

Sick Model: Socialisation of the Sick Role in the Pre-reform China

1949 was a watershed in contemporary Chinese history. The Chinese Communist Party (CCP) rose to power and commenced a new authoritarian regime under the auspices of socialist ideology. In the first two decades of its ruling, the new regime brought extensive social changes into a predominantly agricultural society and dominated nearly every aspect of the people's social life, fostering new cultures, creating new norms, and setting new expectations, in an attempt to change the Chinese people's behaviours, mindset, and attitudes.

In the healthcare sector, changes were particularly evident. In the first time in the Chinese history, state medicine was established. The government assumed the responsibility of providing healthcare to its people. Through provision of public health insurances and the implementation of numerous healthcare policies and programs, the Party-state fundamentally changed its citizens' health and illness behaviours and expectations. One of the CCP's endeavours was to foster a new sick role that would suit socialist values and ethos and serve its public welfare schemes. However, the Party-state's endeavour in this regard has been largely overlooked in the academic world, partly due to inadequate scholarly interest in the Chinese healthcare system in its emerging stage, and partly due to the shrinking acceptance of the sick role as an interpretive framework.

The aim of the present research is twofold. First, it examines a special way that the Chinese authority used in the 1950s and 1960s to promote sick role norms and expectations, namely, sick models, who were sick persons that the authority chose as positive examples demonstrating desirable behaviours and attitudes. Secondly, the research is intended to re-evaluate the sick role theory in an attempt to expand its applicability. I argue that, contrary to the claims that announce its death or destruction (Burnham, 2012; Frank, 1991), the sick role is still a useful conceptual framework, but modifications are needed to strengthen its applicability to other political, social and cultural types. One modification is to include the state as a major actor and analytic element and to expand doctor-patient dyadic system into a tripartite system that involves the patient, the doctor, and the state.

In the following text, I shall first elaborate on the sick role and discuss the part that the state plays in a variety of polities. Secondly, I will discuss the social changes China experienced in

the 1950s and 1960s to set the scene for the emergence of a brand new sick role. Thirdly, I will analyse sick models the Party-state established and promoted to advance a new sick role.

The Sick Role

Parsons noted that illness is a form of deviance and medicine is a mechanism of social control. 'Being sick' constitutes a social role regulated by 'a set of institutionalized expectations and the corresponding sentiments and sanctions' (Parsons, 2012 [1951], p. 306). He identified four features of the sick role. First, the individual is not held responsible for being sick. Secondly, the individual is exempted from normal social role and task obligations on the basis of the illness being a legitimate incapacity. Thirdly, the sick person must recognise being ill is 'inherently undesirable,' and is thus obliged to get well. Fourthly, the sick must seek competent help and willingly cooperate with medical agencies which help them to get well (Parsons, 1979, p. 132). The first two features are regarded as the rights of the occupant of the sick role, while the other two their duties (Arluke *et al*, 1979). These features form the normative expectations legitimating the occupant's claim to 'secondary gains.' However, Parsons argued that in a modern society the individual can be motivated to enter the sick role to secure 'secondary gains' (Parsons, 2012 [1951], p. 307), which are often 'very powerful gratifications' (Parsons, 1979, p. 133). Mechanisms are thus needed to ensure the behaviours of the sick comply with social norms and expectations to the extent that they enjoy their rights to the sick role, fulfil their duties to get well and leave the sick role, and not to abuse secondary gains.

There are two mechanisms to ensure an actor's conformity to normative standards and role-expectations: socialisation and social control. Parsons noted that the social norms and orientations that an actor 'implements in his [*sic*] complementary interaction in roles, are not inborn but have to be acquired through learning' (Parsons, 2012 [1951], p. 144). The learning process is called 'socialisation.' But socialisation itself cannot guarantee individual actors' conformity to standards and norms. In actors' personalities and social situations there always exists 'tendencies to *deviance* (emphasis original), to depart from conformity with the normative standards which have come to be set up as the common culture' (ibid.). To motivate actors 'to abandon deviance and resume conformity' (ibid.) to role-expectations, it is necessary to involve the second mechanism—social control.

Socialisation and social control are the two sides of the same coin (Parsons, 2012 [1951], p. 209). Socialisation is the 'preventative or forestalling aspects of social control,' teaching the actor 'not to embark on processes of deviance' (ibid.), while social control involves 'the unlearning of the alienative elements of the motivational structure' (ibid.). In the sick role, actors learn role-expectations in their childhood through predominantly their families. When growing up, they are supposed to have internalised the values and norms that the social system expects in the sick role. However, tendencies to deviance always exist in an actor, motivating them to violate institutionalised patterns and cultural norms. Therefore, when an actor enters the sick role, social control processes are activated to counteract deviant tendencies and to cope with motivated retreat into illness. According to Parsons, social control functions in a dyadic system with the doctor and the patient as the major actors and patients' families as auxiliary ones. The doctor possesses a dominating position while the patient usually succumbs to the doctor's authority and power (Parsons, 1978).

The sick role concept has received many criticisms, which can be roughly divided into two categories. One category is oriented to Parsons's assumption of the cultural foundation and normative bases of the sick role. Criticisms usually concern what are socialised, namely, what role-expectations and norms are accepted as the common culture underscoring the sick role. A major challenge focuses on Parson's assumption of a uniform set of social expectations and cultural values for the entire American society and perhaps the whole Western world. Critics have revealed that even within America, there exist many different role-expectations and behavioural patterns which are determined by the cultural background, socioeconomic status, gender, and parenting style of the sick (Zborowski, 1952; Twaddle, 1969; Zola, 1966; Ossenberg, 1962; Campbell, 1978). The sick role described by Parsons is just one of many sick roles and is patterned on the behaviours of American middle-class which usually emphasises individual responsibility for good health and a return to normality (Landy, 1977; Wolinsky, 1980; Cockerham, 2016). These patterns may not be shared by patients from other socioeconomic and ethnocultural backgrounds.

The other category of criticisms challenges Parsons's medicocentric assumption about the dyadic relationship between the patient and the doctor (Gallagher, 1976). A common criticism is that the doctor is no longer as powerful as Parsons believed due to changes to the organisation of healthcare delivery and bureaucratisation of professional work, and the rise of health consumerism and patient empowerment (Haug and Lavin, 1981).

A striking feature of the sick role concept is the absence of the state in analysis. Parsons did not accord the state any function in the sick role, although he was not completely ignorant of the role of the state in it. In one of his works (Parsons, 1979), he acknowledged in brief that in the UK and the Soviet Union, the state played a far more noticeable role in the social control mechanism in the sick role (p. 116), but he apparently considered the cases represented by these countries as exceptional and did not explore further. He seemed to take for granted doctors' responsibility in controlling the sick role and their dominant position in the doctor-patient relationship, assuming that doctors were bestowed with this responsibility as an outcome of a spontaneous cultural process (Gill and Horobin, 1972), and exercised control out of their altruistic obligation to the common good of the society. In the socialisation mechanism, family was deemed as the prime location in the learning process. It was chiefly a familial responsibility to culturally prepare an individual for acceptable illness behaviours, and the individual took a secondary responsibility to learn the norms in later stages of life. Supporters and opponents of the sick role theory also focused on what happened between doctors, sick persons and their families. The state has been accorded little role in the formation, promotion, and socialisation of norms and values underscoring the sick role and in the social control mechanism. These values and expectations have been viewed as predominantly societal and emerged spontaneously as a result of social changes or as an outcome of ethnocultural tradition.

It may be argued the sick role was developed from Parsons's observation of the American society in the middle of the 20th century when the American state did not play a distinct role in the healthcare system. But other studies revealed the American state is not inactive in the mechanisms regulating the sick role. On the contrary, its involvement in the sick role is deep and pervasive and can be easily seen in two domains: the regulation of the medical profession and the financing of the sick. Studies have showed that the medical profession interacted with the state closely and resorted to state apparatuses to serve their interests throughout the 20th century (Freidson, 1970). As Moran and Wood (1993) pointed out, '[s]tates are central to the working lives of doctors' (p. 4). Meanwhile, with the introduction of Medicare and Medicaid in the 1960s, patient's behaviour also changed as medical services became more accessible to 'millions of new elderly and poor patients' (Moran and Wood, 1993, p. 6). That means more patients could afford entering the sick role, while doctors became wealthier thanks to the surge of the number of patients.

In welfare states, the state interferes with healthcare delivery in a much more direct manner. For example, in the UK, the state effects mediative control (Johnson, 1972) through the National Health Services, imposing constraints on the doctor-patient relationship, defining the ‘needs and/or the manner in which such needs are catered for’ (Johnson, 1972, p. 77), and participating in the social control process as a major actor.

Apart from coercive power exercised in the social control mechanism, the state also resorts to persuasive power in its intervention with the sick role. A recent example is Sweden. In Sweden’s shift from a ‘collective responsibility of the welfare state towards individual responsibility’ (Michailakis and Schirmer, 2010, p. 931), the government has introduced significant changes to the sick role expectations and embedded responsibilities. It can no longer be assumed that individuals are not responsible for their sickness. That is, one of the features of the sick role has changed to its opposite: the individual *is* responsible for their sickness. A right becomes a duty. The change has repercussions for other expectations in the sick role, such as the sick person’s duty to seek competent help. While in a welfare state, such help is traditionally guaranteed at the cost of the state, in the new scheme, it may be denied or available only at the cost of the individual if he or she is proved to be responsible for being sick.

What is more interesting is the socialisation of the new expectations. According to Michailakis and Schirmer (2010), the Swedish government has employed a wide range of persuasive devices to disseminate new role expectations and normative standards, including propaganda on mass media, research reports by health and medical institutions, public debates, etc. The strategies seem effective and have changed the public’s views toward collective responsibility. Although not digging deeper, the study nevertheless demonstrates the role that the state plays in the socialisation mechanism.

My research follows this lead and explores further how the state creates new expectations and normative standards in the sick role to suit its political and economic goals and how the new expectations and values are socialised. I particularly focus on the socialisation mechanism that the CCP attempted to form in the early years of its regime to demonstrate that the state can be a major actor in the sick role.

Social Changes and Welfare in the Early Years of PRC

Among the numerous new institutions that the CCP established in healthcare since 1949, the most fundamental one was constitutional. In 1954, the PRC promulgated its first Constitution. Article 93 posited that the labourer had ‘the right to material assistance when they are old, ill or disabled.’ And it was the duty of the state to ‘develop social insurance, social relief and public health services, and gradually expand these facilities to guarantee the labourer’s enjoyment of this right’ (1954). The Constitution did not promise a universal, citizenship-based right to healthcare. The term ‘labourer’ indicates the right is employment-based. This is particularly evident in the two publicly funded health insurance schemes covering people with urban household registration.

The first publicly funded health insurance scheme was the Labour Insurance (LI). It was established in 1951 with the promulgation of the Labour Insurance Regulations (LIR) (Dixon, 1981), which stipulated workers’ entitlements to healthcare, sick and maternity leave, disability and retirement pension, social assistance, etc. Generally speaking, if workers sustained sickness, injury or disability from performing their occupational duties, they were entitled to free medical and hospital care and received full wages until they recovered. For total disablement sustained in the course of work, they would receive a pension up to 60 to 75 per cent of their last wage until death. If they were partially disabled, they would receive a pension up to 30 per cent of their last wage until retirement or death. Workers’ dependents were also entitled to subsidised healthcare (ibid.).

The Public Health Insurance (PHI) was a more generous scheme. Established in 1952, it was designed to cover public employees in non-productive work units, such as CCP and government agencies, schools and universities, hospitals, sports organisations, public entertainment institutions, etc. It covered nearly all medical costs, no matter whether the sickness or injury was inflicted in the work or not (Wu, 2014). Public employees enjoyed sick leave benefits similar to industrial workers (State Council, 1955).

These constitutional and institutional changes inevitably resulted in new illness behaviours, role expectations, and norms about being sick. The sick person’s right to exemption from normal social role and task obligations became not only a social right but also a constitutional right. Their obligation to seek competent help could be much more easily fulfilled thanks to the rapid expansion of state-owned and -operated modern healthcare facilities, and the

nationalisation of health and medical professions. Health insurance schemes provided public employees secondary gains at the cost of the public coffers. That is, their exemption from official roles and duties was subsidised by public money, especially in the form of sick leave payment and disability compensation. With these insurances, being sick was no longer 'inherently undesirable.'

Not long after inauguration, the insurance schemes became financially unviable due to two major reasons. The first was the rapid expansion of welfare coverage, and the second was the wide-spread abuse of welfare benefits.

The LI and PHI were employment-based welfare. Since the beginning of the PRC, the CCP strived to achieve full employment in urban area as unemployment was believed a sin of capitalism (Zhang, 2007). That resulted in rapid expansion of insurance coverage. In 1952, 3.3 million workers were covered by labour insurance, while in 1957, the number rose to 11.5 million. National expenses on the LI more than tripled during the period (Frazier, 2002, p. 140). The coverage of the PHI also expanded remarkably. When it was launched in 1952, about four million public employees were covered (Qian and Zhang, 1999, p. 758). In 1957, the number reached over 7.4 million (Zhou, 1992, p. 388).

Compared with the rapid expansion of the number of the insured, the abuse of public health insurances was far more concerning. The authority was particularly concerned about three types of wrongdoings. They were overuse and wasteful use of health services and medical resources, frauds, and malingering.

Overuse and wasteful use of health services and medical resources were identified as the major culprit for health insurance overspending and thus constituted the gravest concern of the top leadership and central health authority. A 1957 government report revealed that public employees and their dependents registered 15 outpatient visits per person per year in average, while urban residents who were not covered by any public health insurance made only 3.5 outpatient visits and rural residents only two visits per year in average. Wastage in public health schemes was appalling due to poor institutional design and mismanagement (Zhou, 1992, pp. 388-9). In a 1966 document, the Ministry of Health and the CCP Beijing Committee (1966) noted that both the LI and PHI expenses significantly exceeded the budget. Wastage, especially of pharmaceuticals, was identified as the No. 1 cause for overspending.

Frauds were also wide-spread among the insured users. A common practice was for a covered person to pretend to be sick and ask for free medicines for their non-covered family members or friends (Ministry of Health and CCP Beijing Committee, 1966). Another practice was masquerading. The insured lent their medical cards to the non-insured so that the latter could receive free medical services and medicines (ibid.).

The LI and PHI offered public employees paid sick leaves. In this connection, malingering constituted a grave abuse of this type of secondary gains. It was not uncommon for ordinary employees to fake sickness and take paid sick leaves to engage in private affairs (Cai, 1958). Another type was that recovered patients refused to return to their normal role and duties. Many of them even refused to be discharged from hospitals, insisting that they were not fully recovered in spite of discharge advice of the doctor (ibid.). Their prolonged hospitalisation, additional medicine consumed, and extended absence were all considered as economic losses to the state (Ministry of Health and CCP Beijing Committee, 1966).

Since the launch of the LI and PHI, regulating the sick role and containing abuse of secondary gains had always been an emphasis of health insurance management by the central and local governments. This task was usually approached through two strategies. One was the strengthening of social control mechanisms in the sick role. During the pre-reform era, the authority made numerous attempts to tighten the control in the sick role and the distribution of secondary gains. Measures included enhancing regulations on sick leaves, hospitalisation and dispense of pharmaceuticals, granting doctors more administrative power over public patients, introducing co-payments in outpatient consultation, and tightening supervision of doctors over their prescriptive behaviours (All-China Federation of Trade Unions, 1964 [1985]). Apart from these coercive measures, the Party-state also utilised mechanisms of socialisation to exert persuasive influence on the people. Sick models belong to the latter.

Sick Models in Pre-reform China (1949-1978)

The CCP has always considered encouraging the emulation of role models an efficient way to exercise the Party-state's persuasive power, to inculcate desired behavioural patterns, and to socialise values and expectations upheld by the Party-state (Boden, 2008, pp. 50-1). The sick model is a role model which is propagated for the purpose of socialising official role expectations and values embedded in the sick role that the regime endorses and endeavours to

promote. Sick models include model workers, soldiers, or cadres who, when sick, demonstrate certain qualities and behavioural patterns epitomising those that the Party-state expects to see.

The exemplary effect of sick models relied predominantly on propaganda for dissemination. Propaganda therefore constitutes the major source for ordinary people to learn the models' packaged stories, to develop awe and respect, and to emulate them. A survey of the stories of model workers, soldiers, and cadres on propaganda shows two types of sick models: the cooperative type and the 'defiant' type. The former refers to patients who demonstrated strong inclination to cooperate with medical professionals so that they could recover quickly and return to their normal social role and responsibilities as soon as possible. The 'defiant' type refers to those who refused to withdraw from their public roles and commitment and to enter the sick role.

The cooperative type of sick model can be best represented by Qiu Caikang (1930-2014), who was erected as a national model worker in the late 1950s not because of the hard work he had delivered but solely because of an injury he had sustained in workplace. Qiu was a worker of Shanghai No. 3 Steel Plant. In May 1958, he was badly burnt by melted iron, and was sent to Shanghai Guangci Hospital, where he was diagnosed as having second- and third-degree burns over more than 89 per cent of his body (Zhai, 1958). According to official reports, doctors of Guangci Hospital were pessimistic about his condition, believing one with burns exceeding 75 per cent of body surface could not be saved. However, with the insistence of the CCP committees of the hospital and Shanghai No. 3 Steel Plant, the attending doctors created a medical miracle and saved his life (*ibid.*). Although the miracle was hailed as a major medical achievement during the Great Leap Forward period (1957-1962), it was Qiu Caikang who became the hero. His story was widely reported on mass media. In late 1958, he was elected a National Young Enthusiasts of Socialist Construction (Xinhua News Agency, 1958a).

Media reports explicitly conveyed two messages. First, it was the CCP, not the doctors, who saved Qiu's life. Secondly, the patient who was blessed by the CCP's generosity and loving-kindness were obliged to reciprocate with more hard work.

The media coverage of Qiu's injury and his salvage expressed in unmistakably terms that it was the CCP that saved his life. The Party did two things that were vital. First, the salvage of Qiu relied on the resources commanded by the CCP. All the expenses incurred in the process of saving his life were covered by public insurance and other public funding. The Party also mobilised and coordinated extensive social and governmental resources to support the treatment. Secondly, it was reported that the Party was the driving force behind the medical miracle. When Qiu was admitted to Guangci Hospital, as reports went, doctors and surgeons were pessimistic about his fate, because, with their vision and thoughts restrained by textbooks and foreign expertise, they did not dare to imagine the survival of someone with such extensive burns. Then the secretary of the Hospital CCP committee was reported to have asked the medical experts why they believed so much in foreign experts. He argued that in a capitalist country, a capitalist was unlikely to sustain extensive burns. It was the working-class people who were likely to get badly burnt. As bourgeois doctors were servants of capitalists, why would they bother to devote their knowledge and wisdom to save the life of workers? But in China, workers were masters, and hospitals must serve them whole-heartedly. That was why, the secretary insisted, the steel worker could be and must be saved (Zhai, 1958). The words of the hospital's Party secretary inspired and encouraged the doctors who decided to join forces across specialties, make bold experiments, and try every possible techniques and methods to save Qiu's life. Without the Party's insistence and efforts, Qiu would have died, so reported on the media. Consequently, the credit of saving Qiu's life went to the CCP, not the doctors (Zhai, 1958; Ai, 1958). It is no surprise that in all occasions, Qiu thanked the Party first for saving his life, claiming that it was the CCP that gave him his second life, and his life belonged to the Party (Xinhua News Agency, 1958a; Xinhua News Agency, 1958b).

Being grateful for the Party was not enough. The publicity of Qiu's story also made it clear that a sick/injured person should not take for granted the Party's generosity and loving-kindness or even take advantage of it. Individuals were expected to reciprocate the Party by working even harder and contribute more to its socialist endeavour. One of the major reasons that secured Qiu the title of model worker was that he demonstrated iron will to recover and great eagerness to return to work. It was reported that on the second day in hospital, Qiu implored doctors to save him so that he could return to his factory to work and continue to contribute to socialist construction. He said, 'You must save my life. My steel furnace needs me. I can leave my wife and son, but I can't leave my furnace' (Yuan, 1958). He said in

another occasion that he had not been very much concerned about his life and safety. ‘What I was thinking was how I could recover as soon as possible so that I could return to the steel furnace and join the “battle” to make more steel’ (Editor, 1966).

Qiu’s strong will to leave the sick role and return to work motivated his cooperation with medical staff (Zi, 2009). As there was no precedence of survival of any patients with over 75 per cent burns, doctors had to experiment many new treatments on him (Editor, 1998). Qiu endured extreme pains caused by medical interventions, surgeries, and drugs applied on the burns, but he never complained. He was always optimistic and cooperative, following professional advice closely and receiving numerous medical interventions and surgeries as a matter of fact.

As he promised, Qiu returned to his factory in 1963 and worked as a production safety supervisor (Xinhua News Agency, 1964). He was reported to have never been late for work and was as devoted as before. In the first year after returning to work, he only took two days sick leave due to malaria (ibid.). He said, ‘some “kind-hearted” people said to me, “Old Qiu! Now you can enjoy your life at home. You don’t have to work but you still get wages, and your wife attends you at home...”’ But as a Communist Party member and a revolutionary, such “contentment” is shameful’ (Editor, 1966). He worked until 1998 when he retired (Zi, 2009).

As a cooperative type of sick model, Qiu Caikang exemplified the desirable behaviours and attitudes expected by the Party-state when entering the sick role was inevitable. First, the sick or injured were expected to be grateful for the CCP as their rights to competent help, exemption from work with pay, and such secondary gains as free medical services were granted by the CCP. Secondly, the sick or injured must show acute consciousness of not abusing these rights. They were expected to cooperate with medical professionals so that they could leave the sick role and resume their normal social roles and responsibilities as soon as possible in order to repay the caring and loving-kindness of the Party-state.

The ‘defiant’ type of sick models behave differently. The term connotes two layers of meaning. First, sick models defy and belittle illness. Secondly, they ‘defy’ medical advice. That is, they usually do not admit they are sick or are not scared of illness and refuse to enter the sick role even though they are diagnosed sick. They frequently display reluctance to

cooperate with medical staff or follow medical advice. Their behaviours and attitudes are motivated by their commitment to work and their unwillingness to have their work interrupted by illness. A basic characteristic of this type is ‘continue to work in spite of being sick’ (*dai bing jianchi gongzuo*). An advanced characteristic is self-sacrifice, namely, the model dies of illness sustained or worsened in the process of relentless hard work. An example of this type is Jiao Yulu (1922-1964).

Jiao Yulu was appointed in 1962 as the secretary of the CCP committee of Lankao County in Henan Province, a position that was virtually the chief administrative officer of a county. He worked in this position for about 470 days before he died of liver cancer in 1964 (Jiao Yulu Cadet College, 2014). Lankao was one of the poorest counties in the province. The poverty was mainly attributable to the recurrence of environmental disasters, such as waterlogging, wind-sand, and salinisation of soil. Its rural population had to rely constantly on government aid. When aid was not enough, a large proportion of the population had to go begging in other places. Jiao resolved to combat the disasters and devote his life to saving the poor peasants from the tyranny of the nature. After his death, his deeds were propagated on official mass media. His story was made into a feature film, a 30-episode TV show, operas, documentaries, picture books, etc.

Jiao’s illness behaviours were considered as a manifestation of his noble character and were highly praised. When Jiao assumed his position in Lankao county, he was suffering chronic liver disease, but he brushed it off without a thought of self. Upon arrival, he immediately started working diligently without rest. He endured severe pain but refused to see a doctor or take rest. His refusal to enter the sick role was manifested in three aspects. First, he belittled the disease. He allegedly said that, ‘Illness is a lion among sheep and a sheep among lions. If you suppress it, it won’t bully you’ (Mu *et al*, 1966). Secondly, he constantly ignored advice on seeking medical help. His colleagues and superiors urged him to take rest and see a doctor in many occasions, but he declined persistently, even though he had to always press his abdomen with his hand or hard objects to reduce pain. More than often the pain was so severe that he could barely move, but that would not stop him from investigating natural calamities and visiting villages across the county, either on foot or by bike. Thirdly, he was reluctant to follow medical advice. His superiors arranged an eminent doctor of traditional Chinese medicine to check him and prescribe some herbal medicine. After three doses, Jiao refused to continue as the prescription was expensive. Although he was covered by PHI, he did not want

to burden local public finance. At last, the local Party committee ordered he take leave and seek medical care and decided to escort him to a provincial hospital, but it was already too late. He was diagnosed with advanced hepatic cancer. Even in his sick bed, he was not concerned about himself (Mu *et al*, 1966). His mind was still on his work. And he never asked for pain medication in order to save public medical resources. Instead he allegedly used cigarettes' butts to burn his skin to alleviate pain (Nursing team of the Affiliated Hospital of Henan Medical College, 1966).

According to a report, Jiao was not completely resistant to medical treatment. When he was hospitalised, he followed medical advice exactly, and took medicine as directed. Apart from not asking for pain medication, he was very cooperative (Nursing team of the Affiliated Hospital of Henan Medical College, 1966). His cooperation was reported to have been solely motivated by his intention to recover as soon as possible and to return to his work so that he could lead the people of Lankao to fight against natural calamities again (Mu et al., 1966; Jiao Yulu Cadet College, 2014).

Both the cooperative and 'defiant' type of sick models share a commonality—commitment to their normal work role and responsibility. They either refuse to enter the sick role, continuing to work in spite of being sick, or, if entering the sick role is inevitable, demonstrate strong desire to leave the sick role and return to their normality as soon as possible. This does not only indicate their enthusiasm for socialist construction and their loyalty to the cause of the Party-state, but also their clear conscience of not taking advantage of public resources. Such behaviours and attitudes qualify them for sick models and prompt the Party-state to propagate them as examples embodying new role expectations and norms. They represent the high standards of being sick in the 1950s' and 1960s' China.

Conclusion

I argue that Parsons's sick role is still a useful conceptual framework for explaining the social process of illness, but it needs to bring in the state as a major actor so that its applicability can be extended to other political and social settings. The sick role should not be regarded as a mere social process in which the state plays a negligible role. On the contrary, at least in some polities, the state is a major stakeholder for it is usually the organiser, regulator, and funder of various national healthcare schemes and facilities, and is thus deeply and

extensively involved in the process. It exercises coercive power in social control mechanisms regulating illness behaviours and the doctor-patient relationship, and also exercises persuasive power by creating norms and role expectations and socialising them to the sick. The state's persuasion can significantly change values, norms, and expectations embedded in the sick role and influence individual sick person's illness behaviour.

The case of China discussed here illustrates the state's exercise of persuasive power. Obligated by its ideological commitment to the people and its constitutional undertaking to the health and wellbeing of the labourer, the CCP established state medicine that offered its people publicly financed healthcare. New behavioural patterns among ordinary users emerged, leading the Party-state to promote new role expectations and norms. On the part of ordinary users, state-organised medicine and state-funded secondary gains encouraged excessive utilisation, wastage, frauds, and malingering. To counter these wrongdoings, the Party-state not only exercised its coercive power by tightening regulation and strengthening social control mechanisms, but also resorted to persuasive methods to encourage the user to adopt desired behaviours and attitudes. Sick models were a major means by which the desired role expectations and behaviours were disseminated.

The present research discussed two cases, representing two types of sick models, namely, the cooperative and the 'defiant.' With these cases I demonstrated two things. First, the Chinese Party-state used sick models as a way of persuasion. Through propaganda, the CCP disseminated new sick role expectations and desirable behaviours among the people and encouraged them to emulate the models. Secondly and more emphatically discussed in this research was the characteristics of illness behaviours of the sick models. In the cooperative model, the sick person cooperated with medical professionals and the cooperation was usually described as solely motivated by the model's eagerness to return to work. Through cooperative models, the Party-state apparently encouraged a timely return to one's normal work position and responsibility if entering the sick role was inevitable. In the 'defiant' type, the sick model tended to refuse entering the sick role or deliberately postponing seeking for competent help. His or her 'defiance' of medical advice or refusal to seek medical help, again, was solely motivated by their selfless commitment to work, and was thus highly praised as an enthusiastic devotion or even a noble sacrifice to the socialist cause. What was propagated implicitly in these models was the Party-state's expectations for restrained use of medical resources and timely return to one's normality and responsibility. All these role expectations

did not emerge naturally among the insured users but were emphasised and disseminated by the Party-state through propaganda. It was the Party-state, rather than mothers and teachers, that carried out the major work of socialisation, although the latter doubtless played their parts in the mechanism.

Limited by space, the present research focuses only on the characteristics of two types of sick models. It is not discussed in greater detail how the role expectations and values were disseminated to recipients and how the latter responded, as situations implied by these questions are complicated. For example, the Party-state's ideological campaigns aiming at promoting sick models were met with strong but silent resistance among the ordinary users of the healthcare system. Towards the end of the pre-reform era, malingering and abuse of the medical insurance schemes were wide-spread. Another topic that is not covered in this paper is the evolution of sick model propaganda in the reform era. Since 1978, economic incentive has replaced political encouragement as a major device to anticipate malingering. The public health insurance schemes have also been overhauled. But these role expectations and values have survived, and sick models are still propagated and called for emulation until now. These aspects of sick models are complex and deserve separate studies. In spite of these limitations, however, the paper demonstrates the state can be an important actor in the sick role. The state not only exerts coercive power in regulating people's sickness behaviours, as in the mechanism of social control, but also exercises persuasive power to encourage the patient to adopt willingly and cooperatively the values and behavioural patterns endorsed by the state. Consequently, the inclusion of the state in the analysis of the sick role has the potential to reconstruct the concept as an alternative biopolitical perspective to examine the interactive dynamics between the state, the profession and the patient, and significantly expand the concept's applicability to other political, social and economic settings.

References:

- The Constitution of the People's Republic of China* (1954).
http://www.npc.gov.cn/wxzl/wxzl/2000-12/26/content_4264.htm, accessed 8 May 2018.
- Ai B. (1958) Zai Dang de lingdao xia chuangzao de qiji (Miracles created under the leadership of the Party). *Renmin Ribao (People's Daily)*, 1 July: p. 7.
- All-China Federation of Trade Unions. (1964 [1985]) Laodong baoxian weiyuanhui gongzuo gangyao (Working guidelines for Labour Insurance committee). In: Shanxi Provincial Labour Bureau (ed) *Laodong Baoxian Shenghuo Fuli Wenjian Xuanbian (Selected Government Documents about Labour Insurance and Welfare)*. Taiyuan: Shanxi Provincial Labour Bureau.
- Arluke A, Kennedy L and Kessler RC. (1979) Reexamining the Sick-Role Concept: An Empirical Assessment. *Journal of Health and Social Behavior*, 20: 30-36.
- Boden J. (2008) *The Wall behind China's Open Door: Towards Efficient Intercultural Management in China*, Brussels: Academic and Scientific Publishers.
- Burnham J. (2012) The death of the sick role. *Social History of Medicine*, 25: 761-776.
- Cai Y. (1958) Weishenme zhidong dui shenghuo fuli de yijian henduo? (Why are the employees not happy about life and welfare?). *Renmin Ribao (People's Daily)*, 18 January: p. 3.
- Campbell J.D. (1978) The child in the sick role: contributions of age, sex, parental status, and parental values. *Journal of Health and Social Behavior*, 19(1): 35-51.
- Cockerham W.C. (2016) *Medical Sociology*, Boston: Pearson.
- Dixon J. (1981) *The Chinese Welfare System, 1949-1979*, New York: Praeger
- Editor. (1966) Gong nong bing tan Gongchan Zhuyi daode (Workers, peasants and soldiers talking about communist morality). *Renmin Ribao (People's Daily)*, 17 March: p. 5.
- Editor. (1998) Guangci Yiyuan qiangjiu Qiu Caikang bingshi dangan xuan zai (Selected medical records of Qiu Caikang in the process of recuing his life in Guangci Hospital). *Shanghai Dangan (Shanghai Archives)* (4): pp. 52-58.
- Frank A.W. (1991) From sick role to health role: Deconstructing Parsons. In: Robertson R and Turner BS (eds) *Talcott Parsons: Theorist of Modernity*. London: SAGE, pp. 205-216.
- Frazier M.W. (2002) *The Making of the Chinese Industrial Workplace: State, Revolution, and Labor Management*, Cambridge: Cambridge University Press.
- Freidson E. (1970) *Profession of medicine: a study of the sociology of applied knowledge*, Chicago and London: The University of Chicago Press.
- Gallagher E.B. (1976) Lines of reconstruction and extension in the Parsonian sociology of illness. *Social Science and Medicine*, 10(5): 207-218.
- Gill D.G and Horobin G.W. (1972) Doctors, patients and the state: relationships and decision-making. *Sociological Review*, 20(4): 505-520.
- Haug MR and Lavin B. (1981) Practitioner or patient--Who's in charge? *Journal of Health and Social Behavior*, 22(3): 212-229.
- Jiao Yulu Cadet College. (2014) *Yongheng de Fengbei: Jiao Yulu de Gushi (The Everlasting Mounument: The Story of Jiao Yulu)*. Zhengzhou: Daxiang Publishing House.
- Johnson J.T. (1972) *Professions and Power*, London: The Macmillan Press Ltd.
- Landy D. (1977) *Culture, Disease, and Healing: Studies in Medical Anthropology*, New York: Macmillan.
- Michailakis D and Schirmer W. (2010) Agents of their health? How the Swedish welfare state introduces expectations of individual responsibility. *Sociology of Health and Illness*, 32(6): 930-947.

- Ministry of Health and CCP Beijing Committee. (1966) Guanyu zai dang nei taolun gaige gongfei yiliao zhidu laobao yiliao zhidu de tongzhi (Circular to launch the internal discussion within the Party about public health insurance and labour insurance). http://www.34law.com/lawfg/law/6/1189/law_250934462489.shtml, accessed 1 March 2017.
- Moran M and Wood B. (1993) *States, regulation, and the medical profession*, Buckingham ; Philadelphia: Open University Press.
- Mu Q, Feng J and Zhou Y. (1966) Xiangwei shuji de bangyang — Jiao Yulu (Jiao Yulu: A model for county party secretaries). *Renmin Ribao (People's Daily)*, 2 February, p. 1.
- Nursing team of the Affiliated Hospital of Henan Medical College. (1966) Huiyi Jiao Yulu tongzhi zai zhuyuan de shihou (Recalling the time when comrade Jiao Yulu was hospitalised). *Huili Zazhi (Journal of Caring)* (3): 119-120.
- Ossenberg R.J. (1962) The experience of deviance in the patient-role: A study of class differences. *Journal of Health and Human Behavior*, 3: 277-282.
- Parsons T. (1978) The sick role and the role of physician reconsidered. In Parsons T (ed) *Action Theory and Human Condition*. New York: The Free Press, pp. 17-34.
- Parsons T. (1979) Definitions of Health and Illness in the Light of American Values and Social Structure. In Jaco EG (ed) *Patients, Physicians, and Illness: A Sourcebook in Behavioral Science and Health*. 3rd ed. New York: The Free Press, pp. 120-144.
- Parsons T. (2012 [1951]) *The social system*, New Orleans: Quid Pro Books.
- Qian X and Zhang Y. (1999) *Zhongguo Weisheng 50 Nian Licheng: 1949-1999 (Fifty years of Chinese Health Care: 1949-1999)*. Beijing: Zhongyi Guji Chubanshe (TCM Ancient Texts Publisher).
- State Council. (1955) Guojia jiguan gongzuo ren yuan bingjia qijian shenghuo daiyu shixing banfa (Trial measures for livelihood benefits for employees of state institutions during sick leaves). In: National Personnel Bureau (ed) *Renshi Gongzuo Wenjian Xuanbian (Selected Documents of Personnel Work)*. Beijing: National Personnel Bureau.
- Twaddle A.C. (1969) Health decisions and sick role variations: An exploration. *Journal of Health and Social Behavior*, 10(2): 105-115.
- Wolinsky F.D. (1980) *The sociology of Health: Principles, Professions, and Issues*, Boston: Little, Brown and Company.
- Wu W. (2014) Xin Zhongguo chuqi gongfei yiliao zhidu jianshe yanjiu - jiyu fan langfei de shijiao (A study of the construction of public health insurance institutions in the early years of the New China - From the perspective of anti-waste). *Jishu jingji yu guanli yanjiu (Technological economy and management study)* (7): 86-90.
- Xinhua News Agency. (1958a) Qiu Caikang jiang dao Beijing chuxin Quanguo Qingnian Shehuizhuyi Jianshe Jiji Fenzi Dahui (Qiu Caikang is coming to Beijing to attend National Young Enthusiasts of Socialist Construction). *Renmin Ribao (People's Daily)*, 12 November, p. 6.
- Xinhua News Agency. (1958b) Yingxiong lian gangtie, gangtie lian yingxiong (Heroes make steel, steel makes heroes). *Renmin Ribao (People's Daily)*, 26 November: p. 6.
- Xinhua News Agency. (1964) Qiu Caikang zai xin gangwei shang qinfeng gongzuo (Qiu Caikang worked hard in his new position). *Renmin Ribao (People's Daily)*, 28 February: p. 2.
- Yuan. (1958) Geming yizhi de shengli (The victory of revolutionary willpower). *Renmin Ribao (People's Daily)*, 9 August: p. 8.
- Zborowski M. (1952) Cultural components in responses to pain. *Journal of Social Issues* 8: 16-30.
- Zhai W. (1958) Dang jiu huo le ta (The Party saved his life). *Renmin Ribao (People's Daily)*, 1 July: p. 7.

- Zhang X. (2007) Xin Zhongguo jiuye zhidu de lishi fenxi (A historical analysis of New China's employment system). *Lilun Xuexi (Theoretical Studies)* (3): 40-41.
- Zhou E. (1992) Guanyu laodong gongzi he laobao fuli zhengce de yijian (Opinions about wages and labour protection and welfare policies). In: Chinese Communist Party Literature Research Center (ed) *Zhou Enlai Jingji Wenxuan (Selected Works on Economy by Zhou Enlai)*. Beijing: Zhongyang Wenxian Chubanshe (Central Literature Publishing House), pp. 374-392.
- Zi L. (2009) Qiu Caikang: 50 nian hou de “gangtie yingxiong” (Qiu Caikang: “steel hero” after 50 years). *Lao Tongzhi zhi You (Friends of Old Comrades)* (8): 12-13.
- Zola I.K. (1966) Culture and symptoms: An analysis of patients' presenting complaints. *American Sociological Review*, 31(5): 615-630.

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