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Cheltenham, UK • Northampton, MA, USA

3. Chinese psychiatric welfare in historical perspective

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INTRODUCTION

Between 2010 and 2012, the American media closely documented a series of knife attacks on rural Chinese elementary schools, each of which was carried out by an individual who was suspected of being mentally ill. The events prompted American journalists to ask why China has not done more to improve psychiatric services for its considerable population. 'Mental health remains a medical backwater,' a *New York Times* journalist declared as part of a two-part series on the 'inadequacies' of mental healthcare in China (LaFraniere 2010). Another reporter similarly claimed that mental illness is a 'closeted topic in China,' as neither 'medication nor modern psychiatric treatment is widely used' (Wines 2010). While both argued for increased government intervention into matters of treatment, prevention, and access to care, others have pointed out that government authorities 'have not kept pace' with rising numbers of mentally ill people in China. Due to insufficient health coverage and cuts in social welfare programs, families have been left to shoulder the burden of mental illness alone (Yuen 2013).

Journalists and scholars generally highlight two main problems with the current state of psychiatric welfare in China. First, public health experts have emphasized the shortage of mental health professionals and the limited access to psychiatric resources. According to recent epidemiological surveys, approximately 173 million adults in China suffer from a psychiatric disorder, but 158 million have never received any professional help (Phillips et al. 2009). This disparity can be attributed in part to the insufficiency of available psychiatric services. Only one licensed psychiatrist exists in China for every 83,000 patients—one-twelfth the number in the United States—and only one psychiatric bed is available for every 10,000 people (Liu 2011; Chang and Kleinman 2002). Despite the fact that highly sophisticated neurological and psychiatric hospitals have been erected in China, they are primarily located in major urban centers and typically offer treatments on a fee-for-service basis. Consequently, many patients in rural areas either lack access to these treatment centers or cannot afford to pay for their services (Yip 2006).

Second, recent attention has also focused on the lack of psychiatric literacy among Chinese families, particularly those located in rural areas. In a survey conducted in 2003, it was determined that 70 per cent of respondents had 'no knowledge of mental illness.' Instead, most attributed the problem to ghosts and spirits, an underlying physical condition, or simply to thinking too much (Ran et al. 2005: 27). As a result of the deficiency of psychiatric knowledge, patients are often blamed and stigmatized for their condition (Kleinman and Guo 2011). When families pursue hospitalization, moreover, existing cultural conceptions about the nature of mental illness frequently undermine the advice of psychiatric practitioners. In her research into a psychopathic hospital in Guangzhou,

the anthropologist Zhiying Ma has demonstrated how families often challenge, subvert, or obstruct the advice of physicians, believing instead that Chinese medicine or religious therapy will be more advantageous to the patient than the type of care provided in a formal institutional setting (Ma 2012).

In seeking to understand the continuing problems facing psychiatric welfare in contemporary China, it is useful to turn our attention to how systems of welfare, particularly in relation to the mentally ill, developed historically across China throughout the twentieth century. Using a combination of primary and secondary sources, including newspapers and unpublished archival materials, this chapter will argue that many of the key issues facing psychiatric welfare in China today can be traced back to longer historical processes that unfolded during the late Qing (1644–1911), Republican period (1911–1949), and Maoist era (1949–1976). In particular, I will highlight three factors that have contributed to the predominantly residual approach to psychiatric welfare that currently exists in China. First, throughout the twentieth century, the family, rather than the State, has been held primarily responsible for the management of the mentally ill. Second, when the State has pursued a more active approach to welfare, it has done so in a way that has perpetuated uneven geographical access to institutional care, with urban being prioritized over rural areas. Finally, popular attitudes, beliefs, and taboos concerning the mentally ill have also contributed to informal care-seeking practices and a reluctance to pursue treatment in a hospital setting. These historical processes, though having evolved in a variety of ways across the twentieth century, continue to exert an influence on the way that psychiatric welfare has developed in contemporary China.

MADNESS IN THE LATE IMPERIAL PERIOD

Throughout the Qing dynasty, the State pursued a largely decentralized and ad hoc approach to the management of madness. When the Presbyterian missionary John G. Kerr arrived in Guangzhou (Canton) in the late nineteenth century, he observed with frustration that the Chinese empire, though having existed for 'thousands of years' and encompassing a 'vast population,' had up until that point never attempted to introduce 'any provision for the insane, except such as could be made in families or in prisons' (Kerr 1898: 177). The American physician Charles Selden, who would later manage the psychopathic hospital that Kerr established in Guangzhou in 1897, similarly observed that the insane 'constitute a very helpless class in China' and that 'no provision has been made [for them] by China's government or China's people.' Most, he noted, were either kept in chains at home or wandered the streets aimlessly; in certain violent cases, they would be thrown in prison 'as if they were criminals' (Selden 1905: 3).

Although missionary observations tended to highlight the very worst examples of neglect or abuse, they do shed light on how the insane were managed during the late imperial era. Throughout the Qing dynasty, the imperial State never developed asylums or psychopathic hospitals for the general management of the insane. Instead, insane persons were typically considered a family responsibility rather than a matter of State or public concern. Between 1731 and 1908, families were forced to register their insane family members with district magistrates, and were subsequently held legally responsible for their confinement and care. If the insane individual escaped his or her confinement

and committed a serious crime, then the family would be held responsible and punished on his or her behalf. In the case that a mad person did not have a family to look after him or her, neighbors or local officials were urged to take up the task. It was only in situations when the individual proved violent or threatened public safety that the State would be called upon to temporarily confine him or her in a local prison (Ng 1990; Simonis 2010).

The Qing's response to madness was very much in keeping with its approach to other forms of social welfare, which tended toward the decentralization of care onto families, local officials and elites, or religious and charitable organizations (Brook 1993). One reason for this relaxed approach toward the insane was potentially because the Qing did not recognize madness as a particular social identity. Similar to other problematic populations, such as refugees and the poor, the insane were simply thought to be experiencing a temporary period of illness or hardship; they were not, however, believed to represent a fixed social or juridical category.[1] The imperial government thus sometimes provided relief or monetary aid to such individuals or their families on an ad hoc basis, but did not erect specific welfare institutions for their long-term provision. It was only individuals who were conceptualized as embodying a rigid and unchangeable social category—such as widows and orphans—who were eligible to be the recipients of permanent government aid. For these individuals, the government either allowed them to stay in local poorhouses (*yangji yuan* 養濟院) or paid them a small pension (Chen 2012: 6).

The belief that madness was a temporary and mutable affliction, rather than a more permanent identity, was largely due to the way that the disorder was constructed in Chinese medicine. Throughout the late Qing, practitioners tended to interpret mad behaviors less as a discrete medical condition than as evidence of an underlying psychosomatic imbalance or malfunction. For example, Qing physicians often attributed the motivating cause of mad behaviors to an accumulation of mucus in the chest, which blocked off the flow of vital fluids and energy (*qi* 氣). The pathological mucus was thought to derive from multiple sources, including internal somatic imbalance and harmful emotional, cognitive, and environmental stimuli. The Chinese medicine practitioner Ding Ganren (1865–1926), for instance, confirmed that his patient's depressive madness (*dian* 癲) had been caused by excessive contemplation and mucus accumulation, while the practitioner Wang Mengying (1808–1867) declared that his patient had suffered from internal heat, excessive mucus, and mad behaviors due to the weather being 'oppressively hot.' In both cases, the physicians prescribed remedies that targeted the presumed source of the disorder: purgatives to rid the mucus in the case of Ding, and cooling agents to rid the internal fire in the case of Wang (Ding 2009; Wang 2009).

Madness was not uniformly interpreted as a medical condition. Particularly among poorer and less-educated families, madness was often believed to be the behavioral expression of demonic possession. When this was the case, families employed shamans, exorcists, and Daoist priests to examine the mad individual and provide appropriate ritual therapies. John Nevius, a missionary who arrived in Shandong in 1861, noticed that local families frequently assumed that madness involved supernatural punishment for moral transgression. They therefore attributed mad behaviours to the retributive desires of spirits, ghosts, and deceased ancestors, rather than to biological explanations like mucus or internal heat. When an individual exhibited behaviors such as laughing erratically, rolling on the ground, leaping about, or contorting the body, the immediate recourse was to call a Daoist priest to offer prayers and sacrifices; to establish a shrine to the deceased ancestor who

might have been causing the problem; or to employ an early style of acupuncture to allow the demon to escape the body (Nevius 1968 [1894]). The American physician Andrew Woods confirmed this observation. Many of his insane patients, he wrote, 'believed in the existence of demons and in the ability of demons to enter and control human beings.' They therefore 'performed during their [insane episodes] according to the ideas that had been previously held of demoniacal behavior' (Woods 1929: 568).

To the chagrin of Chinese medicine practitioners, families frequently bolstered medically based treatments with supernatural or religious therapies. Wang Mengying (2009) noted how a patient named Ms. Chen, who had been sick for over a month with an illness 'that resembled madness,' repeatedly entreated shamans to cure her. Although their 'fees were enormous,' her disease kept getting worse by the day. The Chinese medicine practitioner Zhou Xiaonong (1876–1942) also described how a peasant's madness was made worse after his family sent for a shaman. Although Zhou had previously drawn up a prescription to treat the affliction, its effectiveness was undermined by the family's continuing belief in supernatural cures (Zhou 2008). Throughout the late imperial period, then, pathological and supernatural etiologies of madness coexisted, and families often experimented with multiple forms of therapeutic practice concurrently in order to achieve the most effective remedies for the ambiguous ailment.

From the above discussion, two important themes emerge. First, constructions of madness in Chinese medicine did not conceive of the disorder as a purely 'mental' disease. Unlike the nascent field of neuropsychiatry in the West, which sought to relegate madness either to the physical space of the 'brain' or the metaphysical space of the 'mind,' madness in late imperial China straddled biological, social, supernatural, and moral lines. Second, the fact that madness crossed so many etiological boundaries reinforced the notion that mad behaviors were primarily symptomatic, rather than taxonomic. That is to say, madness was typically acknowledged as the behavioral *expression* of a biological, environmental, emotional, or moral disorder, but was rarely construed as a higher-order affliction. Because madness was not considered a thing-in-itself, the creation of the psychiatric specialist—as well as the adoption of State-governed psychiatric welfare facilities—was rendered unnecessary. Throughout the late imperial period, madness was considered a permeable and temporary disorder that could be treated through a variety of means, but did not necessarily require the long-term intervention of the State.

THE BIRTH OF THE PUBLIC ASYLUM

The above themes would be forced to confront the introduction of new psychiatric ideologies and institutions to China in the early twentieth century. Beginning in 1901, the Qing dynasty belatedly came to the conclusion that if it did not take proactive measures to modernize itself, the Chinese State would progressively be torn apart by the forces of Western imperialism. Throughout the first decade of the twentieth century, therefore, the Qing undertook a series of reforms meant to showcase and reinforce its modernizing capabilities. One of these measures involved the erection of public welfare institutions, including workhouses, poorhouses, orphanages, and reformatories for drug addicts and prostitutes. During this period, the Qing also began to turn its attention to madness. Pressured by Western missionaries to adopt a more proactive stance toward the welfare of

the insane, the Qing erected a poorhouse in Beijing in 1908, which eventually evolved into a 'multipurpose institution' that included an asylum for the mentally ill (Chen 2012: 64).

Although the Qing dynasty was overthrown in 1911, the succeeding governments of the Republican period maintained the asylum and the other welfare institutions that the imperial government had introduced. Yet, despite the fact that the asylum had been built in order to signal the modernizing capabilities of the Chinese State, the logic by which the asylum was run did not necessarily incorporate contemporary Western views about how mental illness should be treated. Unlike psychopathic hospitals in early twentieth-century Western Europe and the United States, which were typically overseen by medical practitioners, the asylum in Beijing was administered entirely by the municipal police (Gamble 1921: 125–6). Indeed, the main goal of the asylum-cum-poorhouse was not necessarily to rehabilitate the madmen and madwomen under its charge, but rather to keep poor, indigent, and insane men and women off the streets and out of public view (Lyman 1937). Local observers, like the American physician J. Lincoln McCartney, wrote that the so-called 'hospital for the insane' in Beijing was really 'nothing more than a prison in which psychopathic persons are confined and sometimes put in chains' (McCartney 1927: 87). J. H. Ingram, another American physician, also recalled that at the time he visited, the facility was 'overrun with about one hundred and fifty petty thieves, for whom no other jail accommodations could be found' (Ingram 1918: 154). The asylum, though ostensibly for insane persons, blurred the lines between madness, deviance, and criminality.

This is not to say that Western psychopathic hospitals were any better. In light of psychiatry's almost complete inability to treat mental illness, restraint was often the psychiatrist's only means of managing the insane (Beers 1907). But while the Western institution at least kept up the *pretence* of offering therapy and rehabilitation, the Beijing asylum made no such promises; indeed, the facility's sole Chinese medicine practitioner was only available four days per week, and archival records suggest that he typically only treated patients who were seriously ill with life-threatening afflictions (Diamant 1994: 24).[2] As Ingram succinctly noted upon visiting the facility in 1918: 'The place is kept up more for the sake of being able to say that [the municipality has] an asylum than for the benefit of the afflicted' (1918: 153–4). The mimetic quality of the Beijing asylum was thus restricted to its external appearance. Its internal logic, however, continued to operate along traditional lines that mandated the preventive confinement of the deviant insane.

Indeed, despite the existence of the asylum, the municipal government continued to view the familial home as the principal site of management for the insane. In 1920, the Beijing municipal government produced a new set of legal statutes that were exceedingly reminiscent of their earlier Qing counterparts. Just as the Qing code had decentralized responsibility for lunacy onto the family, the updated Beijing legal code likewise maintained the centrality of the family in the management and treatment of the insane. If a lunatic committed a crime, the code stated, the police were required to notify the mad person's father, elder brother, or caretaker, who would then be responsible for appropriately detaining and disciplining their charge outside the purview of the State. Although the municipality would willingly detain the mad person under critical circumstances, his regular custody remained in the home; indeed, as the legal code made clear, it was only in circumstances when the lunatic's family could not be located that the police were told to 'consider' removing him to an asylum or comparable facility (Xu 1920).

Families also only considered institutionalization or hospitalization as a matter of last resort. Given the notoriously lax disciplinary and hygiene standards within the municipal asylum, many inmates were only brought there when their families could find no other means of caring for them (Baum 2013). Lack of knowledge about available psychiatric facilities was another reason local families often failed to seek external help. An American physician named Andrew Woods, who was employed at a nearby Western-style hospital in Beijing, noted that, 'The masses of the Chinese are ignorant of the aim of scientific medicine and of the advantages of entering a hospital for treatment.' Citing a recent incident whereby a well-to-do family had not thought to bring their mentally ill father to the hospital despite living only a few blocks away from it, Woods confirmed his suspicions that Chinese families were either unwilling to pursue institutionalization or were unaware of its availability and benefits (Woods 1929: 542).

Throughout the first three decades of the twentieth century, then, treatment of the insane in China remained much the same as it had been throughout the late imperial period. Although the Beijing municipality was ultimately moved to erect a local asylum so as to prove its modernizing capabilities, the institution functioned more as a prison for deviant, vagrant, or insane individuals than as a place where genuine therapy could be sought. Furthermore, throughout this period, the family remained the primary site of care for the insane. Despite the fact that anyone could be admitted to the asylum at absolutely no cost to the patient, local attitudes about the superiority of domestic management were reinforced by legal mandates that continued to prioritize the home. The municipality's tentative engagement with psychiatric welfare thus did very little but perpetuate longstanding views about the appropriateness of domestic management.

THE EXPANSION AND LIMITS OF PSYCHIATRIC WELFARE IN THE REPUBLICAN PERIOD

In the summer of 1928, the Nationalist (*Guomindang*) army arrived in Beijing. Their arrival in the city marked the capstone of the Northern Expedition, a military venture that aimed to defeat the warlord powers that had taken control over China soon after the fall of the Qing dynasty. Expelling the warlord government from Beijing, the Nationalists were able to (more or less) consolidate national leadership under their regime.[3] One of the objectives of the Nationalist Party was to further modernize the country through the adoption of Western medical institutions and hygiene standards, thereby proving to foreign governments that China was capable of undertaking systematic reform. In 1929, a Nationalist proposal advocated for the wholesale eradication of Chinese medicine. Although the proposal met with extremely strong resistance from Chinese medicine practitioners and was ultimately abandoned, it nevertheless signaled that the new government was intent on modernizing the Chinese nation through its support of Western scientific norms (Lei 2014; Andrews 2014).

In keeping with its effort to prioritize Western biomedicine over more traditional therapies, the Nationalists aimed to convert the defunct Beijing asylum into a cutting-edge 'psychopathic hospital' (*jingshen bing liaoyang yuan* 精神病療養院). To achieve this goal, they entered into talks with a local American-managed hospital called the Peking Union Medical College (PUMC). Together, the PUMC and Beijing municipality opened the first public, government-funded psychopathic hospital in 1933 (Baum 2013). The hospital

employed the most modern psychiatric techniques, which were administered under the leadership of licensed neuropsychiatric specialists. Offering treatments like occupational therapy, hydrotherapy (baths, steams, and warm-water wraps), and medicinal treatments (such as fever therapy, an injection of malaria that killed the spirochete causing neurosyphilis), psychiatrists at the municipal psychopathic hospital overwhelmingly championed biological, rather than social or psychoanalytic, explanations for mental disorders (Li and Schmiedebach 2015). These biologically oriented therapies, which were advocated by major American research universities like Johns Hopkins, were representative of dominant neuropsychiatric trends in the United States at the time (Shorter 1997).

Outside of Beijing, too, the Nationalists aimed to expand psychiatric welfare, 'scientize' (*kexue hua* 科學化) the treatment of mental illness, and cement their reputation as a thoroughly modern regime through the establishment of psychopathic hospitals in major urban areas. Recognizing that 'all Western nations . . . have asylums,' the Nationalists laid out plans to erect a modern mental asylum in the new capital city of Nanjing in 1931 (a project that would not be completed until 1947), and also supported the work already being done by medical missionaries in other cities like Guangzhou and Suzhou.[4] In Shanghai, similarly, the municipal government supported the establishment of the Shanghai Mercy Hospital, a psychopathic facility that was managed by an Austrian psychiatrist named Fanny Halpern. Like the facility in Beijing, the Shanghai Mercy Hospital also employed the most up-to-date and internationally sanctioned therapies, almost all of which focused on sedating the brain and calming the nerves. Due to recent advances in psychiatric care, Halpern remained optimistic (perhaps naively so) that 'most mental disorders [could] be cured' through the scientifically sound principles of 'modern psychiatry'.[5]

The Nationalists attempted to modify responses to madness not only at a medical level, but also at a legal one. In 1935, the Nationalist government produced a new version of the penal code (*Xin Zhonghua minguo xingfa* 新中華民國刑法), which stated for the first time that mentally ill criminals should be placed in an 'appropriate facility' (*xiangdang chusuo* 相當處所) and given treatment, rather than kept in the home. In theory, this recognition signaled that the Nationalists sought to expand provision for the mentally ill beyond what they had already done. In practice, however, the political and economic weaknesses of the Nationalist regime meant that it had neither the ability nor the resources to build more public psychopathic hospitals. Consequently, all of the psychopathic hospitals that the regime supported were managed, either jointly or solely, by Western missionaries and physicians, and were therefore located in urban areas along the coastline where foreign settlements were prevalent. Outside of these limited spaces, the vast majority of the Chinese populace did not have access to institutional care, and most mentally ill individuals—criminal or otherwise—continued to be kept within the home (Lyman 1937; Lyman 1939).

The limited nature of psychiatric welfare throughout this period was not simply a product of the Nationalist party's impotence, however. In part, it was also due to the fact that many Chinese people, urban and rural alike, continued to distrust the types of neuropsychiatric practices that were offered in institutional settings. According to Richard Lyman, an American psychiatrist who was employed at the Beijing Psychopathic Hospital, many of his patients were only brought to the facility when they were dangerously depleted and their families had already exhausted all other options of treatment.[6] As Neil Diamant has documented, moreover, the Beijing facility was sometimes forced to pay families to admit their mentally ill relatives so that Western physicians would have enough

cases upon which to perform research (Diamant 1994: 28). Regardless of the fact that the municipal psychopathic hospital was ostensibly the most 'modern' psychiatric facility in China, the newness of the hospital format—combined with the fact that many Chinese families harbored suspicions about Western doctors—contributed to the low standing of the institution within the therapeutic landscape of early twentieth-century Beijing.

As a result of both the limited availability of psychiatric welfare and the widespread skepticism of neuropsychiatric practices, beginning in the mid-1930s, a number of Chinese medicine practitioners began to establish their own private hospitals for the treatment of the mentally ill. These hospitals purposely advertised their services as distinct from those offered at Western-managed institutions, and thereby better suited to meet the needs of the Chinese people. The Wei Hongsheng Psychopathic Hospital (*Wei Hongsheng jingshen bingyuan* 魏鴻聲精神病院), which was established in Beijing in 1934, and the Shanghai Specialized Hospital for the Insane (*Shanghai fengdian zhuanmen yiyuan* 上海瘋癲專門醫院), which was established in 1931, both claimed to employ only Chinese drugs and native medical techniques in the treatment of madness. The founders of both hospitals had not received training in neuropsychiatry, but were instead well versed in Chinese medicine (Wei 1937: preface; Gu 1934: 1–2). Their ability to speak with their patients in a mutually intelligible cultural and pathological vocabulary enabled them to attract a clientele who might not have otherwise been persuaded to seek institutional care.

Wei Hongsheng, the founder of his eponymous hospital in Beijing, had never been formally trained in either scientific psychiatry or biomedical practice. Instead, he learned his craft through participation in a study group that researched the mysterious workings of the *jingshen* (mind, spirit, soul, animative life force).[7] He accompanied his pursuit of medical knowledge with philosophical investigations into Confucianism, Buddhism, and Daoism, believing that all four ultimately sought to understand the workings of the universe and the nature of humanity itself (Wei 1937). At his hospital, Wei employed a curative technique that he referred to as '*jingshen* therapy' (*jingshen zhiliao* 精神治療). *Jingshen* therapy, which had no basis in neuropsychiatric practice, was instead derived from a combination of Chinese medicine and Chinese religious philosophy. It entailed a mixture of hypnotism, meditation, and guided breathing that was meant to relieve blockages of *qi* in the vital organs. Believing that mad behaviours arose out of stagnant *qi*, Wei used *jingshen* therapy in order to 'help the weak *qi* in the organs become robust again' (Wei 1936: 36).

Much like the Wei Hongsheng Psychopathic Hospital, the Shanghai Specialized Hospital for the Insane played off popular distrust of foreign doctors by specifically marketing itself as a hospital run by and for the Chinese. Managed by a Chinese medicine practitioner named Gu Wenjun, the Specialized Hospital only employed 'native' medical techniques, such as acupuncture and *tuina* massage, and prescribed 'indigenous' drugs. Gu promoted his hospital as one that was especially suited to meet the demands of his Chinese patients. 'This institution,' he wrote in the introduction to a pamphlet on the facility, 'was established for the Chinese people, and uses only Chinese medicine and Chinese drugs.' Although 'modern people' (*modeng renwu* 摩登人物) did not pay much attention to the Specialized Hospital, Gu continued, the Chinese inhabitants of the city still recognized that 'it offered great benefits for the society' (Gu 1934: 2). Gu thus marketed his facility as a legitimate medical institution—but one that could serve the needs

of its Chinese clientele more effectively than a facility built upon the precepts of Western medicine.

The existence of private facilities like the Wei Hongsheng Psychopathic Hospital and the Shanghai Specialized Hospital for the Insane highlights two points about the evolving nature of psychiatric care in the Republican period. First, these hospitals attest to the fact that the Nationalists' entrée into psychiatric welfare was extremely limited. Although the regime sponsored the development of (Western-run) psychopathic hospitals when it could, the insufficient availability of publicly funded psychiatric beds allowed for the growth of private, fee-for-service models of institutional treatment. Indeed, as one Western practitioner noted in 1933, only six hospitals in China provided full care of psychiatric patients, and most of these only maintained between one and three beds for this specific purpose.[8] Second, these hospitals also demonstrate the persistence of—and demand for—culturally Chinese therapies for madness. Due to the general distrust of foreign physicians, combined with the fact that Western medicine was largely unable to cure most forms of mental illness, alternatives to neuropsychiatry remained highly compelling—and competitive—within the therapeutic geography of Republican China.

EVOLVING APPROACHES TO PSYCHIATRIC WELFARE IN THE PEOPLE'S REPUBLIC OF CHINA (PRC)

If the advent of psychiatric welfare in the Republican period was met with challenges from both above and below, its further development in the second half of the twentieth century was plagued with challenges of a different sort. After the outbreak of war with Japan in 1937, both public and private psychopathic hospitals in China were forced into closure. The Shanghai Mercy Hospital and Beijing Psychopathic Hospital had both shut their doors by the early 1940s; and although no records from the Wei Hongsheng Hospital or Shanghai Specialized Hospital for the Insane exist after the 1930s, it is likely that they, too, could no longer continue their normal operations following the Japanese takeover of coastal China. By the time the Sino-Japanese War and subsequent civil war concluded, it is estimated that only 50 or 60 psychiatric practitioners remained in practice on the mainland (Shen 1997).

When Mao Zedong came to power in 1949, the state of psychiatric practice was in a shambles. Rather than promote the spread of psychiatric knowledge, however, the new government did much the opposite. In its turn against Western liberalism and science, the Maoist regime fought to delegitimize many of the psychiatric discourses and practices that had previously been imported to China. Of the few psychiatrists who remained in China in the 1950s, many came under attack as part of the push to eradicate 'bourgeois' thinking—an endeavor that was accompanied by the proscription against teaching psychology in Chinese universities (Pearson 2014). A psychiatric journal in 1959 concisely summed up the state of the field in the following way: 'With the arrival of advanced Soviet medical science, China's psychiatric workers [have been] liberated from the ideological influence of the reactionary academic doctrines of Europe and America' (as quoted in Munro 2002: 52–3). Psychiatry under Mao, in other words, aimed to untangle itself from the corrupt influence of the Western world.

The communist approach to psychiatry diverged significantly from the one taken by the earlier Nationalist government. In contrast to the Nationalist effort to eliminate Chinese medical practices, Mao Zedong recognized the utility of Chinese medicine, particularly insofar as it could be used to bring healthcare to rural areas. He therefore proclaimed that Chinese medicine was a 'great treasure-trove,' and encouraged Western-trained physicians to study Chinese medical techniques, in addition to vice versa (Taylor 2005: 109). At the First National Conference of Psychiatric Specialists, held in Nanjing in 1958, mental health practitioners advocated turning away from Western practices that they deemed too bourgeois, and developing indigenous strategies in their stead. In particular, psychiatrists were instructed to abandon the use of restraint and invasive procedures like the lobotomy, and instead ordered to develop Chinese medicine and indigenous herbal remedies (Ho 1974; Chang and Kleinman 2002). These strategies were popularized and extended into rural areas through the use of 'barefoot doctors' (local peasants who were given basic first aid instruction in both Chinese and Western medical techniques). Barefoot doctors were taught to recognize the symptoms of mental and emotional disorder and suggest practical therapies to patients' families, such as herbal sedatives and acupuncture (Lu 1978).

There were distinctions, however, between the type of Chinese medicine that the Communist Party sponsored and the type of Chinese medicine that had been practiced throughout the late imperial and Republican periods. While earlier forms of Chinese medicine had attributed madness to a combination of physical, emotional, and cosmological stimuli, early Maoist medicine tended to downplay the etiological role of emotional or social factors in the onset of mental distress. Taking its cues from Soviet psychiatric models, which championed a Pavlovian understanding of mental functioning, Maoist psychiatry in the 1950s and early 1960s supported a primarily biological interpretation of mental illness, and therefore denied psychoanalytical explanations and approaches (Chang and Kleinman 2002). The reason for the overriding interest in biological etiologies of mental illness had to do chiefly with political concerns. If physicians stressed the role of social factors in the onset of mental illness, they could potentially be accused of criticizing the communist State. Physicians therefore took pains to avoid implicating both their patients and themselves by underscoring the strictly biological nature of the disorder. Depending upon the training of the practitioner, as well as the availability of and access to medicinal remedies, physicians typically combated mental illness with therapies like psychotropic drugs or herbal sedatives (Ran et al. 2005; Pearson and Phillips 1994).

The development of institutions of psychiatric welfare in the early PRC was uneven. Much like the Republican period, all major psychopathic hospitals remained in large urban areas, and few modern institutions were erected outside of coastal cities. In fact, the major centers of psychiatric training—including Beijing, Guangzhou, Nanjing, and Shanghai—were all locations where psychopathic or missionary hospitals had existed prior to the establishment of the PRC (Pearson 2014). Because of the lack of medical infrastructure outside of these key locations, most psychiatric patients—particularly in rural China—continued to be treated at home. In fact, the Communist Party actively promoted domestic treatment for the mentally ill. In a program known as 'Hospital Bed at Home' (*jiating bingchuang* 家庭病床), medical practitioners were encouraged to go to the bedside of the patient, rather than receive patients within the hospital. While this tactic was hailed as a success because of its cost-saving measures, it also reaffirmed the long-held notion that treatment of the mentally ill was a domestic concern, and that the proper place of the mental patient remained within a family setting (Chin and Chin 1969; Lu 1978).

The relative laxity with which mental patients were handled in the 1950s and early 1960s became more stringent with the increasing radicalism of domestic politics. By the outbreak of the Cultural Revolution in 1966, mental illness had become directly conflated with political opposition to communist rule. As Robin Munro (2002) has detailed, mentally ill individuals who possessed 'correct' political thought were liberated from hospitals, while those who espoused 'incorrect' beliefs were summarily imprisoned, forced to attend study sessions, or sometimes executed. During this time, treatment for mental illness centered almost exclusively on learning correct ideas about communist ideology and abandoning heterodox views. Even mental healthcare within rural communities was reshaped to accord with the new emphasis on political ideology and mass movements. Patients were told that their needs should be subordinated to the needs of society, and that their incorrect thinking should be remolded so as to foster the success of the communist revolution. Physicians, meanwhile, were instructed to abandon individualistic (patient-centered) therapies, and instead told to emphasize collective approaches to care as a means of developing correct political ideologies. These approaches typically involved urging patients to overcome their illness not simply for the benefit of their own health, but more importantly for the benefit of the ongoing communist revolution (Sidel 1973; Kao 1974).

The Maoist era thus introduced new standards of psychiatric treatment and welfare at the same time as it perpetuated old trends. On the one hand, much like in the Qing and early Republican periods, domestic treatment continued to be prioritized over institutionalization, and access to psychopathic hospitals remained limited outside of developed urban areas. On the other hand, and in contrast to developments that had occurred under Nationalist rule, Maoism sponsored the promotion and dissemination of indigenous (i.e. non-Western) approaches to treating mental illness as a means of allowing psychiatric welfare to penetrate into the countryside. While this approach helped spread informal access to care throughout the 1950s, its influence waned considerably during the Cultural Revolution (Ran et al. 2005). As a result of the negative political implications that came to be associated with mental illness during this period, the stigma of the condition deepened. Consequently, families of mentally ill individuals often masked the disorder in order to ensure their survival during a politically turbulent time.

TOWARD A NEW VISION OF PSYCHIATRIC WELFARE IN CONTEMPORARY CHINA

Following the death of Mao Zedong in 1976 and the subsequent shift toward decollectivization, Western psychiatric practices slowly resumed. A variety of rehabilitation and support programs were introduced in the 1980s and 1990s – such as family counseling, family support groups, guardianship networks, and community-based mental health centers; and neuropsychiatry was again permitted to be studied as a valid field of scholarship during this period as well (Yip 2006). More recently, the rising demand for mental healthcare has also led to an increase in psychoanalytic services, mental health hotlines, and radio and television programs featuring listener or viewer participation (Huang 2014). Nevertheless, as journalists and scholars have pointed out, severe problems persist.

Access to psychiatric aid remains concentrated in urban areas, and as a result of recent declines in welfare coverage, many families cannot afford the fee-for-service treatment model that has been adopted by most psychopathic hospitals. Moreover, severe skepticism and lack of trust in neuropsychiatric models have induced many families to pursue non-biomedical methods of treatment, such as the use of herbalists and religious healers. Compelled by both economic and ideological concerns, families of the mentally ill have pursued alternative avenues than those sanctioned by neuropsychiatric practitioners. As a result, over 90 per cent of people with mental illness live with their families, and only 5 per cent of the mentally ill have ever seen a mental health professional (Chang and Kleinman 2002; Phillips et al. 2009).

As this chapter has argued, many of the issues currently at stake in Chinese psychiatric welfare have stemmed from earlier historical precedents. First, the family—rather than the psychopathic hospital—has consistently been treated as the sanctioned site of care for the mentally ill. Due to the nonexistence of institutions for the insane throughout late imperial China, the Qing penal code mandated that mad individuals be kept within the home under penalty of punishment for the family. Even after the establishment of the first municipal asylum in Beijing in 1908, warlord governments continued to decree that the family be held primarily responsible for the management and treatment of mad relatives. The emphasis on domestic care was further institutionalized through Maoist-era policies that encouraged medical practitioners and barefoot doctors to embed themselves in local communities and visit the mentally ill at home. To a certain extent, these ideas were also extended after decollectivization through policies that emphasized community-based treatment for those with mental health problems. Because of the consistent political and cultural emphasis on domestic care, many families do not typically consider external institutional arrangements when faced with the mental illness of a relative (Yip 2006; Pearson and Phillips 1994).

Second, the development of 'modern' psychopathic hospitals in China has historically been geographically uneven. When medical missionaries established the first 'refuge' for the insane in Guangzhou in 1897, they set a precedent for the prioritization of urban institutional settings that would persist throughout the twentieth century. Indeed, the earliest psychopathic hospitals were all erected in urban centers along the eastern seaboard, where Western physicians and missionaries were concentrated. When the communists established the PRC in 1949, the few psychiatrists who remained on the mainland—and the five psychopathic hospitals they oversaw—were all clustered in the same key cities that had served as a base for psychiatric care for the past half a century. Today, this geographical unevenness continues to pose problems to those seeking institutional care. Unable to travel to urban centers, many rural residents do not have access to neuropsychiatric treatments; even when they do, however, the fee-for-service model that many of these hospitals has adopted has prevented poorer families from being able to obtain the services they require (Yip 2006).

Finally, popular attitudes, beliefs, and biases concerning the nature and proper treatment of mental illness have also informed contemporary care-seeking practices. On the one hand, the historical association of mental illness with either moral or political transgression has often caused families to feel deep shame when relatives become afflicted with the disorder. This sense of stigma continues to influence how families seek treatment today. In an effort to avoid popular scrutiny, it is not uncommon for families

to simply keep their ill relatives within the home rather than go through the necessary steps to achieve institutional care (Wong et al. 2003; Pearson and Phillips 1994). On the other hand, due to the longstanding skepticism about the appropriateness of Western therapies for mental illness—combined with a dearth of psychiatric education outside of urban areas—many families remain unaware of, or purposely avoid, neuropsychiatric institutions. Instead, and particularly in rural areas, families continue to seek the services of religious healers or local Chinese medicine practitioners as a first option of treatment (Phillips 1998).

By looking at the contemporary state of psychiatric welfare from a historical perspective, we can more easily see why Western forms of welfare do not always function as expected when transplanted into a Chinese context. For the case of mental illness, Western institutional arrangements, such as the asylum or psychopathic hospital, have been forced to confront preexistent ideas about what mental illness is, how it should be treated, and, above all, *who* should be responsible for its management. Further, although subsequent Chinese regimes have experimented with different forms of psychiatric welfare, these efforts have been both informed and constrained by the particular political, social, and cultural backdrop against which they have been implemented. Problems such as colonialism, warfare, and revolution have necessarily complicated reform efforts that have sought to introduce new forms of treatment and aid to Chinese families. It is necessary, then, to keep these points in mind when discussing not just psychiatric welfare, but all forms of contemporary Chinese welfare writ large.

Looking forward, there is reason to be optimistic about the future of psychiatric welfare in China. In 2012, the Chinese Ministry of Health promulgated the first National Mental Health Law, which aimed to expand mental health services and education into rural areas, improve quality of care, and give patients increased rights to both seek and deny treatment. The law, which was the product of almost thirty years of deliberation and debate, represented a major step forward for mental health advocates, and has been hailed as a 'high water-mark for Chinese psychiatry, and potentially for global mental health' (Phillips et al. 2013: 590). Nevertheless, as observers have rightfully argued, 'the real issue is implementation' (Larson 2015). In order for the Mental Health Law to truly make an enduring and positive impact on the lives of the mentally ill and their families, public health specialists will have to take into consideration the historical developments that have led to current deficiencies in psychiatric access and care. Only when mental health advocates recognize that many of the current problems facing patients are, in fact, the culmination of longstanding cultural ideologies, medical practices, and recurring governmental policies will they be able to create solutions that are sustainable, feasible, and compatible with local needs and beliefs.

NOTES

1. This viewpoint changed somewhat in the late eighteenth century, when the Qing legal code mandated that mad people who had committed homicide be imprisoned permanently, regardless of whether or not they had recovered from their affliction.
2. Beijing Municipal Archives (BMA), J181-019-38439, J181-019-35380.
3. After the Nationalist government took control of Beijing in 1928, the name of the city was changed to Beiping. For reasons of consistency, I will continue to refer to the city as Beijing throughout the rest of the chapter.

4. *Huabei yibao*, 21 March 1931.
5. *North China Daily Herald*, 30 June 1935.
6. Rockefeller Foundation Archives (RFA), 'Letter from Richard Lyman to Roger Greene', 1934, CMB, Inc., Record Group IV 2B9, Box 96, File 690.
7. *Jingshen* has no exact translation in English. In Chinese medicine, *jing* (essence) refers to an animative material substance that is produced in the kidneys, while *shen* refers to an immaterial entity, akin to the "spirit," that is located within the heart.
8. RFA, 'Survey of Psychiatric Hospitals', 1933.

REFERENCES

Andrews, Bridie (2014), *The Making of Modern Chinese Medicine, 1850–1960*, Honolulu: University of Hawaii Press.

Baum, Emily (2013), *Spit, Chains, and Hospital Beds: A History of Madness in Republican Beijing*, PhD Dissertation.

Beers, Clifford (1907), *A Mind that Found Itself*, New York: Longmans, Green, and Co.

Brook, Timothy (1993), *Praying for Power: Buddhism and the Formation of Gentry Society in Late-Ming China*, Cambridge, MA: Harvard University Press.

Chang, Doris and Arthur Kleinman (2002), 'Growing Pains: Mental Health Care in a Developing China,' *Yale-China Health Journal* 1 (1), 85–98.

Chen, Janet (2012), *Guilty of Indigence: The Urban Poor in China, 1900–1953*, Princeton: Princeton University Press.

Chin, R. and A. S. Chin (1969), *Psychological Research in Communist China, 1949–1966*, Cambridge, MA: MIT Press.

Diamant, Neil (1994), 'China's "Great Confinement"? Missionaries, Municipal Elites, and Police in the Establishment of Chinese Mental Hospitals,' *Republican China* 19 (1), 3–50.

Ding Ganren 丁甘仁 (2009), *Ding Ganren Yi'an* 丁甘仁醫案 [Medical cases of Ding Ganren], Shanxi: Shanxi kexue jishu chubanshe.

Gamble, Sidney (1921), *Peking: A Social Survey*, New York: George H. Doran.

Gu Wenjun 顾文俊 (1934), *Shanghai fengdian zhuanmen yiyuan* 上海疯癫专门醫院 [Shanghai Specialized Hospital for the Insane], Shanghai: Fengdian zhuanmen yiyuan faxing.

Ho, D. Y. F. (1974), 'Prevention and Treatment of Mental Illness in the People's Republic of China,' *American Journal of Orthopsychiatry* 44, 621–636.

Huang, Hsuan-ying (2014), 'The Emergence of the Psycho-Boom in Contemporary Urban China,' in Howard Chiang (ed.), *Psychiatry and Chinese History*, London: Pickering & Chatto, 183–205.

Ingram, J. H. (1918), 'The Pitiable Condition of the Insane in North China,' *China Medical Journal* 32 (2), 153–154.

Kao, J. J. (1974), 'Psychiatry in the People's Republic of China: A Prospectus,' *American Journal of Chinese Medicine* 2, 441–444.

Kerr, John (1898), 'The "Refuge for the Insane," Canton,' *China Medical Missionary Journal*, 12 (4), 177–178.

Kleinman, Arthur and Guo Jinhua (2011), 'Stigma: HIV/AIDS, Mental Illness, and China's Nonpersons,' in Arthur Kleinman et al. (eds), *Deep China: The Moral Life of the Person*, Berkeley: University of California Press, 237–262.

LaFraniere, Sharon (2010), 'Life in Shadows for the Mentally Ill in China,' 10 Nov., accessed 21 Oct. 2015 at www.nytimes.com/2010/11/11/world/asia/11psych.html.

Larson, Christina (2015), 'China Begins to Bring Mentally Ill "Back to Society",' 21 Dec., accessed 18 Feb. 2016 at http://foreignpolicy.com/2015/12/21/bring-patients-back-to-society-china-mental-illness-law-health/.

Lei, Sean Hsiang-lin (2014), *Neither Donkey Nor Horse: Medicine in the Struggle over China's Modernity*, Chicago: University of Chicago Press.

Li, Wenjing and Heinz-Peter Schmiedebach (2015), 'German Wine in an American Bottle: The Spread of Modern Psychiatry in China, 1898–1949,' *History of Psychiatry* 26 (3), 348–358.

Liu, Jin et al. (2011), 'Mental Health System in China,' *World Psychiatry* 10 (3): 210–216.

Lu, Yi-chuang (1978), 'The Collective Approach to Psychiatric Practice in the People's Republic of China,' *Social Problems* 26 (1), 2–14.

Lyman, Richard (1937), 'Psychiatry in China,' *Archives of Neurology and Psychiatry* 37 (4), 765–771.

Lyman, Richard (1939), *Social and Psychological Studies in Neuropsychiatry in China*, Peking: Henri Vetch.

Ma, Zhiying (2012), 'Psychiatric Subjectivity and Cultural Resistance: Experience and Explanations of

Schizophrenia in Contemporary China,' in Andrew Kipnis (ed.), *Chinese Modernity and the Individual Psyche*, New York: Palgrave Macmillan, 203–228.
McCartney, J. Lincoln (1927), 'Neuropsychiatry in China,' *Archives of Neurology and Psychiatry* **18** (1), 87–95.
Munro, Robin (2002), *Dangerous Minds: Political Psychiatry in China Today and its Origins in the Mao Era*, New York: Human Rights Watch.
Nevius, John (1968 [1894]), *Demon Possession*, Grand Rapids, MI: Kregel.
Ng, Vivien (1990), *Madness in Imperial China: From Illness to Deviance*, Norman: University of Oklahoma Press.
Pearson, Veronica (2014), 'The Development of Psychiatric Services in China: Christianity, Communism, and Community,' in Bridie Andrews and Mary Bullock (eds), *Medical Transitions in Twentieth-Century China*, Bloomington: Indiana University Press, 146–172.
Pearson, Veronica and Michael Phillips (1994), 'Psychiatric Social Work and Socialism: Problems and Potential in China,' *Social Work* **39** (3), 280–287.
Phillips, Michael (1998), 'The Transformation of China's Mental Health Services,' *China Journal* **39**, 1–36.
Phillips, Michael et al. (2009), 'Prevalence, Treatment, and Associated Disability of Mental Disorders in Four Provinces in China during 2001–05,' *The Lancet* **373** (9680), 2041–2053.
Phillips, Michael et al. (2013), 'China's New Mental Health Law: Reframing Involuntary Treatment,' *American Journal of Psychiatry* **170** (6), 588–591.
Ran, Maosheng et al. (2005), *Family-Based Mental Healthcare in Rural China*, Hong Kong: Hong Kong University Press.
Selden, Charles [C.C.] (1905), 'Work Among the Chinese Insane and Some of its Results,' *China Medical Missionary Journal* **19** (1), 1–17.
Shen Yucun 沈渔邨 (ed.) (1997), *Jingshen bingxue* 精神病學 [Psychiatry] 3rd edition, Beijing: People's Health Publishing House.
Shorter, Edward (1997), *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, New York: Wiley.
Sidel, Ruth (1973), 'The Role of Revolutionary Optimism in the Treatment of Mental Illness in the People's Republic of China,' *American Journal of Orthopsychiatry* **43** (5), 732–736.
Simonis, Fabien (2010), *Mad Acts, Mad Speech, and Mad People in Late Imperial Chinese Law and Medicine*, PhD Dissertation.
Taylor, Kim (2005), *Chinese Medicine in Early Communist China, 1945–63: A Medicine of Revolution*, New York: RoutledgeCurzon.
Wang Mengying 王孟英 (2009), *Wang Mengying yi'an yizhu* 王孟英医案绎注 [Medical cases of Wang Mengying], Beijing: Xueyuan chuban she.
Wei Hongsheng 魏鸿聲 (1936), *Jingshen duanlian zhiliao shiyan wenda* 精神病鍛煉治療試驗問答 [Questions and answers on experiments related to the treatment and exercise of the *jingshen*], Beijing: Jingshenxue yanjiuhui faxing.
Wei Hongsheng 魏鸿聲 (1937), *Jingshen jiankang shiyan lu* 精神健康試驗錄 [Records on experiments of *jingshen* health], Beijing: Jingshenxue yanjiuhui faxing.
Wines, Michael (2010), 'Attacker Stabs 28 Chinese Children,' *New York Times*, 29 April, accessed 21 Oct. 2015 at www.nytimes.com/2010/04/30/world/asia/30china.html.
Wong, Daniel Fu Keung, et al. (2003), 'Changing Health Beliefs on Causations of Mental Illness and their Impacts on Family Burdens and the Mental Health of Chinese Caregivers in Hong Kong,' *International Journal of Mental Health* **32** (2), 84–98.
Woods, Andrew (1929), 'The Nervous Diseases of the Chinese,' *Archives of Neurology and Psychiatry* **21**, 542–570.
Xu Ke 徐珂 (1920), *Shiyong Beijing zhinan* 实用北京指南 [Practical guide to Beijing], Shanghai: Shangwu yinshu guan.
Yip, Kam-shing (2006), 'Community Mental Health in the People's Republic of China: A Critical Analysis,' *Community Mental Health Journal* **42** (1), 41–51.
Yuen, Lotus (2013), 'Unable to Cope: China's Inadequate Care of the Mentally Ill,' 29 July, accessed 21 Oct. 2015 at www.theatlantic.com/china/archive/2013/07/unable-to-cope-chinas-inadequate-care-of-the-mentally-ill/278170/.
Zhou Xiaonong 周小農 (2008), *Zhou Xiaonong yi'an* 周小農醫案 [Medical case records of Zhou Xiaonong], 2nd edition, Shanghai: Shanghai kexue jishu chuban she.

PART II

THE WELFARE SYSTEM IN REFORM ERA CHINA

INTRODUCTION

The six chapters in this part delineate the foundations of the contemporary Chinese welfare system and its policies during the reform era. These policies were an attempt to address the primary welfare issues of exclusion – and the inequities thereby created – the result of the reduction and the dismantling of welfare systems and benefits. In particular, this part examines how policies, such as the household registration system (*hukou* 户口), reify and legitimise social divisions and stratification, including those divisions based on constructions of ethnicity (Reza Hasmath and Andrew MacDonald's chapter) and geography, and how these divisions impact access to the welfare benefits of medical insurance (Zhao, Jia and Zhao's chapter), affordable housing (Bingqin Li's chapter), social assistance schemes (Dorothy J. Solinger's chapter) and education (Ye Liu's chapter).

Although the policies discussed here have sought to rectify issues of the inequitable distribution of social welfare, some have, in practice, often resulted in greater exclusivity, stratification and inequality. For example, the challenges of urban housing needs and affordability are not being appropriately addressed by current housing policies, particularly for migrant workers and migrant student graduates (Bingqin Li's chapter and Kimiko Suda's chapter, respectively). Similarly, the Minimum Livelihood Guarantee Programme, directed toward the welfare of laid-off workers and the urban poor, falls markedly short of its goals with its declining baselines. Yet, among a group of programmes that invariably favoured the Han ethnic majority, this was one of the few programmes in which ethnic minorities were able to access welfare at higher levels of inscription than that of the Han. Medical insurance schemes and financial assistance – aimed at improving the health disparities resulting from socio-economic inequalities and healthcare cost escalation – achieved markedly improved healthcare coverage in recent years. Nevertheless, the actual amount of funding remains inequitable, particularly for rural residents and migrants. Thus, a policy goal of achieving universal healthcare coverage without addressing the particulars of financial inequity will ultimately prove ineffective and unsustainable.

Divisions based on place and income not only exist between urban and rural areas, but also between the developed eastern provinces of China and the significantly less developed west. This is particularly evident in terms of funding for, and access to, quality primary, secondary and higher education, as geographical discrimination underlies