price for rice was 0.72 yuan/kg for the grain of the first season of rice, and 1.00 yuan/kg for the grain of second season of rice, the average grain price was 0.86 yuan/kg. So the total income was  $3,150 * 0.86 = 2,709$  yuan; (2) Expenditure. Investment per *mu* included 140-yuan worth of fertilizer (carbon amine and urea), 30-yuan worth of seeds, 20-yuan worth of pesticides, 10-yuan worth of herbicide, 50 yuan to pay for the hired labor, and 10 yuan to pay for water resources. This means the expenses were 260 yuan/*mu* and 1,092 yuan in total. Together with 180 yuan/*mu* for taxation and money set aside (for the collective), the expenses were 1,848 yuan; (3) Net income:  $2,709 - 1,848 = 861$  yuan. That is to say, the annual net income is not able to finance one case of hospitalization.

While from 1990 to 1999, the annual income per capita increased 2.2 times, or from 686.31 yuan to 2,210.34 yuan,<sup>8</sup> the outpatient charge and hospitalization fee increased 6.2 times (from 10.9 yuan to 79 yuan) and 5.1 times (from 473.3 yuan to 2,891 yuan), respectively.<sup>9</sup>

While surplus in cash form was too small, the expenses of medical treatments were massive. Consequently, it was difficult for the peasants engaging in agriculture to bear the expenses of medical treatment. In addition, agriculture follows a natural cycle and investment has to be made periodically; however, when they are paid, the peasants hardly ever paid in cash. As a result, a peasant does not usually have a lot of cash at hand. Thus, for the diseases that are not very serious, the peasants would just delay seeing a doctor until they felt too weak to pull through. In the end, they will turn to any medical resources. As mentioned by a survey in Anhui, Hunan, Yunnan, and Sichuan Provinces by researchers from Peking University in 2001 and 2002, 48.65 % of the peasant families had members who contracted a disease for 2 weeks; 81.25 % of the sick peasants failed to resort to medical resources, among whom half of the patients did not seek medical help because of financial reasons. According to the "Report on the Statistics of the Development of the Health Care Service of 2001" released by the Statistics Center of the Ministry of Health, the expense for each hospitalization was 3,245.5 yuan in 2001. In another survey of the Ministry of Health, it was discovered that the rate of the people in poverty-stricken areas who failed to avail themselves of medical resources for economic reasons increased from 55.9 % in 1985 to 67.7 % in 1993 (State Planning Commission 1999).

"The siren of the ambulance means the selling of a pig to foot the bill of hospitalization." "I spent the whole spring tilling the fields; I spent the whole autumn harvesting the crops. However, when I caught a disease, I found all my efforts in vain." "After exhausting labor I finally harvested some grain; however, they were all gone when a family member sneezed." "When a family member catch a disease, all the family members have to increase their labor; the medical charges still could not be covered after I have sold all the chicks and pigs." "I had been off the poverty line for a couple of years; I went back to the line when I caught a disease." The plain words of the peasants described how they were caught in a genuine dilemma; they

---

<sup>8</sup> Cited in Wang Yanzhong (2001).

<sup>9</sup> Compiling Committee of *China Chronicle of Health Care, China Chronicle of Health Care (1996)*, People's Medical Publishing House, 1997, 408.

can “ill afford to cover the medical expenses,” and they would quickly return to the poverty line if they caught a disease.

Waiting: With the overall environmental devastation, the countryside has been ravaged by pollution caused by modern industry, garbage, and other pollutants,<sup>10</sup> which adversely affects people’s health. In consequence, incidences of chronic diseases and incurable diseases are increasing. Liver cancer and lung cancer are contracted by a growing number of people in some villages, where such cases have never occurred before. Generally speaking, if it were the main laborer who suffers from a serious illness, every effort would be paid to save his life until their financial resources are depleted. Medical treatment will sometimes come to a halt, unfortunately, if funds cannot be raised timely. When resources are exhausted, the patient’s family has no choice but to simply buy painkillers to ease the patient’s sufferings. Unable to bear the torture of the illness and when there seems to be no way out, some patients simply commit suicide to avoid being a burden to the family. The elderly people with chronic diseases, on the other hand, are usually the last ones to receive medical treatment, being generally marginalized for their lack of labor force. Exceptions to the rule will occur unless it is in an area where the clan tradition still remains. During the author’s investigation, many cases of sick elderly peasants who had a hard time enduring the sufferings inflicted by their illnesses, with neither timely treatment nor long-term treatment, were found.

Therefore, the encounter between the small peasant economy and the market would likely result in the phenomenon of the peasants’ having “enough to eat, but not enough to pay in cash.” Their requirements for development can barely be satisfied, and they are increasingly at risk. The rupture of the rural health network only further deprived the peasants of protection against the diseases. In the shifting tide of secularization and in its battle for survival, the originally benevolent medicine has turned into “formula for money-making.” When dangers lurk in reality, the peasants’ chances of averting it are small. There is no way for them to acquire some relief. When diseases like plagues appear on the horizon, the peasants have to either flee, or delay, or await medical treatment. They are fearful, helpless, or even in despair. The Chinese peasants are in a risk society, to say the least.

## References

- Chen Huiyang, & Tan Zhonggui. (2003, October 9). In what way is the new cooperative medical care in difficulty. *Health News*, 10–9. <http://www.51qe.cn/pic/55/15/156.html>
- Chen Qiulin. (2003). Why rural cooperative medical care met difficulties in its implementation. *Social Sciences Front*, 4(4), 35–46.

---

<sup>10</sup>During my investigation in Shaanxi province, I discovered that the river was polluted and contaminated by the paper mill located by the source of the river, judging from the pungent odor that could be felt from a faraway place. It was the villagers’ opinion that the frequent incidence of cancer was directly related with the mill.

- Dethlefsen, T., & Dahlke, R. (1999). *The healing power of illness: The meaning of symptoms and how to interpret them* (Jia Weide & Li Jian, Trans., p. 64). Shengyang: Chunfeng Art Press.
- Fei Xiaotong. (1985). *Rural China* (pp. 63–64). Beijing: SDX Joint Book Company.
- Hu Zhihong. (2002). *Western studies on China's ancient history: An introduction* (p. 289). Zhengzhou: Daxiang Press.
- Huang, P. C. (2000). *The peasant economy and social change in North China* (p. 86). Beijing: Zhonghua Book Company.
- State Planning Commission. (1999). *Articles on district health planning* (p. 241). Beijing: China's Publishing House for Planning.
- Wang Yanzhong. (2001). On the role of the state in the rural medical and health care. *Strategy and Management*, 3(3), 15–24.
- Xu Yong. (2003). *Rural governance and China's politics* (p. 262). Beijing: China Social Sciences Press.
- Zhou Guitian. (1998). Modernity and the risk society. *Taiwan Journal of Sociology*, 21(2), 89–129.