

Serve the People: Communist Ideology and Professional Ethics of Medicine in China

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The ethics of the Chinese medical profession has been guided by and fashioned in accordance with the Chinese Communist Party's ideology since the establishment of the People's Republic of China (PRC) in 1949. It has been an ideological demand for doctors to serve the people unselfishly. Role models, represented by Dr Norman Bethune, have been promoted for medical professionals to follow and emulate. In the pre-reform era, public ownership of means of production and resources and command economy were established to facilitate the ideological commitment to serving the people in health care, as well as in other spheres. Since 1978, Chinese economy has undergone profound changes brought about by market-oriented reforms in almost every economic domain, including health care. In the meantime, however, the guiding principles for professional ethics of medicine continue to be those inherited from the command economy, featuring an emphasis on serving the people selflessly. Consequently, the market-oriented health care reform has created a dilemma that has long confused the medical profession, misled health policymaking, and partially caused the public outcry over the health reform. This paper examines the ideological core of the ethics of the Chinese medical profession formulated in the pre-reform era and the dilemma it has caused in the reform-era.

Professional ethics in pre-reform China – serve the people and bureaucratic medicine

Since the establishment of the PRC, the Chinese Communist Party (CCP) undertook two ideological commitments which shaped the relationship between the medical profession and the Party-state, and that between doctors and patients. One was to unify the economy under public (state and collective) ownership and wipe out private economy. The other was the CCP's ideological undertaking to serve the people. Health policies and the organisation of health care and medical services under the rule of the CCP are inevitably, and have been indeed, shaped by the ideology of the ruling party since the beginning of the regime. One major source to understand the ideology of China's Party-state is the CCP Constitution and the PRC Constitution. Both constitutions have undergone many changes and amendments since the date of creation and enforcement, but their ideological commitment to the welfare of the people has been consistent.

The Constitution of the PRC was first promulgated in 1954. It defined the nature of the PRC as a 'People's democratic country led by the working class on the basis of alliance between the workers and the peasants'; that is, the people of these two classes formed the majority of the population (Clause 1). And this was, and has been true in reality. The Constitution stated that the socialist economy characteristic of ownership by the whole people should be the leading force of the national economy and the

material foundation of socialist transformation (Clause 6). The ‘ownership by the whole people’ is in reality ownership by the state. Not only capitalist ownership should be transformed into state ownership, but the property of individual private proprietors should also be transformed into collective ownership (Clause 7). In terms of health care for the population, the 1954 Constitution promised that the labourers of the PRC had rights to material assistance when in old age, sick or losing working capacity. Social insurance, welfare and health were the responsibility of and would be established and operated by the state, which would gradually expand the infrastructure for these responsibilities in order to ensure that labourers enjoyed these rights (Clause 93). In connection with the ideological goal to nationalise and collectivise economy, this ideological undertaking should be understood as that the entire health-care services should be owned, operated and delivered by the state.

The Constitution of the CCP, in theory, only obliges its members. In reality, its applicability is much wider, because the CCP has been the only functioning and ruling Party. The CCP’s first constitution was formulated in 1921, but the constitution enacted in 1956 was the first one created after the CCP came into power. The tasks of a party before the party seized the power were apparently different from those afterwards. The 1956 CCP Constitution reflected the amended tasks and updated goals of a communist party which had just risen to the ruling position responsible for the economy and wellbeing of the population. It was stated that the ultimate task of the Party was to gradually carry out socialist transformation of agriculture, the handicraft industry and capitalist business. The Party took it as its goal to, using correct methods, turn the residues of capitalist ownership into that of the whole people, and the residues of the ownership of individual labours into collective ownership of the labouring masses. The ideological goal to nationalise and collectivise health care led to the state’s monopoly in medicine and health, and resulted in the state employment of all qualified medical human resources.

In spite of numerous amendments and re-writing to reflect political priorities and environments of different periods, the CCP Constitution has always required the members to understand the identification of the Party’s interests with the people’s interests, and demanded that members serve the people wholeheartedly. ‘Serve the people wholeheartedly’ has been a consistent commitment of the CCP towards the people, which included the exploited, oppressed and pro-CCP social strata before 1949 and refers to the ruling classes of predominantly workers and peasants and other social strata that were not identified as enemies by the regime after 1949. This commitment needs particular attention here for it has been obligatory not only for all party members but also for non-party members who serve in the Party-state organs, including the health-care system.

The CCP’s commitment to the people’s health in the early years of the PRC was apparently drawn from the thinking and instructions of the major leaders of the CCP, especially Mao Zedong. Health care was not a major concern of Mao, but he did have some ideas that had shaped the health polices and system in the pre-reform era. One of the ideas that has been frequently stressed by policy-makers and students of Chinese health care is that health work must serve the people (Sidel & Sidel 1973; Yin 1997; X. Zhang 2003). This ideological commitment has become the core of the professional ethics of medicine and indicates the ideal relationship between doctors and patients.

Ideologically, the doctor–patient relationship was, and is still, defined as one ‘to serve the people wholeheartedly.’ This ideological definition and requirement is most strongly expressed in Mao Zedong’s article ‘In memory of Norman Bethune’. Dr. Norman Bethune (1890–1939) was a Canadian surgeon and a member of the Canadian Communist Party who came to assist the Chinese Communist army in the anti-Japanese War, and died of blood poisoning received from treating Communist soldiers on 12 November 1939. Bethune won his renown mainly due to Mao’s article, which became one of the ‘Old Three Articles’ by Mao during the 1960s and 1970s and recited by people as a political requirement. In the article, Mao speaks extremely highly of Dr Bethune’s devotion to communism. Mao says:

Comrade Bethune’s spirit, his utter devotion to others without any thought of self, was shown in his great sense of responsibility in his work and his great warm-heartedness towards all comrades and the people. Every Communist must learn from him.

We must all learn the spirit of absolute selflessness from him. With this spirit everyone can be very useful to the people. A man’s ability may be great or small, but if he has this spirit, he is already noble-minded and pure, a man of moral integrity and above vulgar interests, a man who is of value to the people (Mao 1939, pp. 337-338).

The essence of Bethune’s ‘spirit’ and legacy is displayed in his communist altruism towards the people, or the patients in terms of the doctor–patient relationship. Bethune himself was very much against using medicine for private profit and a strong proponent of socialised medicine (Bethune 1936 (1998), pp. 100-101).

Bethune’s views of the government’s duties towards the health of the masses bear much ideological resemblance to those of the CCP. Mao’s lavish praise of Bethune should be understood in this context. Although Mao’s article was intended to address communists and communist health workers, with the establishment of communist ruling in China, his call for learning from Dr. Bethune became a political demand for all health professionals, regardless of their party membership.

To serve the health needs of the people thus became the ideological framework for the making of health policies, the organisation of health-care resources, and, most importantly, the foundation of the principles of health care in China. The CCP made efforts in three aspects in the process of building a health-care system for the people and to realise its ideological undertaking. The first aspect is the provision of state and collectively financed health insurance; the second is the nationalisation of medical resources, both material and human; the third is the deprivation of the organisational power of the medical profession.

To improve the health status of the whole population, the CCP took policy initiatives since the early days of its ruling to establish public health insurance schemes intended to cover the whole population. Up to 1978, three health insurance systems were established that financed the health services for almost the whole population. These are the Labour Insurance System (LIS) covering workers and their direct relatives and compensate for disablement, death, retirement, and childbearing (S. Gao 2006; Ho

1995), Publicly Funded Medical Services System (PFMSS) providing social security to the employees of 'nonproduction, nonprofit units' (Ho 1995; X. Lu & Perry 1997, p. 7), and Rural Cooperative Medical System (RCMS) (Wilenski 1976).

The most profound impact on the medical profession came from the nationalisation of medical human resources. When the CCP came into power, it sought to establish a 'perfect publicly owned society' (Anson & Sun 2005, p. 10) in which the needs of the population were met by the nationalisation of key resources and the planned distribution and utilisation of these resources (Wong & Chiu 1998). Drawn from the Soviet Union experience (Blumenthal & Hsiao 2005), as well as from the fundamental ideology of communism, the CCP believed that the state monopolisation of health resources was the best way to improve and provide health services for the population. Since its very beginning, the Chinese party-state started the process of the monopolisation and nationalisation of health resources, including human resources. The nationalisation of medical human resources, particularly medical professionals, progressed along two lines: the absorption of private practitioners into state employment and the complete control by the state of education and employment of new practitioners.

In the First National Health Conference held in 1950, it was agreed that a public health system could not be established immediately and private practice was needed in the society. But the Conference also published the 'Resolution on adjusting the public-private relationship in the provision of medical and health services', which advised that local health administrations should encourage individual practitioners to form united clinics (Xu 1998). At the initial stage, united clinics were group practices, in which individual practitioners had great financial and professional autonomy and the clinics could decide their own work and economic terms. However, in the years up to 1957, united clinics were viewed as non-socialist and were pushed into public ownership. Individual practitioners who had not joined a united clinic were eventually placed in state employment (G. Liu, Liu, & Meng 1994; Xu 1998).

More important for the nationalisation of health human resources was that medical school graduates, as much-needed resources for the modernisation of China, could only find employment in the public sector. Deborah Davis's study shows that by 1953 an across-the-country system of unified job assignment was established, and no university students would be able or would dare to refuse jobs assigned to them or to choose their own jobs (Davis 2000, pp. 256-261). The majority of university students willingly accepted jobs allocated to them by the government, partially because of students' 'enthusiasm to "serve the nation"' (Davis 2000, p. 259) and partially because the best positions were only available in the public sector due to the sharp diminution of the private sector. Because all tertiary educational institutions and all modern industrial establishments that needed university students were nationalised, the private sector could not offer any attractive positions and was excluded from accepting students from the unified job assignment system.

With individual private practitioners pressured into united clinics and then public employment, and without the injection of new blood, the private sector dwindled. During the Cultural Revolution between 1966 and 1976, private medical practice was completely eradicated as 'capitalist residues' (G. Liu et al. 1994).

The public employment of health human resources in a socialist regime severely restricts the organisational autonomy and power of the medical professionals. On one hand, the employment model of the profession rendered the medical professionals powerless organisationally, politically and economically. On the other hand, the close affiliation with the Party-state also empowered the profession, which shared the state power by representing the state authority in the medical field.

China's health-care system is operated through work-units, such as hospitals and clinics. In the medical work-unit, each doctor can be regarded as an individual representative of state authority, namely the authority to practise, although they also form part of the human resources of the hospital and are in the possession of the state. The professional power and authority that a doctor exercises in his or her work is granted by the state through state.

The Chinese health care system is a totalitarian bureaucratic system. Generally, the health-care system has four vertical levels of power: the state, the work-unit, professionals, and patients. The state dictates the work-unit; the work-unit controls professionals; professionals dominate patients. Patients are at the bottom of the power pyramid. The nature of totalitarianism and the hierarchical structure of power delegation do not allow any open challenge to the power and authority of upper levels on the power ladder. Patients are not supposed to challenge the power of doctors; doctors not that of their work-units; while work-units cannot challenge that of the state.

As public employees in institutional work-units, qualified medical professionals gained the identity of state cadre which separated them from the masses. In the PRC's political system, the identity of cadre not only was a symbol of new social status, but also represented the Party-state power and authority in a professional domain, and other special benefits that came with the status, such as food and housing. Although ideologically professionals were required to be responsible for the people, the employment and redistribution modes rendered doctors dependent upon the state for livelihood, benefits and rewards. No mechanisms were established to empower patients and to protect their interests. As representatives of the totalitarian Party-state's power in medical fields, doctors dominated the doctor-patient relationship with little accountability.

The lack of patients' power was only disclosed in the media towards the end of the 1970s and the early 1980s. Medicine in China was described as 'bureaucratic medicine' in the media. Complaints about low quality, long waiting time, poor attitude, negligence, and rent-seeking behaviours were rife in national and local newspapers. For example, *Jiankang bao* (Health News), an organ of the Ministry of Health, published in October 1981 a series of reports, comments and editorials on a story about a patient with an injured finger being turned away by seven hospitals because the incident happened at midnight (Bian 1981). The patient accused these hospitals of practising 'bureaucratic medicine' (Cui 1981). One commentator tried to provide reasons for this and many other similar incidents from an 'objective perspective'. One of the major reasons he blamed the incident on was that the work of the medical personnel was not bound legally and supervised by the people. The egalitarian 'big rice bowl' employment and redistributive system exempted doctors from legal and economic punishment for malpractice, which was fully covered by

hospitals. Under this circumstance, doctors did not have any economic pressure to be responsible for patients, and were not motivated to discipline themselves in their work. The commentator proposed the establishment of a legal framework to regulate the conduct of doctors, and proposed that patients should be empowered to monitor the work of doctors (Gong 1981). Another commentator gave a summation of inappropriate activities among hospitals and doctors. He stated:

Some hospitals treat patients as ‘balls’ and tick them around (i.e. sending them to other hospitals without providing treatment); some doctors are extremely careless in diagnosis, or administer wrong injection or medicine. When serious mistake and malpractice have been made, [hospitals and doctors] cover each other, attempting to ‘turn major problems into small ones and small ones into no problems at all’ (Liang 1981).

Since the early 1980s, health professionals and workers have been accused in the media of being ‘impersonal’, ‘callous’, ‘crude’, ‘confrontational’, and ‘denying’ (*sheng, leng, ying, ding, tui*) toward patients (Gong 1981; J. Jiang 1993; H. Liu 1991; Yan 1998; Yang 1985; D. Zhang 1980). This is typical of state workers employed in work-units that are involved in provision of some kind of services to the public, including administrative services. Rent-seeking activities – ‘eating’ (*chi*, that is, forcing help-seekers to take responsible officials to meals), ‘taking’ (*na*, that is, taking goods of small value from help-seekers), ‘blocking’ (*ka*, that is, intentionally setting up barriers for help-seekers), and ‘soliciting’ (*yao*, that is, soliciting bribes) – are endemic in Chinese bureaucracy, including public health care, and have been the target of the CCP’s efforts to rectify unhealthy trends for a long time. Up to 2006, however, these ‘unhealthy’ work attitudes were still a problem that the Ministry strived to redress (Ministry of Health 2006).

It is demonstrated in the above discussion that in the pre-reform era and continuing deep into the reform era, the ideological emphasis on the profession’s political undertaking of serving the people failed to commit doctors heeding patients’ interests wholeheartedly, leading to the prevalence of bureaucratic medicine, which characterises negligence of patients’ interest. In the reform era, the Chinese government has advanced commercialisation in health care in an attempt to improve the quality and efficiency of health care and to fight bureaucratic medicine.

Professional Ethics in the Reform Era – Serve the People or the Market?

In the reform era, the contradiction between socialist professional ethics and bureaucratic medicine is gradually replaced with one between continuously ideological emphasis on socialist professional ethics and the commercialisation of health care. On one hand, Chinese health care has undergone fundamentally economic changes in health care, including the collapse of public health insurance systems in both rural and urban areas, the reduction in health investment by the government and the soaring health expenditure, and the widespread commercialisation of health facilities. On the other hand, ideological and political changes have not been as substantial (Guo 2000). The CCP retains ideological commitment to the health of the people, which is very much a continuation of the ideology of the pre-reform era. Politically the CCP continues to assume domination over almost every aspect of the medical profession. The clash between liberalism in the economy of health care and

totalitarianism in the ideology and politics of health care has created tremendous tension in the power relations between the profession, the state and the public.

The constitutional commitment to the health of the Chinese population continued into the reform era. The amended PRC Constitution enforced in 2004 continuously proclaims that China is a socialist country of people's democratic dictatorship led by the proletarian class on the basis of worker-peasant alliance (Clause 1), but the commitment to the nationalisation of economy is abandoned. Instead, the state exercises a socialist market economy. In terms of health care, the Constitution withdraws slightly from the firm stance of the 1954 Constitution, claiming:

The state develops medical services and health care, develops modern medicine and the country's traditional medicine, encourages and supports rural collective organisations, state-owned productive and institutional organisations and neighbourhood organisations to establish and operate different types of medical and health facilities, carry out mass health activities, and to protect the health of the people' (Clause 21).

In spite of the slight withdrawal from the 1954 undertaking that the state provide health care, the 2004 Constitution nevertheless obliges the state to protect the health of the population.

The government's obligation to the people's health is more clearly expressed in the 'Resolution of health reform and development' jointly formulated by the Central Committee of the CCP and the State Council in 1997 (Central Committee of the Chinese Communist Party & State Council 1997). The 'Resolution', which has been regarded as the health reform guideline, opens with the announcement that 'everyone enjoying health care and continuous increase of national health condition is a significant indicator of the construction of socialist modernisation.' The goal that the Party and the government undertake to achieve in health care is

following firmly the Party's fundamental lines and policies, to unintermittedly deepen the health reform under the guidance of Marxism-Leninism, Mao Zedong's Thoughts and Deng Xiaoping's theories of constructing socialism of Chinese characters. By 2000 ... it should be realised that everyone has access to primary health care.

The fundamental principles that health reform must follow include 'serving the people' and 'centring around improvement of the people's health condition.' Skilfully, the 'Resolution' does not obligate the Party and the government to take full responsibility for the health care of the people. Nonetheless it does not relinquish the Party-state's ideological commitment to the health of the population.

In the reform era, the professional ethics have been continuously guided by the CCP's ideological call for its members to serve the people. Codes of practice have been formulated and enforced by the government. In 1981, a new concept – socialist medical ethics (*shehui zhuyi yide*) – was formulated in the wake of the First National Medical Ethics and Morality Conference (Qiu, Sun, & Wang 2008), and has been the overarching guidance for medical professional ethics since then. Socialist medical ethics was defined in 1981 as 'serving the people wholeheartedly, healing the

wounded and rescuing the dying, preventing and treating disease, and exercising revolutionary humanitarianism' (J. Lu & Fan 1981). In this definition, 'serving the people wholeheartedly' is the most important characteristic that 'distinguishes the socialist medical ethics from the medical ethics of all exploiting class societies. In a socialist country, the people is the master of the society. Serving the people is the goal that each medical person must pursue all the time, and is the essence of the principle of socialist medical ethics and code of practice' (ibid.). Up to date, this definition has not changed. The socialist medical ethics continues to be the fundamental guidelines for medical professional conduct and continues to be defined in the same light. For example, in a popular textbook of medical ethics for university students, the medical professional ethics of China is defined as 'preventing and treating diseases, healing the wounded and rescuing the dying, practicing medical humanitarianism, and serving the people's health wholeheartedly' (Qiu et al. 2008). The differences between the definitions are the replacing of 'revolutionary humanitarianism' with 'medical humanitarianism', and the replacing of 'serving the people wholeheartedly' with 'serving the people's health wholeheartedly'. The replacements reflect political changes in the CCP's ideology, but they do not change the core of the definition.

Since 1981, codes of practice for medical and health professions have been formulated and amended, itemised and expanded in light of the concept of the socialist medical ethics. In October 1981, the Ministry of Health published the first code of practice for medical professions – 'Code of practice and rules of medical ethics for hospital workers' (Qiu et al. 2008, p. 21). In 1985, the Ministry of Health enforced the 'Rules for hospital workers', which had only eight rules. Rules One to Three are of particular relevance to the current research. Rule One required hospital workers to 'love the motherland, love the CCP, love socialism, and stick to Marxism and Mao Zedong's Thoughts.' Rule Two demanded the workers to 'study politics diligently, and to perfect professional work in order to be both red and specialised.' Rule Three encouraged them to 'carry forward the revolutionary humanitarianism of healing the wounded and rescuing the dying, to sympathise with and respect patients, and to serve the people wholeheartedly' (Ministry of Health 1985).

In 1988, the Ministry of Health formulated and enforced the code of practice for medical personnel in particular (Ministry of Health 1988). The code contains thirteen items. Item 3 prescribed the ethical conduct in particular in seven sub-items. The first four of the seven good practices required doctors

- (1) To heal the wounded and rescue the dying, practise revolutionary humanitarianism. To think for the patient all the time and to try every possible way to free the patient of disease and pain.
- (2) To respect the integrity and rights of patients, and treat them equally regardless of nationality, sex, occupation, status and wealth.
- (3) To provide services with good manners ...
- (4) To be clean and honest in serving the public, to obey rules and laws, and not to abuse medicine for personal gain.

These seven rules are further itemised and standardised in the guidelines for establishing the ethics evaluation system for doctors, published in 2007 by the Ministry (Ministry of Health 2007). The guiding principles for the 'Guidelines' are stated to be derived from Deng Xiaoping's theory of preliminary stage of socialism,

Jiang Zemin's 'important thought of "Three Represents"' and Hu Jintao's socialist outlook on honour and shame and the scientific outlook on development. The professional conduct of doctors is evaluated in light of the seven sub-items provided in the 1988 code of practice. The evaluation contents for each sub-item are given in detail. For sub-item 1 – 'to heal the wounded and to rescue the dying, and to serve the people wholeheartedly' – doctors are expected to 'strengthen the study of political theories (i.e., the ideological contributions of all the great CCP leaders) and professional ethics, in order to establish the conscience of healing the wounded and rescuing the dying, centring on patients, and serving the people wholeheartedly; and to carry forward the Bethune spirit assiduously.'

In the reform era, Norman Bethune continues to serve as the role model for public employees. In 1979, Deng Xiaoping called upon the members of the CCP and medical workers to become 'Bethune-style revolutionaries and Bethune-style scientists' (Deng 2005). Jiang Zemin also called upon leading cadres to follow the role model of Bethune. In a speech addressed to the fifth plenum of the Fourteenth Central Committee, Jiang (1995) said:

I suggest that everyone should read comrade Mao Zedong's 'In memory of Norman Bethune'. Chairman Mao required Communist Party members to learn Bethune's spirit of complete selflessness, and to be a noble-minded man, a pure man, a man of morality, a man above vulgar interests, and a man of value to the people. Under the circumstance of developing socialist market economy, the social environment is entirely different from that of the wartime. Are Chairman Mao's words outdated? No, they are not. I should say they have more relevance to reality.

In the new era, a new moral requirement has been developed and added to the fundamental ideology. The new requirement is expressed in a political slogan called '*wusi fengxian*', which means 'unselfish sacrifice'. The apex of the application of this moral standard was in the period of SARS in 2003. Medical professionals were called upon to 'sacrifice selflessly' in the battle against SARS. Those who contracted the disease through treating the infected were highly commended for their courage, the willingness to selflessly sacrifice themselves to serve the people, and to practise the 'important thought of "Three Represents"' that the former President Jiang Zemin contributed to the communist ideology (Chen & Liu 2003; Chongqing Municipal Health Department 2003; W. Liu 2003; Ministry of Health 2003; Ministry of Health & Ministry of Personnel 2003; The General Office of Guangdong Provincial CCP Committee 2003). Since then, 'unselfish sacrifice' has become the moral standard that the public and the state expect the medical profession to exercise this every day.

In spite of the continuous emphasis on socialist medical ethics and the ideological commitment to serving the people, in the reform era, the economic environment that had sustained the health care in the pre-reform era has been drastically eroded to the extent of non-existence.

Health care has not been an emphasis of the CCP's work since the beginning of the reform era. An obvious indicator of the negligence is that health care was barely mentioned by Deng Xiaoping on any occasion. Health care has no place in the 'Deng Xiaoping Theory', which is the official term for the reform and economic

development theory developed by Deng Xiaoping and enshrined in the ideology of the CCP. This legacy has been inherited by the successive leaderships. The state's indifference to health care has led to the collapse of public health insurance systems. According to the Third National Health Services Investigation conducted by the Ministry of Health in 2003, only 29.7 per cent of the Chinese population was covered by certain types of medical insurance, including commercial insurance. 70.3 per cent of the entire population paid for medical services out of pocket (MOH Statistics and Information Centre 2004).

With the decline in public health insurance coverage is a growing cut in government funding for the public health-care system and an increasing integration of market elements into the system. The total health expenditure has seen a steady rise since the early 1980s and its percentage of the GDP has increased from 3.28 per cent in 1980 to 5.7 per cent in 2000. With this increase, however, came the sharp decline of government public health budget, which dropped from 36 per cent of total health expenditure in the early 1980s to only 14.9 per cent in 2000 (*China Health Year Book* Editorial Board 2002, p. 503). In 2004, the percentage of state investment increased slightly to 17.1 per cent (*China Health Year Book* Editorial Board 2006, p. 646).

Until the early 1980s, public health facilities received subsidies to cover running deficits (X. Liu, Liu, & Chen 2000), although the government might not always pay the subsidies in full. Towards the late 1980s, hospitals were granted a fixed subsidy to replace flexible budgets, which were extremely insufficient (X. Liu et al. 2000; Ministry of Finance 1979; Ministry of Health 1981b). It is pointed out that while government budgets accounted for 30 per cent of the revenues of hospitals in the 1970s and 1980s, in 2000, only 7.7 per cent of their revenues came from the government budget (Q. Gao 2005). At present, hospitals can barely receive any funding from the government. They have to generate literally all their income from fees-for-services.

The collapse of health insurance systems and the decreased government investment in health facilities have caused great difficulties for both users and providers. To address these problems, the state initiated contradictory policies. On one hand, the health-care system is heavily regulated by the government in an attempt to contain costs and make health care accessible to the people who have been facing diminishing health insurance coverage (Anson & Sun 2005, p. 46). On the other hand, commercialisation has been strongly pushed through the health-care system. It is demanded that public health facilities operate according to market principles. These reforms seem to have created more problems than they have solved, especially in the domain of pricing of medical services.

In the reform era, China's health facilities have some degree of economic autonomy, but they have little say with regard to setting the prices for most of their medical services and products (Eggleston & Yip 2004; X. Liu et al. 2000; The World Bank 1997). The strict control has resulted in price distortion in consultation and service fees. A frequently used device to increase the health-care accessibility is for the government to mark down the value of medical services in order to keep prices low (Hsiao 1995; X. Liu et al. 2000; Wong & Chiu 1998). The Chinese government reduced medical service fees three times from 1958 to 1978. Consequently, in the early years of the reform era, the revenues from providing services were not enough

to recover the costs of services (Ministry of Health 1981a). The device is still used in the present day. According to a study of unit costs of major health services in Shandong Province in 1994, the regulated hospital fees only allowed an average cost-recovery rate of 50 per cent. Only 4 per cent of services had their fees set above costs (X. Liu et al. 2000). Ten years later, the situation was not much improved. A survey of 32 hospitals in Zhejiang Province in 2003 reveals that the regulated fees for 92.9 percent of surgical procedures could not cover the costs (Gu 2007). Setting medical service prices low seems to have been a major resort to contain cost, to appease the increasingly dissatisfied public, pursuant to the CCP's ideological commitment to 'serving the people'.

The effect of over-regulation, however, is readily offset by the government's encouragement of commercialisation. In 1988, public hospitals were demanded to implement all forms of contracted responsibility systems, and were encouraged to set up special clinics to provide higher quality services for patients who could afford higher out-of-pocket fees. In terms of services using new technology and equipment, hospitals were also allowed to charge fees according to real costs (labour costs excluded) (Ministry of Health, Ministry of Finance, Ministry of Personnel, State Price Bureau, & State Taxation Office 1988), which always means higher fees. In 1989, the fiscal reform in health care saw public health facilities being allocated fixed budgets. The government was no longer responsible for the deficit of public facilities. Hospitals were allowed to keep the surplus of the budget but had to take responsibility for any deficits. At the same time, hospitals were permitted to generate and increase incomes through various forms of services, and to associate self-generated income with the benefits and welfare of staff. As a result, pursuing profits has become the common goal of public health providers (Ge & Gong 2007).

According to the CCP's ideology, public health insurance schemes and public investment in health should be, and was the responsibility of the Party-state. However, in the reform era, government input in both domains contracted immensely, indicating that the Party-state actually abandoned its commitment to the health of the people. In the meanwhile, the CCP continues to pay lip service to its fundamental ideology and dictates public health facilities to shoulder the responsibility that the CCP has discarded. This contradictory demand is best illustrated in the 'Resolution of health reform and development'. The 'Resolution' dictates that health reform and development must follow the principle of serving the people and correctly balancing the relationship between 'social effect' and 'economic returns', with 'social effect' coming before 'economic returns'. 'Social effect', in the CCP's terminology, refers to the communist commitment to the public good and the general welfare of the people.

As a result, public health institutions have been caught in a dilemma. If they follow the principle of 'serving the people', they have to operate at a loss and thus cannot achieve the goal of economic development required by the economic reform. If they make profits to fund reform and development, they have to deviate from the principle of 'serving the people' required by the fundamental ideology. When the hospital breaks down these political and economic goals and assigns them to individual doctors, the latter face the same dilemma. Consequently, both hospitals and doctors have to resort to activities that are not sanctioned by the Party-state to cope with the difficulty.

To motivate or coerce doctors to pursue profits, the government has encouraged public medical facilities to introduce performance wages. The performance wage is designed to link the individual's income closely with his or her economic performance, especially sales performance, although the employer would also consider other dimensions of his or her work, such as the quality of services, the number of complaints and so on. Usually, a substantial part of the doctor's normal wage is converted into a contingent wage.

For example, Shenyang TCM Hospital enacted a new wage scheme in 2003. It features a 'redistribution according to second performance assessment' paradigm. All the doctors and nurses are only guaranteed 30 per cent of their wages (most probably referring to their position wage), and are required to find their own 'ways' in their work to earn the rest of the 70 per cent or more. A position with a normal monthly wage of 1,700 *yuan* is only paid around 700 *yuan*, including a 500 *yuan* fixed wage. The rest of the salary has to be earned through prescription of drugs, tests, and other services. At the same time, there is an entire scheme of kickback rates for prescriptions. For instance, doctors get 11 per cent for prescribing herbal medicine, 10 per cent for pathology tests, 13 per cent for injections and bandage changes, 17 *yuan* for CT, etc. Consequentially, doctors of some popular departments could pocket up to 10,000 *yuan* extra money per month as a reward for prescribing drugs and services, while others from the least popular departments could only receive 100 to 200 *yuan* 'kickback' from the hospital (Cong, 2004). Wage schemes like this have been widely adopted to motivate doctors and as a means to increase revenues for the hospital (Ji, 2005; X. Tang, 2004b; Xie, 2006). Under this circumstance, inappropriate activities in breach of socialist professional ethics become widespread. These activities have explicitly termed in the media as 'corruption'. In the Chinese health-care system, inappropriate practices occur at both hospital and individual levels. Hospital-organised and sanctioned inappropriate practices include over-prescription, overprovision and overcharging. Individually organised inappropriate activities include taking drug kickbacks, moonlighting and receiving informal payments.

Discussion

Throughout the CCP's regime, the core of the medical professional ethics has been serving the people wholeheartedly and selflessly, but this ideological requirement has never been effectively practised in reality. In the pre-reform era, the nationalisation and bureaucratisation of the medical profession promoted the social status of doctors and their dominance over patients and resulted in the practice of 'bureaucratic medicine', which features negligence of patients' interests and wellbeing. In the reform-era, the policy shift to economic development has prioritised commercialisation of health care amidst proportional decline in public financing of health care. Medical facilities and personnel are forced to pursue economic benefits at the expense of professional ethics. With the CCP's superficial persistence on its ideological commitment of 'serving the people' and its strict regulation of medical service pricing to contain costs, many of the popular economic activities that medical facilities and doctors pursue have been labelled as 'corruptions'. In conclusion, the ideology of the socialist professional ethics which requires the medical profession to serve the people wholeheartedly has always remained an ideal.

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