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Chinese Rural Health-Seeking Behaviour and the Dilemma of Sufferers of Chronic Sickness: A Case Study from Inner Mongolia

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Chinese society is entering a 'period of chronic sickness', especially hypertension, hyperglycemia and hyperlipidemia, resulting from a more easily available diet rich in animal fat and protein. The damage is greatest in rural areas where medical and welfare facilities are limited and patients present late, which they justify as needing to continue farming despite sickness. Thus, contrary to Parsons's observation regarding Western medical treatment, a patient's sick role is neither 'deviant' nor separated from their everyday social role and lifestyle. Villagers might however be officially encouraged to regard biomedical, religious and traditional folk therapies as neither old-fashioned nor in conflict, but as a spectrum providing emotional/psychological and sometimes physical benefit, reinforced by returning to the greater community and family care existing before village social fragmentation. This recreation of a holistic perspective could enhance the quality of rural life, especially of chronic sickness sufferers.

Keywords: Rural Chinese; Recent Chronic Sickness; Biomedicine; Religious and Folk Therapy; Sick Role Integration

Introduction

Chinese society is entering a period of chronic sickness becoming the leading source of mortality, requiring change and adjustment on the part of society, as well as government policy that addresses this challenge.

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According to Parsons, sickness from a Western medical perspective is regarded as an undesirable, unproductive and, therefore, deviant condition. The doctor first legitimates the patient's withdrawal from normal responsibilities such as paid and domestic work, caring for others and so forth. The doctor later requires the patient to cooperate responsibly in getting better and returning to normal, productive activities. This social recognition and acceptance of the responsibilities of the sick role ideally work in tandem with welfare and professional medical treatment and constitute a social contract between patient and wider society. Parsons' account has been criticised for its overt paternalism and for being too 'medico-centric' insofar as the sick role is prescribed by medical authority while individual patients passively accept the designation of their role as submissive and dependent. Patients are not encouraged in this one-sided doctor-patient relationship to develop knowledge about and so master their situation. Nor does Parsons distinguish between the greater possibility for patients with acute sickness to return quickly to socially productive activities compared with chronic sickness sufferers for whom the sick role often cannot be a provisional step towards discharging the social obligation to return to health and full social reintegration.

Although often criticised, rejected and considered out of date (for example, Shilling 2002), Parsons's 'sick role' theory (for example, 1951) has recently been reconsidered by sociologists who argue that it can critically inform current accounts of health and illness (Burnham 2012; Hal et al. 2013; Hallowell et al. 2015; Higgins, Porter, and O'Halloran 2014; Sanders 2018). Thus, Berk et al. (2013) argue that it can be extended to include the social premise that chronically sick patients, and not just those with acute sickness, should overcome their 'deviance' and seek recovery, including through integration of their chronic sickness into their lifestyle. Such recovery means accepting the presence and consequences of the sickness, seeking treatment, adjusting lifestyle and following recommended strategies (Eckel et al. 2014; Telford, Kralik, and Koch 2006) such as losing weight, increasing physical activity, lowering salt intake, adopting a healthy diet, and moderating alcohol consumption (Eckel et al. 2014). Locker and Kaufert (1988), however, criticise Parson's claim that the sick role is in fact 'deviant' and therefore unintegrated with mainstream society. They argue that patients' sick and social roles should be seen as reconcilable (Locker and Kaufert 1988), but they do not specifically describe whether and how patients might integrate the sick role with their lifestyles.

Despite the paucity of studies in China applying Parsons's sick role theory, we can ask whether these suggested modifications can in fact be applied. Adopting the sick role theory, Siu (2016) analyses how old cultural stereotypes and new social understandings of overactive bladder (OAB) in Hong Kong come together and influence an adaptation of the sick role for those with this chronic condition. Can we see a comparable adaptation of traditional cultural concepts with regard to medical seeking in rural China, on which however there has been little research?

Contrary to the Western perspective presented by Parsons, in the rural areas of many developing countries, patients (whether suffering acute or chronic sickness)

are entirely self-reliant in their work and lack a sick leave wage system, medical security and medical knowledge. Parsons' sick role emphasises moreover the institutional superiority of the biomedical professional role, neglecting other traditional treatments such as religion and folk therapy in rural China. Also, illness was traditionally defined not just as a form of social deviance as in Parsons' sick role, but more as deviance from the harmonious relationship between men and nature under the 'Unity of Man and Nature' (*tian ren he yi*)—a traditional and holistic Chinese cultural concept. In the light of this holistic concept of harmony, how can patients reconcile their chronically sick role with their lifestyles and with their wider social roles? It is here argued that local medical and government authorities can encourage a return to the holistic perspective of traditional healthcare, mutual help and community and religious welfare that existed prior to the village fragmentation that has occurred in China. This could especially benefit chronic sickness sufferers by lifting the onus on them to have to continue to be socially productive while at the same time offering them emotional, psychological and sometimes physical relief.

This question is addressed through analysis of case material drawn from a village in Inner Mongolia in rural China, with a focus on patients suffering from the so-called 'Three High' sicknesses of hypertension, hyperglycemia and hyperlipidemia, which are common in rural China following nutritional changes since 1978. A key issue is whether Parsons's argument in favour of socially integrating the chronically sick is feasible given China's current policy of rural social development. In examining the Parsonian relationship between sickness and social responsibility, we first ask why chronic sickness now besets rural China and how patients define their sick role.

The Paradox of Increasing Wealth and Declining Health: 'Three-High' Sufferers in Village CL

Village CL is located in Ta'er Lake Town, Wuyuan County, Inner Mongolia Autonomous Region, and comprises 75 households and 270 people, 180 of whom are permanent residents. Villagers mainly live by farming and planting. With increasing annual income of migrant workers, the average per capita village income of RMB 10,760 in 2015 equals that of most rural residents of Inner Mongolia Autonomous Region (10,776).

Since 1978 higher incomes in rural and urban China have dramatically increased food consumption, but these dietary changes have created malnutrition and nutrient deficiency. The greater intake of animal meat and fat, displacing grains and vegetables, has resulted in more non-communicable diseases such as obesity, diabetes, cardiovascular disease and cancer (Du 2001; Levenstein 1993; Popkin and Du 2003; Stookey 2001; Zhai et al. 2009). In Village CL this increased meat consumption occurs in 'potlatch-like' competitive feasting.

China reflects the situation reported for a number of (recently) developing countries (Belasco 2005, 205). This shift to over-nutrition associated with increasing socio-

economic standards, aspirations (Kim 2004; Stookey 2001; Zhai et al. 2009) and non-communicable chronic sickness, affects first the better-off and then the poor who may themselves eventually earn enough to eat obesity-producing foods (Du 2004; Popkin 2004, 143).

Household surveys and in-depth interviews by our team in Village CL identified 27 patients with 'Three-High' sicknesses, one-ninth of the village's total population with, on average, a patient in every second household. Most are between 40 and 70 years old. There are no clear age differences associated with medical care and there is no formal age of retirement. Ethics approval was obtained from the Committee on the Use of Human and Animal Subjects in Teaching and Research at China Agricultural University prior to the study.[1] An interview question guide was developed prior to the interviews. The questions aimed at investigating the meanings of patients' 'Three-High' experiences, treatment, and coping and behavioural responses.

Despite its location in Inner Mongolia, Village CL and the surrounding county are largely populated by people of Han ethnicity, who comprise all those surveyed and interviewed. Most patients suffering from the 'Three Highs' have limited education and are often illiterate, especially women. Most patients have low to middle household incomes and a low standard of living, with those over 60 subsisting on below average farm earnings only. Why do these under-educated poor figure so largely among the chronically sick, given the fact that villagers of higher education and socio-economic status also eat high fat meat foods?

One reason is that the poorer villagers, including the 'Three-High' patients, work so hard to improve the farming productivity on which they depend that they replenish their energy by habitually eating salty food. They have gradually formed a strong preference for salt in their diet, unaware that salt accumulation in the body and excess water in blood vessels are associated with increased blood pressure (Sun et al. 2008). Moreover, when they have extra money, these agricultural labourers consume large quantities of high fat and high protein food. Secondly, they lack the education and awareness to keep up to date with healthcare information and to seek regular physical examinations of the effects of these practices. Nor, for the same reason, do they recognise or seek early medical advice for negative health symptoms, thereby delaying and perhaps neglecting diagnosis and treatment for their chronic sickness. They may attend hospital only when it is so serious that it drastically affects their body's ability to function. By contrast the wealthier, educated villagers monitor their diets and are aware of the risks of over-nutrition and of the value of physical exercise and accessing healthcare information and regular medical examinations. The paradox of increasing wealth in rural China is, therefore, that economic improvement may increase levels of income, but does not necessarily bring health and may promote chronic sickness driven by the new spirit of consumerism drawing in both rich and poor, rural and urban. (The possibly different circumstances of urban living in China are not, however, addressed in this paper).

Let us now turn to consider how rural chronic sickness is dealt with in Village CL. What we see is the increasing rural preference for biomedical treatment over other

non-biomedical therapies. Yet, it can also be inferred that these alternative therapies have potential value in providing a possible basis of village community care in the absence of adequate biomedical provision.

Four Methods for Diagnosis and Treatment: Health-Seeking Behaviour of 'Three- High' Sufferers in Village CL

In an epidemiological survey of Village CL by our team that focused on the causes of various chronic diseases and their definition by villagers, 'Three-High' sicknesses were classified as falling within the category of 'ailments that are easy to be ignored but cannot be ignored'.[2] In delaying diagnosis and simply enduring serious illness, villagers see themselves as able to cope, viewing sickness as expensive, time-consuming and keeping them from farming and other work. This precludes the self-responsibility for the 'sick role' that Parsons would see as the prerequisite for seeking treatment and recovery.

For patients with chronic sickness who do eventually seek diagnosis and treatment, there are four main modes: 'Western' biomedicine; traditional Chinese medicine (TCM); religious healing; and folk beliefs and practices.

Biomedicine is available at the four levels of village, town, county and city, the latter three at distances from the village of 8, 40 and 70 kilometres respectively. There are no health clinics or village doctors in Village CL, but two biomedical doctors are located in a neighbouring village. While the town hospital is preferred over village treatment, patients will only attend at this or the higher county or city level if they are seriously ill.

While there are no practitioners of traditional Chinese medicine (TCM) in Village CL, TCM hospitals are located at the county and city levels, with a hospital specialising in traditional Mongolian medicine (TMM) also located in the latter. Sick people normally first seek help from 'Western' biomedicine and then TCM/TMM, thereafter turning to folk and religious healing, even when non-believers.

The often family-based emotional/psychological comfort provided by religious and folk treatments complements the more physiological benefits of biomedicine and Chinese medicine.

The 'Convenience' of Biomedicine

The physiological focus of biomedicine tends to ignore psychological and family influences on a patient's health (for example, Kleinman 1988; Wang 2003). Regular, short-term pain relief of chronic sickness may aggravate a chronic condition, yet patients may prefer the immediacy of such temporary relief, as the following typical case illustrates.

Case 1

Mr Sun is a 62-year-old Han man of junior middle school education. His four children married, moved to find urban employment, and left Sun and his wife alone at home.

No longer a farmer, he is chronically sick with cardio-cerebrovascular disease and hypertension, for which he takes prescribed biomedicine. In 2015 his household income was RMB 2000, mostly earned from renting out land. At the age of 57 he suddenly experienced chest, heart, shoulder and back pain and was taken to the town hospital by his wife and son. After diagnosis of 'non-serious' arrhythmia, he was prescribed medicine, rest and 'better' nutrition but to no avail. Mr Sun went back to the two hospitals. In the first, up-to-date equipment found no cause for his symptoms. In the second, a diagnosis of cardio-cerebrovascular disease requiring heart bypass surgery was made. After undergoing the operation, the symptoms were controlled at home through medication and daily health monitoring. After two years the symptoms recurred but, despite further hospitalisation and home-administered medication, Mr Sun's chronic sickness precluded labour-intensive work and leaving his home.

Mr Sun's medical expenses are mainly met from household income and contributions from his four children. Despite his failing condition he values biomedicine for its immediate effect and has never consulted a Traditional Chinese Medicine doctor. Nevertheless he rejects as unaffordable daily healthcare recommendations for chronic sickness made by his doctor and health promotion on TV, such as a physical examination every three weeks.

Reflected in this case, biomedicine has become first choice for patients with chronic illness in spite of being far from fully effective. It works quickly at first, with regular medicines easily available in town after diagnosis. Medicines having the same effect may differ greatly in price, so the 'Three-High' patients usually choose the cheapest —which are still expensive for them. While recognising this, private drugstore owners also stock expensive medicine in case customers ask for 'good' ones.

Nevertheless, 'Three-High' patients still face inadequate medical provision, given the distance between the village and well-equipped city hospitals. The new rural cooperative medical care system reimburses hospitalisation expenses but not other costs. Nor does biomedicine draw on the help of family relationships. It expects the patient him/herself to be responsible in chronic sickness for such personal medical care as diet and exercise, with much of the technical competence (for example, in pursuing a prescribed regimen) transferred to both patient and family, except when undergoing surgery. In this way the patient consents to a passive role in treatment, as indicated by Cogswell and Weir (1964). Other therapies in Village CL fill this healthcare gap.

Traditional Chinese Medicine Recommendations Require Persistence

In attributing chronic sickness to damaged internal organs which must be restored, and to disorders of *qi*, blood, and *yin* and *yang*, traditional Chinese medicine is sometimes explained through the metaphor of boiling water, seen as 'treatment based on syndrome differentiation and holism' (Wang 2003, 88). Thus, to stop water from boiling, traditional Chinese medicine first asks why the water boils. The water boils

because the fire is too strong and so needs to be extinguished. Removing heat is not as fast as adding cold water, but fundamentally solves the problem of the water boiling. This slow but longer-lasting technique is analogous to traditional Chinese treatment of chronic illness.

Since Village CL is located in Inner Mongolia, traditional Mongolian medicine is available which, like Chinese therapy, treats the mental as well as physical state of the chronically sick patient. This is done through acupuncture, meridian analysis, moxibustion, herbs, diet, physical exercise, bloodletting, diagnosing problematic internal organs, and adjusting heat/cold and hyper/hypo-functional imbalances. The key aim is to unblock obstructed meridians, rebalance *yin* and *yang*, adjust *qi* (regulating 'blood') and eliminate pathogenic factors (Agoura 2007, 11). Mongolian medicine thus belongs to the Chinese tradition, having over time incorporated its essence and also that of Tibetan medicine. The holistic approach offers a communal and family-based perspective on care.

Case 2

Mrs Zhang is a 55 year old illiterate Han woman farmer, with most of her family also farm labourers. Her net income of RMB 60,000 is average for the village and is derived mainly from agriculture. Mrs Zhang has suffered cardio-cerebrovascular disease and hyperglycemia for 15 years. In 2015, she was hospitalised because of the pressure of a cervical vertebrae on a nerve. Though a member of the rural cooperative medical care system, her medical expenses were RMB 4000 more than she was reimbursed.

Her condition was first evident when, working in the fields, she experienced intermittent weakness and vertigo over two months which neither she nor her husband treated seriously. She continued working. However, one day Ms Zhang was immobilised by weakness and entire bodily pain. She first attended the town hospital where the doctor diagnosed cardio-cerebrovascular disease and suggested a week's hospitalisation during which, despite infusions and medication, the condition worsened. Ms Zhang therefore transferred herself to a city hospital practising traditional Mongolian medicine. During her 20-day hospitalisation, the doctor of traditional Chinese medicine gave her Mongolian therapy alongside biomedical treatment. The Mongolian medicines prescribed for Ms Zhang were unfamiliar to her, including some so bitter and spicy that she added honey. Feeling double the pain when taking the medicine, Ms Zhang wanted to give up but her doctor insisted on the medicine's efficacy and urged her to persist. The doctor also applied acupuncture and moxibustion daily to regulate the body's meridians, alleviate the discomfort caused by the heart and cerebral vessels, and prevent worsening of the condition that might cause difficulties for her mobility and even hemiplegia. On successive days acupuncture needles were placed head to foot over one side of her body and then the other. The doctor connected the acupoints with a pincer and energised them, causing, in her words, an unbearable combination of numbness, itching and pain, and testing her limits of endurance. Yet, the treatment

had a positive effect during the 20-day hospitalisation and she felt better, while referring to it as a 'near-death' experience.

At the time of her hospital discharge the doctor told her to avoid sugary, starchy and greasy food such as fish and meat and eat more roughage instead, lest her sickness be aggravated. She was also prescribed long-term physical exercise but to refrain from too much labour-intensive work. She was 'to fit work and rest to the laws of nature, keep her body coordinated, retain a happy mood, and not burden herself psychologically nor bottle up inside her anything unpleasant'. She was to tell others about her problems in time to get help and hospital medical treatment promptly if any discomfort occurred.

However, in following up later on her illness, it was evident that Ms Zhang had not continued her prescribed regime of exercise, diet and psychological self-care. Nor did people around her urge her to do so. She reported that she was less fit than before and weaker when working, suffering bad moods and discomfort.

Consistent with the holistic and dialogical nature of TCM, doctor and patient share in a broad, ongoing, negotiated assessment of the patient's condition taking account of social and personal as well as physiological symptoms. The doctor posits the cause of sickness, regulates the patient's meridians through the use of Mongolian acupuncture, moxibustion, *qi* and blood regulation, and prescribes Mongolian medicine. The patient is asked to readjust their daily life in order to restore the functions of internal organs. Although the therapy reportedly helps, patients experience difficulties following its recommendations. These include the bitter taste and difficulty in swallowing Mongolian medicine; acupuncture and moxibustion pain; and limited transportation between village and hospital. Crucially, unless the patient's family provide everyday support and encouragement, the doctor's recommended self-treatment is unlikely to be successful.

'Sickness and Sin' in Sanshu ('Three Expiations') Religion

Unduly prolonged and recurrent chronic sickness prompts some patients to doubt the efficacy of biomedicine or Chinese traditional medicine and so they may turn to folk-based therapies or to religion, including Christianity. For example, after unsuccessful biomedical and TCM treatment, three 'Three-High' patients chose Sanshu Christianity[3]. They also tried the more regionalised Zao Wang Ye, which advocates management of the family diet through belief in the Kitchen God.

Consideration is here confined to Sanshu Christianity, which states that 'sickness is a result of sin' arising from 'a violation of discipline', and will disappear if the sin is expiated,[4] for which belief and devout prayer are prerequisite, with harmonious family and community relationships also helping recovery. Sanbao Ji, the religion's founder, could allegedly 'cast out devils and heal the sick', and even 'make the blind see, the lame walk and the dead revive'. Believers thus concluded that taking medicine wasted money.

God's role is emphasised in the healing process which focuses on the testimony of believers who have recovered without taking medicine. When lengthy praying does not work, religious leaders tell the patient to 'dig out all the sins', public and private, from birth until the present. The sickness remains if sins are concealed. Religious leaders thus avoid personal responsibility if the patient is not healed.

Case 3

Mr Wang is a 66 year old Han of primary school education. He no longer farms. Mr Wang has been ill with cerebral thrombosis and hypertension for six years, and has recently often been hospitalised. His household income in 2015 of RMB 6000, is below the village average and derived mainly from his son who farms his land. While trying treatment through Sanshu Christianity, friends and relatives introduced him to a Sanshu Christian missionary (called 'deacon') who could reportedly 'cast out devils and heal the sick like Jesus'. Wang could be expiated and recover without medicine provided he believed in Sanshu Christianity, for which Wang and his wife had to study Sanshu Christian doctrine daily at a table bearing two lighted candles. They were also to kneel on the ground, with arms out-stretched in the shape of the cross, praying. The deacon stayed more than 20 days with Mr Wang, who did not improve. Doubting the treatment's efficacy and questioning the treatment, Wang was told by the deacon that it had not been long enough for God to have felt Wang's devotion and that more trust was needed for his health to improve. Wang's wife persuaded him to continue Sanshu Christian treatment despite his doubts.

One morning the deacon visited Wang at home as usual, but this time was accompanied by two other Sanshu deacons. They asked Wang and his wife to pray facing the table with lighted candles, while they themselves put their palms together devoutly to receive the will of God, each thereafter declaring God's will separately for Wang and his wife. The declaration was written on paper, but the couple could not read it. Instead, the deacons read the paper which was then burned, designed to make the declaration effective. The ceremony continued for an hour by which time the couple were very tired, finding the process strange and disturbing. Wang asked the deacons to stop. When they refused, Mr Wang flared up, yelling at the three deacons and his wife, who dared not say anything. The deacons tried to comfort Mr Wang, but he would not listen and ordered the men to leave. He told them that he no longer believed in Sanshu Christianity and that they were no longer welcome. They never returned and Mr Wang ceased believing in Sanshu Christianity and sought no other religious-based treatment.

Wang rejected the treatment, but many other cases endorse Hunter's claim (1993) that Christianity is spreading in rural China through its appeal to heal through God's help. Sanshu Christianity emphasises the similarity of the miraculous power of its founder Sanbao Ji to that exercised by Jesus. It thus belongs among emerging Chinese rural cults which practise beliefs and divine cure under the umbrella term of Christianity. Through conversion and salvation, Sanshu Christianity resolves

villagers' desperate dilemma of obtaining present and future treatment while lacking medical resources.

In connecting sickness and sin Sanshu is similar to mainstream rural Christianity, with sin resulting from a violation of religious discipline (original sin is not emphasised), and repentance the only means of restoring peace and cure.[5] The crucial difference between the two beliefs is that mainstream rural Christianity does not exclude biomedical treatment and allows believers to seek it, along with confessional prayer and expurgation. For its opposition to biomedical treatment, Sanshu Christianity has been banned by the Chinese government. In the above case, however, religion may have provided preliminary or supplementary comfort to biomedical treatment had it been allowed.

'Anger of the Kitchen God'

Folk treatment centres around people's belief in the Kitchen God, who is venerated by villagers on the twenty-third day of the twelfth lunar month every year when they pray for blessings and to avoid disasters—under the guidance and expertise of the feng shui master.

Patients seeking folk-based treatment usually turn to the village feng shui master. 60 years old, a graduate of a junior middle school and living in the village since childhood, he is familiar to the villagers. A feng shui master reportedly discovers his ability to contact gods from the age of 30, by 'feeling' the existence of a certain god and understanding its meaning. He tells villagers' fortunes and helps them solve problems, even contacting them by phone after he had migrated to the city.

Case 4

Mr Han, himself ethnic Han, is 41 years old, and a farmer with junior middle school education in a family of five. Han weighs 105 kg, and is medically obese. He has been ill with hypertension for 15 years and with hyperlipidemia for four years and was hospitalised in 2015. His medical expenses during treatment totalled RMB 20,000, not including expenses reimbursed by the rural cooperative medical care system. His net income was RMB 50,000 derived mainly from farming, which placed him in the middle-income bracket in the village.

While planting sunflowers in April, Han's eyes suddenly developed discomfort and blurred vision which lasted until evening, which he attributed to excessive internal body heat. Previously obtained medicine was ineffective. Being generally healthy, Han disregarded the symptoms. He was no better on the third morning and, as before, he and his family approached the feng shui master.

The feng shui master told Han that he had killed too many animals and had eaten too much meat without sacrificing to the Kitchen God, who in anger punished him. Han had to burn three joss sticks before his hearth at 7am, and kowtow (prostrate himself) three times. As homage he had to apologise and beg the Kitchen God's forgiveness for three days and reduce his meat consumption. With the Kitchen God's

forgiveness, Han's punishment and ailment (fundus hemorrhage) would end. Doubtful of a cure, but lacking other solutions, Han agreed to try. He meanwhile stopped taking any medicine and pinned his hope on the feng shui master's solution. But after three days his fundus hemorrhage worsened and he hurried to the town hospital for treatment. The doctor diagnosed hypertension as causing the fundus hemorrhage. Feeling cheated by the feng shui master, he sought biomedical treatment instead.

The folk and religious healing featuring in the cases of Wang and Han has been increasingly less sought in Chinese rural society since the May Fourth Movement of 1919, and especially since the Cultural Revolution. Such 'de-mystification' has percolated throughout Chinese society with the rise in popularity of ideas associated with science, progress and democracy. However, Village CL inhabitants still ask the feng shui master to help them choose auspicious wedding and funeral dates, and geomantic site selections for buildings, or to resolve inexplicable situations and phenomena. But, with regard to therapy, unsatisfied patients will abandon feng shui treatment and seek instead biomedicine with, however, an indirect benefit in the Kitchen God's attribution of sickness to excessive animal killing, which helps patients control their sickness through diet. Feng shui treatment is thus nowadays best regarded by villagers as good for addressing everyday uncertainties but not for bringing about physical cure.

The main social premise is to be seen to provide for one's family and to be useful persons and gain esteem in the village. Being capable of work is very important for 'Three-High' patients, however old. This premise determines how severe patients assess their sickness and how they reconcile medical treatment with continuing to work as best they can. If they can work hard and so feel good about themselves, they will stop taking medication. They return to medication if the sickness worsens and adversely affects their work, so perpetuating a vicious cycle, reflected in Higgins, Porter, and O'Halloran's (2014, 53) assertion that, 'Parsons observed that the defence against the threat posed to society by the dysfunction deviance of illness was to be found in the social norms that governed the appropriate roles for those who were ill'.

The Dominance of Biomedicine and the Decline of Other Methods of Diagnosis and Treatment: People with 'Three-High' Seeking Therapy in CL Village

In summary, biomedicine has become the primary choice for villagers seeking healthcare in view of its convenience. Its primacy began in the era of the 'barefoot doctor' in the 1950s and 1960s and continues in the current period of the new, rural cooperative medical care system. In Village CL in 1960 a 'barefoot doctor' combined Chinese and biomedical methods, replacing the folk therapy of then-called 'witches' and 'witchcraft-based treatment'. Until the 1980s villagers sought treatment from this doctor or from Chinese medicine in town, attending hospitals only when seriously sick. Since the 1980s, and especially since 2006 when CL village set up the new rural cooperative medical care system, villagers have increasingly chosen biomedicine for

diagnosis and treatment. For 'small sickness' such as headaches and colds, they use the town drug store, and for more serious ailments, including shock and coma, they go to the town hospital for tests, only attending a city and county hospital for extreme sickness or when previous treatment has failed. Currently, none of the city and county Chinese and Mongolian hospitals nearest to Village CL match the reputation of biomedicine among villagers and it is only in the face of chronic and seemingly incurable sickness that villagers seek treatment through religion or folk beliefs and practices. With the popularity of the rural cooperative medical system, biomedicine has thus become dominant, overwhelming the 'voice' of other methods of diagnosis and treatment. This can be verified by existing studies (Wei et al. 2013). Instead of these different methods being harnessed and coordinated as local knowledge and information of benefit to patients, they are marginalised by the aspiration for biomedicine. Yet such aspiration often falls short in practice. Medical technology in township and county hospitals is in reality inadequate, especially for treating the 'new' chronic diseases. Sufferers, in vain, seek biomedical help while unable to assume a socially acceptable sick role. Their predicament not only reflects the shortage of rural medical resources, but also the problems faced by rural institutional development which fails to foster family and community as integral and informed elements of social and health welfare. In the absence of such welfare, patients are left to cope with difficulties of access, information and communication.

Alongside the inadequacy of the rural cooperative medical care system, a survey by our team revealed that villagers are unaware of how and which medical expenses can be reimbursed, and that there is a cap on reimbursement. Nor do they understand why 'unspent money' (as they see it) in one year, cannot be transferred to the next or refunded, why there should be a deductible sum on reimbursement, amounting to RMB 90 in 2015, or why travel expenses to hospital are not covered.

The latter constitutes the second major need for improvement. Not only does the new rural cooperative medical care system not cover the full reimbursement of chronic diseases involving hospitalisation, it also fails to meet the cost of daily medicine which, for chronic patients, may be lifelong. It becomes especially difficult when chronic patients beyond 60 years of age, are unable to keep working and then need to rely on their children, pension or land contract income.

A third need for improvement is the complicated application procedure for reimbursement. While diagnosed serious sicknesses of pulmonary heart disease, high blood sugar and high blood pressure are covered for some reimbursement, villagers delaying diagnoses may miss the point at which they are entitled to claim, which can only be at a hospital at county level or above. They may also be unaware of the fact that the deductible sum of outpatient expense is significantly higher than the payment standard of township health institutions. Moreover they do not know which hospital-issued receipts to keep for the purpose of reimbursement without anyone guiding them.

Conclusion

The Parsonian view of the sick role is that it will never be completely relinquished but will become transformed, and that periods of sickness and living with the problems of impaired functioning will become permanent features of self and of a publicly defined identity. Thus, the nature of the chronic illness and its bodily consequences have to be incorporated permanently into conceptions of self and are likely to become a basis for the imputation of identity by others (Kelly and Field 1996, 250).

Burnham (2012) concludes that the sick role persists as an enabling concept, since it is a reminder that the way any society constructs social responses to illness and disability 'tellingly reveals the fundamental processes at work in that society' (15). Further, as expressed by Hal et al. (2013, 14), 'Parsons' modernist thought of either "being ill" or "being at work" is very much present in this practical logic'. This is also true in rural China. For chronic patients in CL Village, insofar as they feel able to control their bodies for farming and housework and pay medical expenses, here too there need be no conflict between their personal selves and their publicly defined identities. However, once patients find that they cannot control their own bodies and cannot work, they encounter a panic of identity crisis and selfhood. This is reinforced when families no longer care for the patient (especially with more and more young men moving to cities for employment, and leaving old people behind) and farm work is not done, so subverting rural community integration. Building on Durkheim's investigation of suicide, many studies have focused on how a person's health may be affected by the extent to which their roles are ambiguous and (un)integrated (Stewart and Sullivan 1982). For China, Wu (2010) further documents the crucial significance for such community integration of family relationships by analysing the incidence of rural, mainly female, suicide. Chronic sickness may not normally lead to suicide but, without family support in China, it still precludes communal role integration.

Despite literature on chronic illness behaviour in Western societies (Cook, Fine, and House 1995; Pierret 2003), little attention has been paid to this subject in rural China where, as in CL Village, patients cannot integrate their role as a sick person in their social role, even though the harmonious co-existence of these two roles would benefit patients' rehabilitation. How might this be done?

While overshadowed by biomedical discourse, the various traditional Chinese medical, religious and folk treatment methods have advantages as well as disadvantages. Their advantage is in making possible a wider treatment of chronic sickness by reaffirming supportive communal and family ties, such as once operated in villages. This coordinated local knowledge would build on the holistic tradition in Chinese therapies, which, ideally at least and to some extent in practice, values harmony between a patient's lifestyle and their place in nature, family and community, and is intentionally prolonged in its treatment. It contrasts with biomedicine's swift efficacy and intermittent curative bouts, its reluctance to go beyond treatment of the damaged organ and its symptoms and its focus on the individual patient without much regard

for their family network and emotional environment. Religious therapy is closer to Chinese medicine than biomedicine, but exists alongside and to some extent between them. It stresses the relationship between sickness and purported sin. It sees the 'Three-high' chronic afflictions as deriving from violations of individual morality and of the 'peace' of the community and of individuals' bodies and minds. Religious therapy aims to reverse these effects and to reincorporate patients' 'deviant behaviour' within normal life. As an example, by attributing sickness to offenses against gods, such as the Kitchen God, who punish excessive killing of animals, folk beliefs indirectly encourage patient improvement through diet control. Coordinating the variety of healthcare possibilities with a view to improving the conditions and status of medical services for Chinese rural chronic disease patients is a project worth further study.

In basing his theory on Western urban living and experience, Parsons posits two rights and two duties for the sick patient: (1) the right of the patient to be exempt from individual responsibility for the incapacity (that is, s/he is not to be blamed for it);[6] (2) the right of the patient to be exempt from normal social responsibility (that is, not to be expected to perform tasks to the full) and yet continue to keep their positions and be paid; (3) the duty of the patient to recognise that illness is inherently undesirable and to try to get well; and (4) the duty of the patient, therefore, to learn to recognise his/her sickness in good time, to seek technically competent help and to cooperate in the process of trying to get well.

However, as noted by Kassebaum and Baumann (1965, 18), the medical distinction between sick and able-bodied becomes irrelevant when there is no choice but to continue carrying out daily work and tasks. This situation especially applies to patients with chronic illness in China's rural areas. First, the identification of chronic illness is a problem. Of those 'Three-High' patients (patients with hypertension, hyperglycemia and hyperlipidemia) in Village CL, most did not seek biomedical treatment until vertigo, collapse or shock occurred, sometimes after unsatisfactory attempts at alternative therapies. Once identified biomedically, it was found that the patients had been sick for years, underwritten by the moral premise that 'Whoever cannot endure the pain is not a good farmer'. Second, it matters little to villagers whether they are defined as suffering acute or chronic sickness, given that they themselves have to take on the social responsibility for its consequences. Most of China's rural residents subsist by their own independent resources, and so their sickness endangers the livelihood of the whole family. They will not receive compensation for income lost through not working and so must continue to provide for the whole family. They cannot therefore be exempted from 'social responsibility' to use Parsons's concept, either as individuals or as members of a community (Butler 1970, 242).

Not being granted such exemption, the most that patients afflicted by 'Three- High' sickness can do is constantly adjust their so-called 'deviant behaviour', as Parsons calls it, and try to continue performing their many social roles (Radley 1989). They develop strategies to reconcile their sick and social roles (Locker and Kaufert 1988), maintaining meaningful continuity by redefining and renegotiating their individual and public

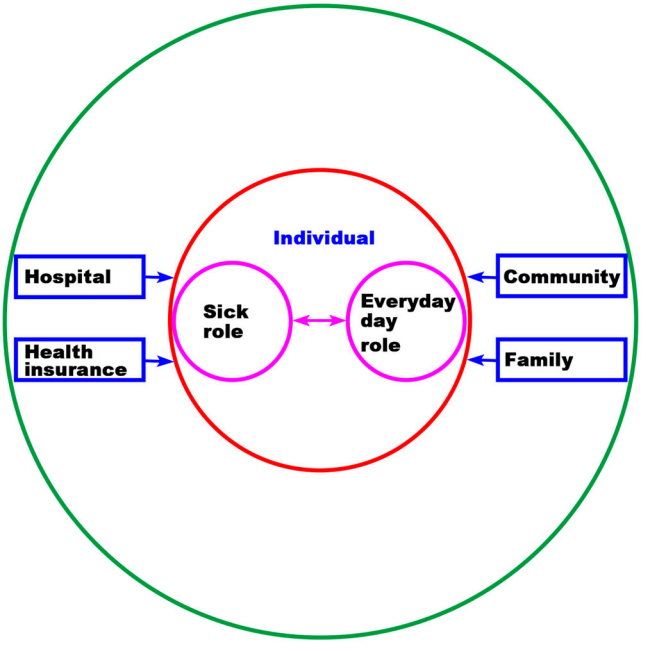

Figure 1 Integration of the Sick Role

identities (Mathieson and Stam 1995). As Shilling (2002, 627) points out, 'the productivity ethos so central for Parsons is still behind much of contemporary health-seeking', including nowadays that of chronically ill patients in rural China. Scott (2006) however identifies 'moral economy' or 'livelihood ethics' as an alternative tradition in which the social norms of peasant community are reciprocal, rather than those of individual profit maximisation, and which can therefore ameliorate the condition of chronic patients in rural areas. This holistic perspective can then be applied to the sick role of patients in rural China, but is lacking in Parsons' sick role theory.

In seeking such holistic continuity and 'social reintegration', chronic sufferers do need the economic and emotional help of families and community (Bartmann et al. 2008, 7), sometimes via religious and folk beliefs, as well as access to adequate biomedical and other therapeutic resources and equipment, a process illustrated in Figure 1. That is to say, based on Parson's functionalist perspective, we advocate that a patient's sick role should be integrated within their lifestyle and everyday social roles, which can be adapted to the distinctive circumstances of rural China in attempts to enhance the quality of life of 'Three-High' sufferers.

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Notes

[1] All research activities were conducted in line with generally accepted ethical principles and approved by the ethics committees of China Agricultural University: all participants read a statement that explained the purpose of the survey and gave written informed content before participation in the study and none of the personal information of these medical staff involved in the survey is available to people outside of the study team.

[2] Also called 'delaying the ailment and enduring serious illness' after a period of not going to hospital because of the (unaffordably) high cost.

[3] Mainly found in the rural north, it is also called 'Mentuhui' (Disciples of Christ) or 'Erliangliang', and was established by a farmer, SanbaoJi, in Yaoxian County in Shanxi province in the late 1980s.

[4] Sanshu Christianity promotes 'Ten Commandments': worship God; revere immortals; do not burn joss sticks or kowtow; observe the Sabbath; do not hate, kill, beat or curse others; be filial to parents; abstain from lust; abstain from stealing; distinguish between true and false; do not be greedy for money, and 'Six Principles': endurance, harmony, good temper, good attitude, love for others, filial piety for parents at home.

[5] For more about how rural Christianity views illness and seeks efficacious medical treatment, see Zheng, Wang, and Wang (2015)

[6] Parsons (1975) sees sickness as impairment of the sick person's integration into robust relationships with others in the context of the family, workplace, and other settings. From this perspective, therapy is interpreted as mainly a reintegrative process.

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