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Old and new Rural Co-operative Medical Scheme in China: the usefulness of a historical comparative perspective

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This work compares the health cooperatives fêted in Maoist China in the 1960s to the New Rural Medical Co-operative Scheme (NRCMS) that has been operating in China since 2002. Organizational and ideological similarities between the old and new co-operative medical schemes are described. By mapping continuities and discontinuities in the way the co-operative organizational model has been deployed under different contexts, we argue for the usefulness of blending historical method and organizational analysis as a means of understanding some of the challenges of contemporary Chinese social policies. Using this technique of historical comparison, this work concludes that the NRCMS, despite being different in orientation, is still affected by political influences, and organizational traits, evident within its former incarnation. This acknowledgement, we argue, has important implications for policy and practice today.

Keywords: China; co-operative; healthcare; history; New Rural Co-operative Medical Scheme; organization

1. Introduction

One of the challenges of China's booming growth in the past few decades is the search to find an affordable and effective means of providing equitable medical care to the millions of rural inhabitants who constitute almost half of the total population of China. To this end since 2002, the Chinese government has sought to implement a New Rural Co-operative Medical Scheme (NRCMS), providing basic medical insurance to the majority poor in return for annual membership payments. This scheme was not entirely new and was broadly based on an older scheme of co-operative rural healthcare (Rural Co-operative Medical Scheme) formally inaugurated by Mao Zedong in 1965. Understandably given the large differentials, in terms of market and political contexts, which have evolved between 1965 and 2002, these two schemes demonstrate key differences. Perhaps most prominently, while in the past the health co-operative was given a degree of autonomy in terms of organizing its own local structures and medical services, today, the NRCMS is obviously more voluntary and centrally led comprising all broad intents and purposes an imitation of a western-style mutual scheme whereby individuals can invest in return for basic health insurance.

Today, the NRCMS initiative is proudly displayed by Chinese health policy makers as one of the cornerstones in the development of a sustainable health framework for contemporary China. This position has been most recently exemplified by the public announcements to introduce new pilot pension schemes in Shanghai and Beijing as a

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means to address the financial burdens on its rapidly ageing population (UNDP 2013). With huge challenges ahead of China with its large and unequal population, health care policies have been in the public eye as never before capturing the attention of not only academics, but also social and political commentators within both governmental and international organizations.

The motivation behind this study is to understand the differences and similarities between the two incarnations of this health scheme. For all of its claims for modern relevance, the NRCMS is, we believe, strongly historically rooted with Maoist policy. It is perhaps a surprising choice for the government of China to so obviously resurrect a scheme from a past that in many ways it chooses to forget, but what is even more surprising is that scholars have not studied the meanings and implications of these continuities and discontinuities (in ideology and organization) with the past. This presents a large gap in the literature of analysis of Chinese health provision and highlights the importance of the past as a tool to better understand both the present and the future. Despite inherent difficulties in comparing dissimilar contexts, particularly when the political and socio-economic landscapes have changed as much as they have in China, a glance historically backwards can, and regularly should, offer useful insights.

Additionally, we argue that the use of historical perspectives can have very tangible relevance for practice and research. To this end, our work extends non-comparative studies of the co-operative medical system in China (for example, Zhang 1982; Yip and Hsiao 2009; Babiarz et al. 2010; Qin et al. 2012; Dong et al. 2013) and also adds a new dimension to other academic works examining the modern health problems of China (Wagstaff and Lindelow 2005; Wang 2009; Wagstaff et al. 2009). Moreover, it will supplement understandings about the development of the co-operative ideal in China (Cheng-Chung 1988; Gao and Chi 1996). Two research questions are to be explored:

- (1) To what extent can both the old and the new Rural Co-operative Medical Schemes (RCMS) be seen as ideologically similar?
- (2) To what extent is the new organizational approach of the NRCMS similar to or different from western models of mutual insurance?

We stress from the outset that this research is firmly historical, offering new perspectives to contribute to and extend already existing work within the Chinese and international literature on health care, co-operatives, management, and economic policy in China. The method therefore is principally one of qualitative textual analysis of both primary and secondary literature on the topic. It is based on extensive archival research undertaken in both historical and contemporary Chinese and English source material, including research at the World Health Organization (WHO) archive, Geneva, and original documental research undertaken in China. The data collection took place between 2009 and 2013 when both authors were employed in an academic institution in China. This made it possible to visit a number of co-operatives and hold discussions with co-operative leaders and members in the Beijing, Shanghai, Hong Kong, Zhejiang, and Guangxi areas. It was conducted as part of a larger research project on Chinese co-operatives. The archive work has uncovered data never analysed before with this comparative historical perspective and has never been subjected to organizational analysis.

The co-operation of History and Organizational Studies to the understanding of contemporary Chinese policy presents something original in itself as although cross-disciplinary analysis has become more favoured in recent years (Wadwani and Bucheli 2013; Rowlinson, Hassard, and Decker 2014; Greenwood and Bernardi 2014), the need to look back at organizational developments historically is nevertheless still far from

assumed behaviour. To this end, the techniques of analysis deployed are both historical and sociological with the joint authorship also reflecting the truly cross-disciplinary nature of this endeavour. Additional to the historical approach, Institutional Theory is also used as a secondary-level analytical tool to explain how Chinese co-operatives have been deeply shaped by the socio-economic transition and the political contingencies.

Given the predominantly historical nature of this work, it is necessary to separately outline the contextual circumstances and subsequent literature around each health co-operative scheme. Section 2 presents the literature review and the data on the old RCMS. Section 3 presents the literature review and the data on the NRCMS. Section 4 compares the old and the new systems, answering in turn our two central research questions. In Section 5 we argue for the usefulness of the historical method in organization studies. There, we also consider the limitations of this study and the need for further research. Section 6 presents the implications of this research for theory development, for practice and policy. Short conclusions follow in Section 7.

2. The rural co-operative medical system (1934–1981)

The modern co-operative model arrived in China (comparatively late compared to Europe) in the first decade of the twentieth century from England, Japan, and Germany based directly on their experiences of co-operative farming and banking (Fairbank and Feuerwerker 1986). Chinese intellectuals and practitioners with western education developed a local co-operative movement with the active support of western expatriates and missionaries (Cook and Clegg 2012).

Although small-scale singular examples existed in the early years of the twentieth century, the concept took some time to be established, with the first co-operatives in China, established in 1912. Despite this cautious start, however, during the first two decades of the century intellectuals, politicians and social reformers (Sun Yatsen had a Christian education) increasingly tried to disseminate the co-operative ideal in China, just as intellectuals and elites had disseminated it in Europe in the previous century. A particular turning point can be identified in 1939 when, stimulated by war-time exigencies, co-operatives were embraced as part of the ‘Gung Ho’ movement proposed in Shanghai two years before. Gung Ho’s central principles were of voluntary organization, self-funding, self-governing, independent accounting, democratic management, and distribution to each according to his/her work and dividends according to shares. The accession of Mao and his now famous programme of collectivization (commenced 1958) meant that the Chinese co-operative movement suddenly changed and began to embody deviations from the original western notion of co-operative firm and co-operation. This is therefore not just a history of the development of co-operatives in China as an alternative business model, but rather is a story of how a model was adapted to suit a regime and to mesh with changing political intrigues.

In terms of health co-operatives specifically, it is notable that the idea (Scott 2003) of organizing healthcare in this way also had a pre-history. Indeed, it can be seen that for at least 30 years previous to the launch of Mao’s scheme, health co-operatives were being seriously investigated as a sustainable possibility. In fact, the first call to reform rural healthcare provision system occurred during the early 1930s, with a regulation by the Department of Health coordinating and integrating rural public health passed in 1934 (Zhang 1982, 24). Although the chief objectives were agreed in principle at this early stage, it was not until 1937 that a national medical scheme of this type was formally enacted through legislature. It may seem ironic that the idea officially adopted in 1965 by

the Communist Party originated within the nationalist Kuomintang (KMT, or Chinese Nationalist Party).

In 1945, Mao announced his intention to ‘follow the co-operative route’ in terms of his healthcare reforms (Mao 1991, 1078).² Correspondingly, by 1950, the then Deputy Minister of Health, He Cheng outlined at the first National Health conference that without serious attention paid to problems of disease and sanitation, the ‘national production and construction and people’s peaceful life cannot be ensured’.³ Thus, in the political rhetoric, health became formally intertwined with nationalist discourses of strength and survival from early on.

In 1956, the Third Session of the National People’s Congress adopted the document ‘The Regulations of the Practice of Advanced Agricultural Production Co-operative Model’. Here it was stipulated that co-operatives should be responsible for the care of members who had become wounded or ill during work. This seems to have been the spur for further action as after this, medical units, based on either the collective economy or on the combination of collective and individual funding, began to develop in many rural areas. During the period from the foundation of PRC to the late 1950s, a coherent rural co-operative medical care plan was formed mainly out of the experiences of local areas. In November 1959 in Jishan County in Shanxi Province, the Ministry of Health held the National Rural Health Conference, in which the adoption of the system was formally affirmed (Cai 2009).

The final impetus to turn the rhetoric into action seems to have come from the broader political momentum to set up agricultural production co-operatives as the cornerstone of the People’s Commune. To this end, through the Great Leap Forward, millions of Chinese peasants who moved into collective farms were said to move from an agrarian economy into a modern communist society. These communes needed healthcare services and it seemed logical to also organize these, like production, around the fundamental organizational model of the co-operative (Mao 1956, 1958). Before the scheme came to fruition, several trials were undertaken at a provincial level, notably, the Ding County Test and the Shaanxi–Gansu–Ningxia border drug agency. Stimulated by posted reports over the success of these trials, Mao took the issue further when in 1960 he published his *Instructions for Public Health* (Mao 1960). This began by emotively regretting the inattention made to date on public health issues and stated that people should ‘rekindle the patriotic public health movement which has been left behind during the Great Leap Forward, and be sure that achievements are to be made within the period from 1960 to 1962’.⁴ The solution proposed was to convert all existing health services into a collectively owned model. It was also partially a response to the severe criticisms the Department of Health had been under as the available health services had been largely confined to the elite urban-based population (Xu 1997).⁵

The scheme was launched on 26 June 1965 with Mao giving his famous speech ‘Directive on Public Health’ (Mao 1965). Within the next months, the Department of Health issued its supportive statement entitled ‘Report Prioritizing Primary Level Medical Services to Rural Areas’ strenuously pointing out that ‘more than 80 per cent of China’s population are farmers, if the medical and health problems of these farmers cannot be dealt with seriously, the socialist health policy will come to nothing’ (Department of Health 1965).

In September 1965, the central committee of the Communist Party of China approved the document ‘A Report Concerning Putting Emphasis on Medical Care in Rural Areas’ and sent it to the party committee of the Ministry of Health. Following this lead, by the end of 1965, medical co-operative systems were initiated in Shanxi, Hubei, Jiangxi, Jiangsu,

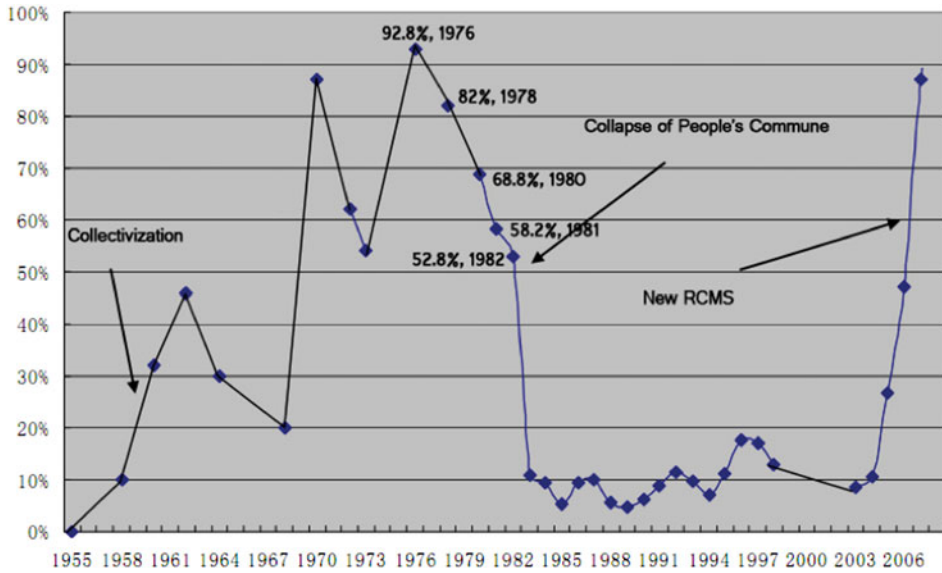


Figure 1. Rise and fall of the Rural Co-operative Medical Scheme: percentage of participation among local level administrative units in rural China (Liu 2004).

Fujian, Guangdong, and Xinjiang provinces and shortly after were started all over China. The scheme was successfully propagandized nationwide via publications like the *People's Daily* and the *Newspaper of Health* (an official newspaper run by the Department of Health). By 1976, it was estimated (although this is an official, and therefore unreliable, estimate) that 90% of peasants participated in the co-operative medical care system nationwide. In Figure 1, it is possible to observe the fast rise and decline of membership to the RCMS.

Although coverage was extremely good during the 1970s (another estimate in 1975 estimating that 84.6% of the rural population of China was covered by this medical system) (Zhu et al. 1989, 431–441), official discussions at a conference of barefoot doctors in Shanghai still quietly acknowledged that more could still be done and 100% coverage was never achieved (Department of Health 1976). Nevertheless, in the middle of the 1970s, around 5 million staff participated in the RCMS, of which 1.8 million were barefoot doctors (Appendix E), 3.5 million other health personnel, and 0.7 million midwives, making it undoubtedly the centrally most important medical scheme of China (Zhang, Wen, and Liang 2002, 28). It was an army in dimension as well as in organizational design. Horn described the barefoot doctors as 'a million-strong army' (Horn 1975, 22). The system at its peak comprised a huge branching system of ambulatory, provincial, and local health management intertwined with the local organizational structures of the Chinese Communist Party (CCP). At its peak, in the mid-1970s, it involved millions of personnel and covered 90% of the country (Wang 2009, 14).

In December 1979, the Ministry of Health, Ministry of Agriculture, Ministry of Finance, and the State Pharmaceutical Administration of the National Federation jointly issued the document 'The Regulation of Rural Co-operative Medical Care Service'. This converted the majority of the co-operative medical care institutions into private clinics of village doctors. According to the survey of the 45 counties in 10 provinces in 1985, the peasants' participation rate in rural co-operative medical care had dropped dramatically to

only 9.6%, while 81% of the peasants paid for medical care at their own expense. In 1986, only 5% of the villages nationwide supported the rural co-operative medical care system, including the suburbs of Shanghai, Zhaoyuan County in Shandong Province, Wuxue County in Hubei Province, Wu County in Jiangsu Province, Wuxi, and Changshu. Although some attempts were made to revive the model, it was to take until 2002 for it to return with any political force, revamped and revived.

But although the scheme died a fairly conclusive death in China by 1981, this did not mean that interest in the scheme diminished globally. Indeed, significant international interest can be identified during the 1970s and 1980s as other nations and health organizations looked for new ways to deliver healthcare to rural populations, a drive particularly motivated by the WHO's goal of *Health for All by the Year 2000*. Indeed, as one report suggested, 'the time was ripe for the Chinese model and method to be hailed as the ideal' (Skeet 1984, 292). Throughout the 1970s and 1980s, the WHO (1974, 1988, 1989) conducted a series of study missions to China publishing widely on the RCMS potential merits (Bryant 1978, 144–148; Li 1985; Prescott and Jamison 1984; Lambo 1980). It seemed that even though the system had flaws (usually pinpointed as the fact that it operated under an oppressive political regime), it contained within it a centrally viable kernel of an organization model to apply to rural healthcare provision in other national contexts.

Given this international interest and enthusiasm, the rapid decline of the RCMS needs brief mention. At first, the decline of the RCMS did not seem at all inevitable with the new Constitution of the Republic of China of 1978 specifically stipulating that provision should be made for the co-operative medical service (PRC 1978). Quite quickly, however, the tone changed from one that presumed continuity to one that advocated change. Particularly the experiences of one County, Xiangxiang, were widely cited as evidence that farmers were not able to shoulder their current burden (Central Political Bureau 1978). After this initial declaration, other provinces quickly followed the route, also stating that they found the economic burden of the RCMS too heavy (Zhang 1982, 31–33; Wang 2009). The decline was rapid – by 1985, only 39.9% of the rural population in China were covered by the scheme. A substantial drop since the 1970s, not least as the rural population had grown by nearly 14% between 1975 and 1985 (Zhu et al. 1989, 431–441).

The reasons for the decline have been the subject of much debate, with most scholars identifying political and economic changes as the root causes (Jamison et al. 1984; Huang 1988; Young 1989; Yu 1992; Bloom and Gu 1997a). After the 1980s, the restructuring of the Chinese rural economy individual production became prioritized over collective production, thereby increasing the pressure on peasants to devote themselves to farm work and de-incentivizing participation in the scheme (Zhu et al. 1989, 431–441, 433). Crucially, central support was perceived to have gone – thereby robbing the scheme of the 'political will, national commitment and community involvement' essential for its success (WHO 1988).

All three institutional pressures to conform (Scott 1995; Suchman 1995), *coercive*, *normative*, and *mimetic* isomorphism, had suddenly gone. Mao became very rapidly a controversial figure and the allegiance to him and the previous scheme disappeared (*normative*), the rigid central supervision on the system declined (*coercive*), along with the dramatic declination in the need to strictly correspond to the overall collectivist structure (*mimetic*). We would add to this the impact of Deng's reforms, particularly those that dealt with the ownership rights system that saw no place for this organizational model.

3. Modern visions of the new rural co-operative medical scheme

After many years of inaction on behalf of the Chinese government, finally the catastrophic implications of ignoring rural health were acknowledged and in October 2002 at the China National Rural Health Conference, the model for the NRCMS was announced (Klotzbücher et al. 2010). It is unsurprising that the way the new scheme was presented was one which stressed its progressive modernity and was keen to present it, despite its roots and its name, as far removed from the old Maoist model. The system was publicized as predominantly a mutual health insurance scheme (Brown, De Brauw, and Du 2009), such as frequently existed within the contemporary western context (the French case for instance, although this was not monopolistic as the Chinese one was going to be). Its Chinese predecessor, as explained in Section 2, was a huge structure in charge of health care operations such as the management of the medical practice, the organization of pre-emptive public medicine works in the villages, the production of herbs, and the training of barefoot doctors.

The impetus behind this urgency for change and reform is clear. Figures 2 and 3 show the gap of opportunities between members of the rural and urban populations in China. The economic success of the most privileged areas of development in coastal provinces and urban areas made this rural problem all the more visible. It must be noted though that Figure 2 also represents an improvement since 2009.

This scheme was to comprise nine new directions for all. As such, China declared its intention to work towards a social insurance model as opposed to other alternatives (such as private insurance or full direct government financing). In its current incarnation, the scheme is heavily subsidized at both central and county levels, essentially using tax revenues to supplement household contributions (payable by all members at a flat rate accept the very poor).

In October 2002, it was pointed out in the document ‘The CPC Central Committee and the State Council’s Decision on Further Strengthening Rural Health Work’ that ‘China aims to gradually establish a New Rural Co-operative Medical Scheme’. Here the plan for the scheme to unfold was outlined in detail, projecting the hope that ‘by 2010, rural

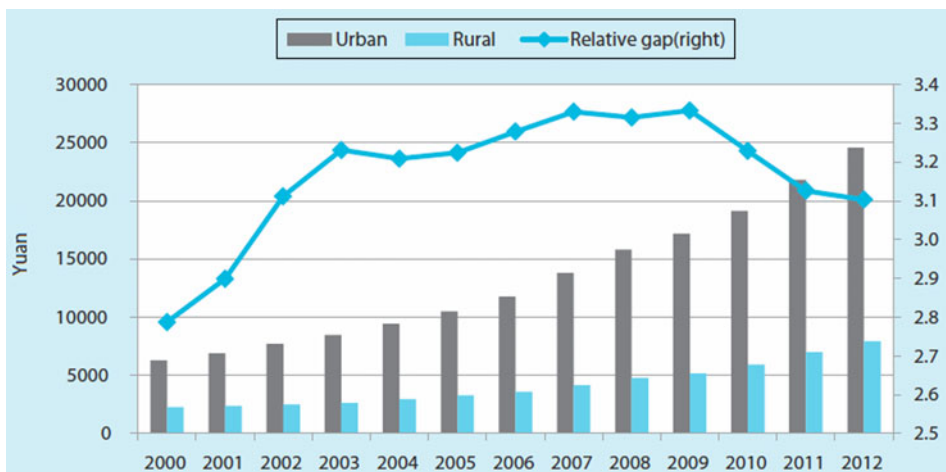


Figure 2. Absolute and relative gap of China's urban and rural residents' per capita income, 2000–2012 (UNDP 2013).

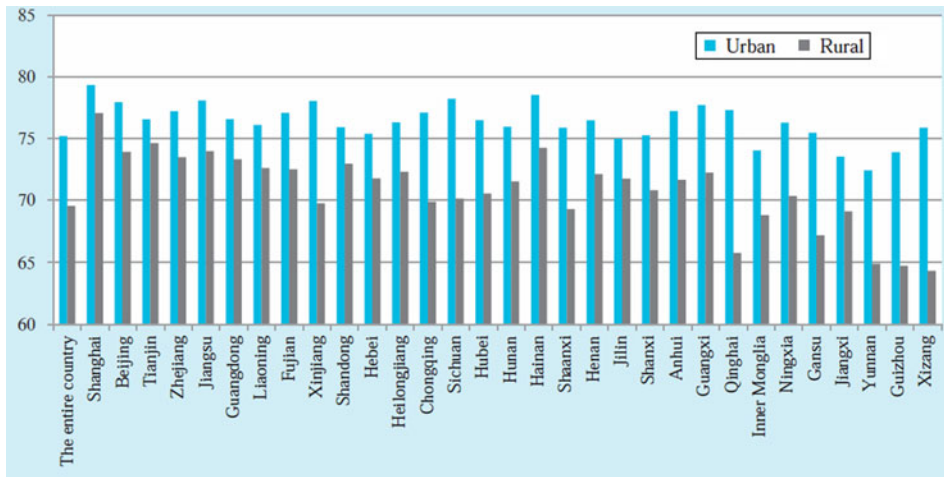


Figure 3. Urban and rural life expectancy by province or metropolitan areas in 2000 (UNDP 2013).

residents should be involved in the new rural co-operative medical care system generally'. The scheme promised from 2003 that:

the central finance department will provide RMB 10 per person annually for those farmers who participate in the new rural medical care system in the middle and western China. Local financial departments should provide at least RMB 10 financial subsidies for those farmers who participate in the new rural medical care system. (CPC Central Committee and State Council 2002)

By December 2004, a total of 310 counties nationwide participated in the New Rural Co-operative Medical Scheme. By March 2009, see [Figure 1](#), the coverage of the new RCMS was said to have reached 830 million people. This seems impressive, even if we accept the unreliability of government statistics.

In accordance with the requirements of the '11th Five-Year Plan', at least 80% of rural areas were expected to participate in the New Rural Co-operative Medical Scheme in 2010. On 17 February 2011, the Chinese government released the document 'The Arrangement of Five Key Reforms Concerning Medical and Health Care System in 2011'. This document pointed out that the government would raise the financial subsidies for peasants' medical care from RMB120 per person annually in 2010 to RMB 200 per person annually in 2011. In 2012, government budget at all levels raised the financial subsidies for peasants' medical care from RMB 200 per person annually in 2011 to RMB 240 per person annually. In [Table 1](#), it is possible to observe some key trends of wealth and well-being before and after the introduction of the NRCMS.

If we look at [Table 1](#) considering the curve displayed in [Figure 1](#), mapping the four stages of decline and growth of the RCMS, it is clear that from 2005 the private expenditure on health (as a percentage of total expenditure on health) declined. The public involvement had risen, though the total expenditure on health (as a percentage of gross domestic product) remained rather stable between 1999 and 2009. This information should be considered together with our knowledge that the per capita government expenditure on health had been raised much less than the per capita total expenditure on health. This suggests that other actors, different from individuals and the government, are now contributing to finance the system: for instance the local authorities or their agencies.

Table 1. Key indicators of wealth and well-being in China, 1990–2002–2009.

	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	1991	1990
Private expenditure on health as a percentage of total expenditure on health	49.9	52.7	54.7	59.3	61.2	62.0	63.8	64.2	64.4	61.7	59.1	58.2	55.8	53.4	49.5	–	–	–	–	–
General government expenditure on health as a percentage of total expenditure on health	50.1	47.3	45.3	40.7	38.8	38.0	36.2	35.8	35.6	38.3	40.9	41.8	44.2	46.6	50.5	–	–	–	–	–
Per capita total expenditure on health at average exchange rate (US\$)	169	146	112	93	81	70	61	54	48	44	39	36	31	27	21	–	–	–	–	–
Total expenditure on health as a percentage of gross domestic product	4.6	4.3	4.2	4.6	4.7	4.7	4.8	4.8	4.6	4.6	4.5	4.4	4.0	3.8	3.5	–	–	–	–	–
Out-of-pocket expenditure as a percentage of private expenditure on health	82.6	82.6	82.6	83.1	85.3	86.5	87.6	90.0	93.1	95.6	94.5	94.3	94.8	94.8	93.7	–	–	–	–	–
Social security expenditure on health as a percentage of general government expenditure on health	66.3	66.3	66.3	57.3	54.1	55.2	53.4	54.8	55.1	57.2	54.2	55.8	60.4	62.1	64.2	–	–	–	–	–
Polio (Pol3) immunization coverage among 1-year-olds (%)	99	99	94	94	87	87	87	86	86	86	86	85	85	84	82	87	90	93	95	98
Private prepaid plans as a percentage of private expenditure on health	6.2	6.2	6.2	6.5	5.8	5.5	5.8	3.3	1.9	1.0	1.70	1.3	0.8	0	0	–	–	–	–	–
Per capita government expenditure on health at average exchange rate (US\$) (PPP int. \$)	85	69	51	38	31	27	22	19	17	17	16	15	14	12	11	–	–	–	–	–
Per capita total expenditure on health (PPP int. \$)	309	265	234	215	191	170	152	135	117	107	95	85	73	62	52	–	–	–	–	–
Gross national income per capita (PPP int. \$)	–	6010	5430	4700	4100	3590	3180	2830	2560	2330	2110	1950	1810	1640	1480	1340	1170	1020	890	800

Note: The grey area represents the introduction of the New Rural Co-operative Medical Scheme in 2002. The bold values mark the peaks.
Source: Authors' selection and elaboration from WHO data.

Nevertheless, the scheme has not been unequivocally successful (Qin et al. 2012; Dong et al. 2013). A study found that while the NRCMS reached more people (Wagstaff and Lindelow 2005; Wagstaff et al. 2009) and gave them access to better medical facilities and technologies, in fact the expense of medical care per visit tended to be higher than previously.

The increase in healthcare costs is a trend common to most nations, particularly those with ageing populations, the public regulation or intervention in health care insurances is a very current and complex topic (Gertler and Gruber 2002). In the Chinese case, some bad practices (for instance the excessive use of antibiotics and over referring as a means of making more profits) seem to have made the situation worse. Several studies have monitored the effectiveness and the efficiency of the scheme in contemporary China (Babiarz et al. 2010; Yip and Hsiao 2009; Dong et al. 2013). This situation meant that despite heavy government subsidization, people (especially the poorest groups of society) were actually more out of pocket than they had been under the old scheme. This meant that the poor, cognizant of this extra expense, were less likely to seek this sort of formal medical care (Wagstaff et al. 2009; Wang et al. 2005). Furthermore, Liu has argued that the leadership currently offered by the Chinese government for the scheme is still not strong enough; without this, he argues 'China will not be able to establish a sustainable rural health insurance system' (Liu 2004, 164). The assessment of the first decade of NRCMS is not yet clear. The United Nations, for instance, by way of contrast recently wrote that:

Policies implemented in the new century, including the rural tax reform, the policy for rural compulsory education, the new rural co-operative medical care and medical assistance policy, and the new insurance policy for rural old people, have all played their roles in rural poverty reduction and provided policy support for China's achievements in poverty reduction. (United Nations 2013, 12)

4. Data analysis: comparing the past and the present

Turning now to our research questions: what insights does this historical analysis give us? To this end, we have considered it important to build from the archive work our organizational analysis of the past and present RCMS, as suggested recently by Decker (2013) and Wadwani and Bucheli (2013). It is instructive to map the differences and similarities between past and present models of health co-operatives in China. Broadly, these can be divided into two categories: first, the differences in the political climate in which both schemes variously operated and second, (but connected to the first point) the way the organizational remit and structure of the system has been altered to fit this changing context.

(1) To what extent can both the old and the new Rural Co-operative Medical Schemes be seen as ideologically similar?

The NRCMS clearly was different in some of its fundamental orientations and approaches. Most prominently it was now very much recast as a voluntarily participatory insurance scheme, which although clearly had funding and support from central government, nevertheless was far distanced from the old RCMS model that had been specifically tailored to fit the political ideals of collectivization and its associated needs for production. All studies of the RCMS in the 1960s have centrally acknowledged the strictures put upon it by the political context in which it operated. The first WHO study mission to China noted (Appendix E) that it felt there was 'no mystery' in the success of

the RCMS that was based ‘on the rational utilization of resources locally available and on the mobilization of the masses’.⁶ As the first article of the *Code of Conduct* stated: ‘RCMS is a socialist medical system built by the members of People’s Commune on the basis of voluntary and mutual help. It is collective welfare services for commune members’ (DAHF 1980, 62).⁷ In short, the RCMS was fully integrated with the wider political organizational units of the state. This immediately raises questions of true freedom and autonomy. As scholars of socialist systems have already mentioned in other contexts (Kornai and Yingyi 2009; Tsoukas 1994, 33), when membership was obligatory and allegiance to the State essential (Shenkar 1996), to what extent can this be conceived as a true co-operative in the western conceptualization? Can the barefoot doctors within this structure be accurately seen as free agents working for the community when ultimately how they worked and where they worked needed to be within the constraints of party political acceptability? Is there a central problem in being both a disinterested doctor and an interested party member? What is clear is that the Maoist government clearly stated that their preference in terms of recruitment of barefoot doctors was for ‘children of the poor and lower-middle peasants’: in short stipulating that candidates needed to be loyalists to be selected for the role (Zhang, Wen, and Liang 2002, 25; Mao 1968).⁸ In accord with this, the clearly-stated mission of the RCMS was to promote favoured party strategies, so for example, barefoot doctors were explicitly told to promote the one child policy, see Appendix B (DAHF 1980, article 3 points 1 and 6, 62). It must be noted that the largest federations of co-operatives in China, for instance All China Federation of Supply and Marketing Co-operatives, were (and still are) directly influenced by the state authorities.

When we examine the situation in which health co-operatives originally flourished in China, we find ourselves in an entangled web that integrates healthcare and CCP politics even at the most local level, despite the government rhetoric, which celebrated the way this scheme allowed considerable community self-management. The stated mission of the RCMS explicitly sustained the government’s priority of supporting production (DAHF 1980). As Article 10 of the Code of Conduct of the RCMS stipulated in 1979: ‘co-operative medical facilities at each level should be collective welfare units, they should not be run as enterprises or side-line business and should not be required to hand in profits’ (DAHF 1980, 63).⁹ In the simplest terms, the RCMS provided the first basic tier of healthcare provision available to rural Chinese people as part of their collective farming units. Significantly, the role of the barefoot doctor therefore was very publically interwoven with that of the regime it served. As a local observer was recorded as pointing out: barefoot doctors were referred to by their patients as ‘tongzhi’ (comrade) rather than as ‘yisheng’ (doctor) (WHO 1978, 94). They served as an interface between community and government and became a commanding socialist symbol of power and knowledge in the hands of the proletariat, of self-management and the collective ideas of community self-help.

A common organizational pathology, the means-end inversion (Crozier 1964; Merton 1936), can therefore be seen in the Chinese context as caused by this central problematic role of ideology and politics running through most organizational endeavours. This in turn brings to mind frequent examples of ineffectiveness and inefficiency that have characteristically plagued state-dominated institutions (Scott 1995; Shenkar 1996; Tsoukas 1994). There is no doubt that the original RCMS exemplified leadership patterns, managerial styles and decision-making processes primarily shaped by their explicit ties to the Maoist State but also because of Chinese ideals of man fundamentally differ from those in the West (Ho 1978).

We can answer the first question by concluding that the *explicit* ideological mission has disappeared from the NRCMS. Observing the posters in the rural clinics that we have visited, accessing the official documents and reading the national and international literature, it seems that this propaganda side is certainly less openly declared as part of the scheme's mission. During our fieldwork (Appendices C and D), visits to the clinics belonging to the NRCMS showed us that advertisements for the new system stressed the individual's responsibility to utilize health insurance, guided by state help and advice. This contrasts with the old-style health propaganda posters¹⁰ for the RCMS, which emphasized the scheme as a cornerstone of the broader scheme of collectivization (Landsberger and van der Heijden 2009, 186). Here health provision was closely wound up with the necessity to have a population that could maintain production, with figurative depictions of barefoot doctors clearly keen to represent them as comrades and workers. Today, the tone has a subtler message of individualism, emphasizing that Chinese people need to have access to specialists and hospitals and medicines, a message underscored (although never explicitly stated) with the WHO/UN ideals of good health access as a basic human right.

Local authorities and local political leadership have more autonomy and flexibility in applying national policies or in finding innovative ways to meet national goals. It is still true that local doctors are supposed to work towards, sometimes controversial, national policies such as family planning, but today's rural doctors are a dim reflection of the centrally organized Maoist Barefoot Doctor.

(2) To what extent is the new organizational approach of the NRCMS similar to or different from western models of mutual insurance?

Perhaps the most dominating difference between the old and new incarnations of the scheme was that the NRCMS emphasized the responsibility of the central government for its funding in a way the earlier scheme never did. Investment from the governmental budget increased from 1.5 billion in 2004 to 3.5 billion in 2006 (Central Committee of the CCP and State Council 2002). Furthermore, NRCMS differed significantly in emphasis because it focused on paid contributions to join the scheme. This also protected the scheme from financial ruin. What makes the more recent scheme additionally distinctive, however, is that it was also put in place in some urban areas, though with a different infrastructural emphasis (since the cities are already provided with hospitals) and with a different financial contribution system, reflecting the higher cost of care (Brown and Theoharides 2009).

This modern focus upon centralization and reliance upon government funding is in contrast to, at least the rhetoric of, the original RCMS. Indeed, the RCMS that operated under Mao prided itself on its local flexibility and reliance upon self-management. Even if ultimately all services were rendered as part of the Maoist regime, the RCMS was locally able to organize the cultivation of natural plant remedies, the management of physical structures, the selection and training of staff, and the construction of public health facilities such as village draining systems (WHO 1973).

On one hand it can be seen that the way that the RCMS was conceived and organized reflected both the centrality of the state and the priorities given to local collective decision-making, one that seemingly affords precedence to the decisions of the local community above those of the remote central government. Perhaps this emphasis is most directly illustrated in Article 4 of the *Code of Conduct of the RCMS*: 'The form of the conduct of RMCS should be based on the local conditions and full discussion of the people's commune members' (DAHf 1980, 62).¹¹

Similarly, although the state dictated what the code of conduct of barefoot doctors should be, and what the ideal ratio of barefoot doctors to population should be (normally 1 barefoot doctor for every 500 people was recommended), provision was also made for the local commune to decide the number of barefoot doctors according to local conditions (DAHf 1980, 63).¹² For example in more dispersed communes, it might be convenient to have more barefoot doctors for fewer people, simply because of the inconveniences of travel between the patients. Selection, training programmes, and re-training refresher courses were therefore organized according to local judgements (DAHf 1980, article 16, 63). Organizationally then, despite the power of the state ideology and state responsibility for ‘broad policy, technical direction and financial support’ at a county and provincial level, the original RCMS was publically promoted as being ‘decentralized and flexible, in keeping with the principles of self-reliance’ and providing ‘full opportunities for peripheral units to solve their own problems’ (WHO 1978). This can well be read with the lenses provided by Mintzberg (1993) to observe the role of ideology, power, decentralization, and flexibility in organizational design (Zeffane 1989).

Furthermore, if one looks at the way personnel actually operated, it is clear that there was no real autonomy. The barefoot doctor’s role was more one ‘of execution rather than of conception or supervision’.¹³ Although simple decisions were in the hands of the individual to decide how to treat the patient, in fact these rarely went beyond the purview of the extremely limited immediacy of the doctor–patient relationship. Any wider decisions on when to conduct vaccination campaigns, when to perform public sanitation campaigns, the content of health education programmes were all determined at a commune level. These decisions were guided by government policy (the most obvious expression of which being the edict to promote the one child policy, see Appendix B) (DAHf 1980, article 3, points 1 and 6, 62). In terms of Institutional Theory (Powell and DiMaggio 1991; Jepperson 1991), the local branches of the RCMS were subject to organizational isomorphic pressures of all three kinds: *coercive*, *normative*, and *mimetic* (Scott 1995). Local officers and doctors were forced to follow the policies and the orders (*coercive*), many of them might truly believe in the system (*normative*), most of them wanted the organizational unit under their responsibility to look pretty much the same (Suchman 1995) to the other parts of the system (*mimetic*).

The differences however, between the old and the new schemes seem in this regard perhaps more slight than one might necessarily assume. Indeed, although the NRCMS emphasized the role central government had to play in funding subsidies, it nevertheless organized itself in a way surprisingly similar to that of the RCMS. For sure, the new scheme was organized around larger operational units at the county level (rather than at a village level as during Mao’s time), but nevertheless the emphasis of the NRCMS is still on decentralization (Mintzberg 1993; Zeffane 1989). Local decision-making and experimentation are promoted above any single state policy (Wagstaff et al. 2009). In a sense, the distinctions are subtle – in the old RCMS, the state promoted local initiative, did not fund the scheme centrally, but ultimately dictated its policies. In the NRCMS, the state also talks of local responsibility, but this time funds the scheme centrally, and still dictates general policies, but in a way less ideologically heavy-handed than that experienced under Mao.

Finally, mention needs to be made of the way the schemes had different financial structures. The RCMS was a prepaid medical service but one that essentially conformed to structures typical of co-operatives in other national contexts in that it was based upon a co-financing, risk sharing approach to disease control (Bloom and Gu 1997b). Local people paid an annual membership fee – which varied slightly between regions, but was from 0.35 Yuan to 3.60 Yuan per year. This amount represented between less than 1% and 3% of a

family's disposable income (Zhu et al. 1989, 431–441). Some other subsidy was available from brigade and commune funds, but the government itself made no payments to the RCMS, except exceptionally in the very poorest regions (Zhu et al. 1989, 432). Communes supplied the RCMS with housing, equipment, and essential drugs from commune-owned estate and public welfare funds. The financial contributions received from the peasants were used locally to pay healthcare costs and the costs of medicine. Their local commune considered the contribution of barefoot doctors voluntary, with them receiving no payment for their health work specifically, rather only for their agricultural work.

This is a big contrast to the way that the NRCMS is financed and funded in modern China. In the new voluntary system, contributions are paid at a flat-rate per household, and while all contributions are then in turn subsidized by government funds, both at a county and national level, the very poorest members of the community have their contributions *entirely* subsidized by the government (Wagstaff et al. 2009, 3).

Membership to the RCMS was not theoretically obligatory, but the political structures in place greatly encouraged it. Whereas in the 1960s membership was entirely voluntary on an individual basis, from 1971 once a brigade had voted to join the system, all members of that brigade found themselves to automatically be part of the scheme and their payments would be expected. Households were organized into teams, then teams formed brigades, and brigades formed the commune. This, essentially mandatory, necessity for enrolment in the scheme should be seen in marked contrast to the entirely voluntary membership promoted as an integral part of the NRCMS today. Mirroring the spread of market culture, perhaps even the slightly more democratic tendencies, starting to become acceptable in modern China today.

This tension between centralism and either apparent or true local initiative can be situated in the broader tradition of socialist organizations; 'This seemingly paradoxical leadership style was the translation of Leninist democratic centralism to the economic and organizational domains: a combination of centralized direction of the economy by the state with the democratic initiative of the people' (Tsoukas 1994, 35). But significantly, this also fits in with other scholarly work illuminating that China might not be as centralistic as it might appear to be in its institutional structures. Even within PRC, from the time of its very foundation, there appears to have been more space for innovation than the dominance of the State might suggest. Several bottom-up political innovations, protests, local bargaining, and competition (Whiting 2000) still now continue to shape Chinese policies, values, and organizations in ways unanticipated and unplanned from Beijing (Fairbank 1998).

While the very hierarchical nature of the relationship between centre and periphery and between political and administrative level is still a strong characteristic of China, the NRCMS is no longer part of the huge bureaucratic and political machine of collectivist China (Appendices A and B). There is no army of Barefoot Doctors and the emphasis has shifted to be more on financial sustainability rather than creating an organization fully integrated with state propaganda. Households and individuals are today subject to higher fluctuations of income and wealth. This has meant, for most, better living conditions but also more uncertainty about their futures. This is why the new scheme is perceived as an insurance against catastrophic healthcare expenses (Yip and Hsiao 2009; Babiartz et al. 2010) in the eyes of both the policy makers and the subscribers. This hope is interesting because it is paradoxically reliant on historical foundations no longer considered relevant for modern China. Although cast differently, several organizational and ideological continuities between the two systems can be discerned. The next sections will describe the theoretical and practical implications of our findings and the needs for further research on this topic.

5. Discussion: history and organization studies

Answering the research questions, we have specifically addressed a gap in the existing literature on the NRCMS, as most medical, political, and economic studies have avoided analysing the heritage of the Maoist version of the scheme when investigating the current one. We consider this to miss a vital part of the story. It is intriguing to look at historical precedents in the light of the dramatically abrupt fall of the past scheme. The subsequent and sudden rehabilitation of the system in 2002, without any apparent mention in the public documents about the past scheme, but clearly embodying a strong ideological similarity to the former incarnation, we argue, needs to be considered. Organization Theory, when combined with historical analysis can offer further insights into the understanding of organizational reality. Institutional Theory has also been drawn upon to provide insights on the way that these organizations emerged, diffused, disappeared, and reappeared under a new institutional context (Powell and DiMaggio 1991; Jepperson 1991).

In the past 30 years there have been increasing calls advocating the wider use of historical research methods of analysis within social science disciplines, particularly those within Management Studies, Organizational Studies and Institutional Theory (Kieser 1994; Gherardi and Strati 1988; Decker 2013; Wadwani and Bucheli 2013; Rowlinson, Hassard, and Decker 2014; Greenwood and Bernardi 2014).

This work responds to these calls, arguing that NRCMS events are both historically contingent and contingent upon modern socio-political dynamics. As it has been argued among historians and organizational studies scholars (Greenwood and Bernardi 2014; Rowlinson, Hassard, and Decker 2014), using historical methods does not mean abandoning discrete disciplinary differences between historically separate fields of enquiry. Indeed, we do not expect any sort of seamless integration between two fields. To this end, we use the example of comparing and contrasting the old and new incarnations of the Chinese Rural Co-operative Medical Scheme using both historical methods and Organization Theory. Our recent visits to rural clinics in China have given us the contemporary perspective, but this is less meaningful if we do not also use history to assess the place from which the new organizational structures and ideological commitments of the scheme have evolved. While history gives us the toolkit to assess change over the passage of time, Organization Studies can additionally give us the means to further critique this analysis by allowing us to examine the structures and power relations that have been present in both schemes.

This study has a few limitations. The language barrier meant we only had access to interviews and Chinese Mandarin documents through the mediation of a translator. Furthermore, the understanding of Chinese politics is a very complex exercise that we make no special claims to have mastered. Finally, the understanding of the Chinese co-operative movement itself presents several challenges, not least because it is so different in many fundamentals to the international model that we assume as a paradigm.

These limitations should be seen as signals for the need for further research. The Chinese co-operative movement deserves more research; it is not clear how much it is in line with the international co-operative movement. Another issue that as well deserves further research is the relationship between contemporary communist leadership and Maoism. Also, the measurement of the effectiveness and efficiency of the NRCMS should be investigated further; 12 years after the establishment, its successes and failures shall be visible.

6. Implications: theory, practice, policy

This research conveys implications for theory (the need of an historical approach in contemporary Chinese Studies), for practice (the need of modernization for the Chinese co-operative movement) and for policy (the effectiveness and efficiency of NRCMS).

With regards to theory, we have learnt that no studies to date have examined the modern system directly comparative to the older one. In particular, most analysis has focused either on the financial or the medical side, without considering the ideological component of the old system and its inheritance to the NRCMS. The later scheme may have differed in emphasis but broadly followed historical patterns in its structure and priority. There were key differences in political context, organizational priorities, and membership terms between the two models, but nevertheless it is arguable that the NRCMS relied on its historical antecedents as part of its modern story of national acceptance. Certainly it seems that the original scheme has left an ambiguous legacy, on one hand its demise was nationally seen with a large amount of regret, certainly if we are to believe the Party line, emanating from the Department of Health which stated that the decline of the RCMS was ultimately to be regretted because the majority of farmers had welcomed this system (Zhang 1982, 32). Yet also by understanding the close associations the earlier scheme had with Maoism and enforced collectivization, we are able to see why there maybe some resistance to co-operatives within modern China. We realize that the health co-operatives that functioned during the 1960s are of a different nature to the NRCMS embraced in 2002. Yet to view modern developments in a vacuum is to ignore an important part of their rationale. Even when contemporary models are significantly different from their forerunners, their divergences from similar past conceptions should be seen as much as a reaction to historical precedents, as it is an adjustment to the social and political factors of the contemporaneous context. Chinese institutions are very ritualistic (Weber 1951) and have a very long memory (Douglas 1987); this makes the understanding of the past very important issue.

With regards to practice, our story of the resurrection of a Maoist co-operative model in post-Maoist China says much about the way co-operatives can adapt, survive, and flourish in different political climates (Scott 2003). Propagandist intent is no longer a central driving force of the new scheme, but nevertheless is present in a subtler and less obvious form. The language has changed from one of collectivism to individualism (all be it with State protection); the spirit of the new scheme is one of voluntary participation and self-responsibility, except for the very poorest sectors of society. The organization seems to have centralized, whilst also simultaneously becoming less authoritarian in its public demands. As explored in Section 4 however organizational differences are perhaps not so bold as the government would have us believe. The 2002 NRCMS policy, together with the 2007 Specialized Farmers Co-operative law, represent the evident resurgence in the interest of contemporary Chinese governments in the co-operative organizational model. The comparison of the old and new Rural Co-operative Medical Scheme confirms that China is indeed involved in a process of convergence (Scott 1995) towards the western notion of co-operation. The reputation of cooperatives was severely damaged by the ideological rule of Mao, but nevertheless, the contemporary Chinese co-operative movement, although different, owes much more than it would like to admit to its troubled past. Further convergence to the international co-operative model will require to deal with that past.

With regards to policy, we have learnt that both schemes have been measurably effective in delivering a broad improvement of health conditions in rural China. Having said this, on the efficiency side, the results are less clear-cut. The measurement of

efficiency and effectiveness is beyond the boundaries of this work and would involve broad statistical analysis of the data before and after these schemes were implemented. Leaving the judgement on the efficiency to economics studies, and the judgement on the effectiveness to public medicine studies, we can, however, add to the debate the useful point that (however effective) the organizational form adopted is never neutral, both because of its past heritage and also because of its contemporary influences and objectives. This means that in this case, as in others, the effectiveness and efficiency of Chinese social and economic policies may be affected by the degree of modernization and transparency on politics, ideology, and past Communist leaderships.

7. Conclusions

This paper has described the old and the new Rural Co-operative Medical Scheme. After a detailed narration and historical contextualization, the data analysis made it possible to answer both research questions. We have shown that ideologically and organizationally both schemes are crucially different. However, we argue, these differences are perhaps not that large.

The New Rural Co-operative Medical Scheme is not an ideologically run health care provider, but it nevertheless is far from ideology free. Vitrally, under the administration of the national and local authorities, the influence of politics is still visible (as in many other economic sectors) and the CCP are, of course, still conveying some ideological messages, modernized by the new language of individual responsibility and the persuasive appeal of the image of providing a universal entitlement to basic health care. By comparing the ideological commitments of both of the schemes, we can see a distinct reduction in the direct use of political ideology as a cohesive rationale for not only the modern scheme itself, but also for the way it is run and staffed at a micro-level. The NRCMS is still, for sure, part of the policy template put forward by the politicians of modern China, but it is one that now prioritizes long term health affordability and community healthcare management above the need to publicize and justify the central regime.

The old and new RCMS are not similarly organized in the core way in that the NRCMS has aligned itself closer to the western model of mutual insurance. In fact, most of the structure and maintenance of healthcare and public medicine operations are no longer directly managed by the NRCMS. The new incarnation of the scheme is closer now to western models of mutual insurance than it ever has been at any previous point. Political emphasis has shifted and in turn so have consumer expectations. China is now no longer inward looking, but as the second largest economy and a key player in the modern world stage, is attempting to apply broadly western models of insurance to tackle its population challenges.

This work has also argued that using history, as core part of the analytical method, can give deeper insights to organization and management scholars working on contemporary Chinese policies and business practices.

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Notes

1. Email: anna.greenwood@nottingham.edu.cn
2. Original Chinese: ‘至于如何解决广大农民的医疗卫生问题，那时共产党只有一个粗略的思路，既是走合作的道路’.

3. ‘生产建设与和平生活就无从获得保障’, He Cheng, Deputy Minister of Health, quoted in Hu (2007, 51).
4. Original Chinese: ‘要把过去两年放松了的爱国卫生运动重新发动起来, 并且一定要于一九六〇年, 一九六一年, 一九六二年这三年内做出显著的成绩’ quoted from Mao Z., *Instructions for Public Health/关于卫生工作的指示*, 18 March 1960.
5. WHO/E/5/418/11 SomnuekUnakul, *Report on Rural Sanitation in China*, February 1975, p. 3.
6. WHO/AFR/MCH/66 3.9.75 V. Agbessi, ‘Organisation of Health Services in China’; Report on a Mission, 21 October 1974, p. 2.
7. Original Chinese: ‘农村合作以来哦是人民公社社员依靠集体力量, 在自愿互助的基础上建立起来的一种社会主义性质的医疗制度, 是社员群众的集体福利事业’ (Article 1).
8. Original Chinese: ‘尤其应优先挑选具有上述条件的贫下中农子女.’
9. Original Chinese: ‘合作医疗站是集体福利事业单位, 不用办成企业及副业, 也不应要求他们上缴利润’ (Article 10).
10. See also The Shanghai Propaganda Poster Museum and the website database curated by Marien van der Heijden: <http://chinese posters.net/>.
11. Original Chinese: ‘举办合作医疗的形式要根据当地的实际情况和条件, 经社员群众充分讨论决定’ (Article 10).
12. Original Chinese: ‘赤脚医生的人数, 应根据实际需要进行配备’ (Article 13).
13. WHO/N52/180/2 CHN (2), File 1, WHO Study Missions to China, 1973–1978, ‘Medical Care in Rural Areas’, p. 2.

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Appendix A. 'Barefoot doctors are all over the mountain villages, cooperation creates a new atmosphere of medical treatment', 1974, IISH / Stefan R. Landsberger Collections



Appendix B. 'Practice birth control for the revolution', 1972, IISH / Stefan R. Landsberger Collections



Appendix C. A clinic in Guanxi, 2012, photo taken by the authors



Appendix D. A picture of Mao Zedong in a clinic in Guanxi, 2012, photo taken by the authors



Appendix E. ‘Three barefoot doctors’, 1974, from WHO Archive, WHO/N52/180/2 CHN (2), File 2, WHO Study Missions to China

