

John B. Grant and Public Health in China

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One day in the summer of 2005, I was searching books on the subject of public health at the National Library in Beijing. The only author who popped up on the computer screen was John B. Grant. I was disappointed to find that few American libraries contain Grant's writings on public health. Grant was an internationally active leader of public health in the mid-20th-century. His contribution to global public health work, however, was shaped by his early career of experimental accomplishments in China in the 1920s-1930s. In light of current debate on efficient delivery of health care, recent scholarship demonstrates the valuable relevance of Grant's ideas to present public health issues and concerns.¹

My recent research at the Rockefeller Archive Center (RAC) examined three interrelated aspects of Grant's work that had long-term implications for China's public health profession and health care system. First, the development of a department of public health at Peking Union Medical College (PUMC) to train public health professionals; second, the creation of health stations in rural and urban settings as experiments of pilot projects to study health conditions and deliver health services; and third, assisting the Chinese government in establishing a modern national health administration with state medicine. Each of these three aspects seemed a necessary step leading to the building of a national health edifice, but this neat historical hindsight should not be taken to indicate that Grant started with a blueprint in hand, for an

examination of Grant's work revealed an evolving process where persistence and tactic persuasion were mixed with shrewd observation and sensitive negotiation in a tumultuous time of highly nationalist aspirations. Nonetheless, the Rockefeller Foundation's (RF) original plan for Grant's mission in China undoubtedly set the path for the development.

Grant's Mission in China and His Views of Public Health

Grant arrived in China in 1921 with three major responsibilities assigned by the RF.² First, to develop a curriculum of hygiene and preventive medicine for teaching purposes; second, to establish an intramural "College Health Service" for the PUMC staff, which hopefully was to extend as a model to schools and colleges in China; and third, most important of all, was to "ascertain ... the possibility of initiating public health activities in the country, which would be of a permanent and progressive character, aiding the quicker establishment of a national public health movement."³

Grant believed that public health was an integral part of the socioeconomic development of a society and that health care could be most efficiently achieved through an integration of preventive and curative medicine in a community health service. This kind of view was not typical among the medical and health professionals in the United States, but more in line with British health reformers who advocated social medicine and state responsibilities for public health. Grant received his medical education at the University of Michigan and continued his public health studies at The Johns Hopkins University, where he met and studied with the British public health reformer Arthur Newsholme. Instrumental in the public health movement that led to the establishment of the Ministry of Health in Britain in 1919, Newsholme emphasized state responsibilities for public health.⁴ Grant was also influenced by the British public health physician George Newman, who published widely on the social problems of public health and

emphasized the importance of preventive medicine.⁵ Grant cited Newsholme and Newman frequently to support his idea of a combined preventive and curative medicine when he presented his proposal for a department of public health to the China Medical Board (CMB) of the RF in 1923.

Grant's belief in social medicine and state responsibility for public health may very well have been reinforced by his early working experiences in rural North Carolina and in the coal mines of central China, where he had first-hand observations of the social causation of epidemic diseases.⁶ If the North Carolina field-work taught him the frustration and ineffectiveness of disease control with the separation of preventive and curative medicines, the Chinese field-work in the coal mines made him realize the crippling prospect of public health work when industrial leaders and government officials paid no attention to health issues of the workers. These and later experiences in China convinced Grant of the necessity of state responsibility to take care of the health of the people. In designing a Department of Hygiene and Public Health at PUMC, Grant drew lessons from his field work and adopted an innovative approach to public health education where integration of preventive and curative medicine was emphasized.⁷ Grant would later apply his success in China to public health programs in other places such as India, Europe and Puerto Rico.

Creating the Department of Public Health and Training Public Health Professionals

In October 1923, Grant sent the CMB in New York an eighty page proposal for a Department of Hygiene with a demonstration health station. In the proposal, Grant was critical of the separation of curative and preventive medicine and was determined to avoid it in his development of a curriculum of public health at PUMC. Grant believed that "any artificial separation of curative and preventive medicine is detrimental to the efficiency of both" and that

the “medicine of the future” required the “establishment of this combined curative and preventive medicine in a community in ... a real ‘health station.’”⁸ By the same token, the training of public health professionals should be deeply rooted in a community where preventive and curative medicines were integrated in practice.

Grant envisioned that the future of medicine lay in the general medical practitioner as nucleus working with hygiene specialists in a community.⁹ There was, however, no available example of such integrated model of curative and preventive medical education or practice. Grant therefore had to experiment with his own vision of a health demonstration station. In so doing, he moved away from the primarily “laboratory-based” model of public health education that W.H. Welch—known as the “dean of American medicine”—created at The Johns Hopkins University, and set a “community-based” model of public health education where students directly engaged in studying public health problems on a daily routine in the real world.

This bold departure from the exalted Johns Hopkins’ model was a manifestation of Grant’s independent orientation rooted in the belief of medical efficiency. Grant conducted a wide range of research about the different models of public health education in dozens of countries in Europe and around the world. Moreover, he gathered information on the experimental health stations/units being built at the time by the international health officers of the RF in different parts of the world. Correspondence between Grant and RF officers indicated the sharing of this type of information. Additionally, Grant’s familiarity with malaria stations in the American South and hookworm programs in China, no doubt, helped inform his design of a health station that would include medical services, disease prevention, and vital statistics collections.¹⁰

The station, named the Public Health Experimental Station of the Metropolitan Police Department of Beijing [京师警察厅试办公共卫生事务所], was in reality a collaborative endeavor of the PUMC, the Central Epidemic Prevention Bureau, and the Beijing Metropolitan Police.¹¹ The station constituted “the practice, investigation and most of the teaching fields for the work of Hygiene [Department].”¹² In 1928, all medical students at PUMC were required to take a three-week internship at the station in their fourth year. In the 1930-1931 academic year, a total of sixty-four medical students received public health training at the station varying from three months to a year.¹³

Spreading Health Stations and Building National Health Administration

The work of the Beijing health station not only inspired Chinese doctors like Yan Fuqing, but also boosted Grant’s confidence in expanding the experiment to other urban and rural areas. Yan Fuqing and his colleagues at the Department of Public Health of Shanghai Medical College (SMC) established the Wusong Health Demonstration Station in July 1928, which was clearly modeled after the Beijing health station. Several prominent doctors of strong public health advocacy were on the faculty of SMC, including Hu Xuanming, Huang Zifang, and Zhang Wei. Xuanming was in charge of the Wusong demonstration station, where all medical students of SMC were required to intern for a month. Their internship included conducting public health education, clinical treatment with disease prevention, sanitation, maternal health, and dental hygiene.

Although Wusong was the first rural health demonstration station in China, it was rarely recognized as such, but categorized as one of the first three rural health stations established in 1929, the other two being Dingxian near Beijing and Gaoqiao of Shanghai.¹⁴ The Dingxian

health station, which was integrated into the Mass Education Movement led by Yan Yangchu (James Yen), was initiated by Grant, but was operated and led by C.C. Chen. Its inception demonstrated the shift of Grant's view on rural health demonstration in China. Back in 1923, Grant thought rural public health in China "entirely impracticable at this moment."¹⁵ But by 1927 he was seriously working to extend health stations to rural and urban locations as pilot experiments to achieve two major goals, i.e. the study of local health conditions and the delivery of health care services to local people. Since the extraordinary achievements of the Dingxian experience have been well studied by scholars,¹⁶ I will briefly explain the Gaoqiao experience here.

The Gaoqiao health station started as a collaborative project between the RF (IHD demonstrations) and the Health Bureau of Greater Shanghai. Additionally, the collaboration included a school demonstration station as well. Gaoqiao was a better than average Chinese rural area, having various small businesses and merchants and a forty percent literacy rate (cf. China's literacy rate was less than ten percent at the time). Sitting on the east bank of the Huang Pu and the south bank of the Yangtse and twelve miles from the city center, the area contained about two hundred villages and a town with a population of 33,959. Medical services were the main activities of the Gaoqiao station, although it followed the model of the Beijing health station in conducting vital statistics collection, prevention of communicable diseases, and popular health education.

The first quarterly report showed the working hours of the station each day: 8:00 a.m.-10:00 a.m. surgical clinic, 10:00 a.m.-12:00 p.m. medical clinic, and 2:00 p.m.-4:00 p.m. gynecological obstetrical and pediatric clinic. A total number of 1,281 patients were treated for medical services, out of a population of 34,000. The report indicated a lack of interest among the

locals in the medical services and health demonstration.¹⁷ Observations showed that gastrointestinal diseases, malaria, rabies, tuberculosis, syphilis, smallpox, leprosy, puerperal sepsis, and infections in newborns were prevalent.¹⁸

As Gaoqiao was relatively large and travel was not easy for locals (not much interest as well), the station developed a Traveling Clinic, which was conducted under the subdivision of Infectious Disease Control. “The main idea for having this clinic was to give smallpox vaccination to those villagers of the district, who for various reasons, were not able to attend the health center clinic. It consisted of two wheel-barrows, carrying a staff of three—a doctor, a public health nurse, and a sanitary policeman. It was equipped with a bag containing vaccines, knives, antiseptics, other necessary medical supplies, and health pamphlets.” In 1929, the traveling clinic made fourteen trips and vaccinated six hundred thirty-four individuals.¹⁹ The sixth quarterly report did not show much progress with total vital statistics of birth [58/34/92 (male/female/total)] and death [43/38/81(male/female/total)] collected. Medical services (patients seen from September-December 1930) included medical 532, surgical 1758, pediatrics 81, and gynecological and obstetrical 67.²⁰ These statistics indicate the limited and ineffective work of the health station in delivering medical services and collecting data.

In 1934, two important reports of surveys were published, one on rural public health practice and the other on urban public health practice.²¹ The rural health report indicated that seventeen health stations/centers were established in rural coastal provinces during 1929 through 1934. The urban health surveys covered nineteen cities during 1924 through 1931 in eight provinces. How did the health practices of these stations/centers impact local population? As far as the rural stations were concerned, the work was limited.

“All of them undertake curative work; next to curative work in importance is the control of communicable diseases, which has frequently been the cause for the establishment of

the center. The less frequent activities are public health publicity, school health, maternity and child health, sanitation and treatment of opium addicts. Industrial health and vital statistics are very minor activities in all of the centers. Seven centers are reported to serve as training centers for public health officers or medical students, or both.”²²

The urban health practice bore similar features of the rural health practice in many aspects, but the report detailed the leading causes of morbidity and mortality such as gastrointestinal diseases, tuberculosis, malaria, tetanus, which were all controllable diseases. However, none of the surveyed cities took

“systematic steps for their control ... Only 5 out of the 19 cities have attempted to give free smallpox vaccination. Cholera vaccination was not extensively practiced.... Immunization against diphtheria and scarlet fever was not mentioned. No measure was described for the control of venereal diseases or tuberculosis.... no facilities for obstetrical service and child health work. Poverty has always served as an excuse for failure to adopt public health measures in Chinese cities.”²³

However, the authors of the surveys did not agree with local claims. They felt that the “chief requirement for the establishment of modern health administration appears to be competent technical personnel rather than finance.”²⁴

From Public Health to State Medicine: National Health Policy

The almost negligible impact of health stations on improving people’s health posed a serious question of what kind of health system China should have in order to effectively protect its entire population. As aforementioned, Grant was much influenced by the British public health philosophy and practice that took shape since the mid-19th century. In a pamphlet on public health for Chinese officials, Grant pointed out: “Gladstone, the great English statesman, is responsible for the statement that ‘the first duty of government is a safeguarding of the health of its citizens.’ A study of the present important position of public health in any efficient government of the leading nations of the world shows an appreciation of this statement.”²⁵ In

discussing public health, Grant emphasized the obvious importance of rural public health to a large agricultural country like China. Looking at what was being done in similar agricultural countries such as Russia and India, Grant felt the urgent need for China to pay considerable attention in this respect.²⁶

How would China be able to take care of the health of its vast population? Looking at the health practices across the world, Grant summarized two types of medical systems—private-run and government-run. Citing different countries such as England, Russia and Australia, he pointed out that most western nations had developed a health system along the lines of partially governmental and partially private. Given China’s particular conditions, such as a large population, low-level socioeconomic development, and limited medical personnel and facilities, Grant believed the logical policy for China was state medicine.²⁷ The reason being that under private medicine there would be “a haphazard and inefficient distribution of curative facilities” with two outstanding deficiencies: rural areas would be insufficiently served while in urban cities some districts would have an *unjustified* concentration of hospitals with duplication of expensive equipment, causing the disadvantage of other districts being inadequately served. Moreover, under a private medical system there would be “an unequal availability to each class of population of medical science. The rich will command the best of medical service, the poor will have it made available through charity clinics and the large middle class will be unable to afford either.” In light of this analysis, Grant thought that state medicine—the entirely governmental responsibility for medical service for all people—was suitable for China, because state medicine “would make certain outstanding benefits compulsory” and “ensure an adequate position for Hygiene in General Education.”²⁸

How to implement state medicine? In Grant's opinion, the first step was to secure efficient personnel. "Such personnel should equal in training and administrative ability the best medical men in the world." It was imperative that "political leaders appreciate that medical affairs are non-partisan and scientific in nature ... that personnel was chosen on merit alone." Second, "most important would be the establishment of a centralized medical authority with power to execute the adopted policy on a nation-wide scale."²⁹ Grant made the argument for state medicine on January 27, 1928, at the annual conference of the Chinese National Medical Association, and he published his paper a month later in the medical journal of the Association.

Grant's call for state medicine set in motion an extensive debate about state medicine in China in the next two decades. Many Chinese medical leaders supported state medicine, but they seemed to understand the concept differently. Some focused on the health service to all—rich or poor, rural or urban; while others emphasized the importance of a centralized health system. Xi Gao's examination of the state medicine debate indicated that the connotations of state medicine shifted from the original "health service for all" to a bureaucratic sense of "centralized medical system" when Chinese health professionals searched for the delivery of state medicine.³⁰ The original meanings of state medicine in Grant's definition actually contained both the service for all and the establishment of a national health administrative system as two sides of a coin.

Long-Term Implications: State Medicine and Prevention First Policy

In the early 1950s, the Chinese government defined its national health policy in these four key elements: prevention first, combining Chinese and western medicine, serving the people, and combining health and mass movements. In the cold war environment, John B. Grant could not possibly have had any influence in socialist China's state medicine. Nevertheless, his

idea of a combined practice of curative and preventive medicine in a community as the effective means to protect people's health and his concept of state medicine were practiced in different forms under the guidance of a distinct socialist ideology. Many of Grant's colleagues and students, such as Li Dequan, Chen Zhiqian, Yan Fuqing, Jin Baoshan, and Yang Chongrui stayed in mainland China and held key positions in medical institutions as technical experts. Li Dequan, for instance, served as the Minister of Health of the People's Republic of China. These people were all strong advocates of state medicine and public health. It was through this professional continuity that the concepts and methods Grant used with his Chinese colleagues went on to gain new lives in the new social and political environment.

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The ideas and opinions expressed in this report are those of the author and are not intended to represent the Rockefeller Archive Center.

ENDNOTES:

¹ Socrates Litsios, “John Black Grant: A 20th-Century Public Health Giant,” *Perspectives in Biology and Medicine* 54: 4 (Autumn 2011), pp. 532-49; and Liping Bu, “Beijing First Health Station: Innovative Public Health Education and Influence on China’s Health Profession.” In Liping Bu, Darwin Stapleton, and Ka-che Yip, editors, *Science, Public Health and the State in Modern Asia*, editors, London, England and New York: Routledge, 2012; and Liping Bu, “From Public Health to State Medicine: John B. Grant and China’s Health Profession.” *Harvard Asia Quarterly* 14: 4 (December 2012), pp. 26-35.

² Grant was appointed as Associate Professor in Pathology in 1921 when he arrived in China, and he was appointed Professor and Head of the Department of Hygiene and Public Health in 1924, when he created the department at Peking Union Medical College (PUMC). See letter to Russell from W.S. Carter, December 14, 1925, Folder 528, Box 75, RG IV 2B9, CMB Inc., Rockefeller Archive Center (RAC).

³ Memo, “The Purpose of the Founding of the Chair of Hygiene.” September 26, 1921, Folder 525, Box 75, Series 2B9, RG IV, CMB Inc., RAC.

⁴ On Arthur Newsholme, see John M. Eyler, *Sir Arthur Newsholme and State Medicine, 1889-1935*. UK: Cambridge University Press, 1997.

⁵ Conrad Seipp, “Introduction,” in *Health Care for the Community: Selected Papers of Dr. John B. Grant*. (Baltimore, Maryland: Johns Hopkins University Press, 1963, pp. xiii-xiv.

⁶ Biographical files of John B. Grant, RF. RAC. For Grant’s field work in the American South and in the Pingxiang mines in China, see Mary Bullock, *The American Transplant: The Rockefeller Foundation and Peking Union Medical College*. Berkeley: University of California Press, 1980, pp. 135-138.

⁷ The name of the department was changed to Department of Public Health and Preventive Medicine, and then to Department of Public Health.

⁸ John B. Grant, “A Proposal for a Department of Hygiene for Peking Union Medical College,” 1923, p. 42, Folder 531, Box 75, Series 2B9, RG IV, CMB Inc., RAC.

⁹ *Ibid.*, p. 26. It was ironic that preventive and curative medicine completely diverged in the West, while in China the government made prevention the first priority of medical policy in the 1950s-1980s.

¹⁰ For details, see L. Bu, “Beijing First Health Station: Innovative Public Health Education and Influence on China’s Health Profession.” In Liping Bu, Darwin Stapleton, and Ka-che Yip, editors, *Science, Public Health and the State in Modern Asia*. London, England and New York: Routledge, 2012.

¹¹ The health station was originally called Public Health Experimental Station, Metropolitan Police Department, Peking [京师警察厅试办公共卫生事务所]. After it showed some satisfactory results, the word “experimental” was dropped in 1926 and the station was called Public Health Station, Metropolitan Police Department, Peking [京师警察厅公共卫生事务所]. Then in 1928, as the city’s name was changed to Beijing, with the re-organization of city districts, the station’s name was changed to Health Station of the First Health Area, Special Municipality of Beijing [北平特别市第一卫生区事务所]. In 1930, in order to reduce municipal expenditure, the Municipal Department of Public Health was merged with the Police Department and the station became Health Station, First Health Area, Department of Public Safety, Beijing [北平市公安局第一区卫生事务所]. (Ting-an Li, Director, “The Health Station of the First Health Area, Beijing,” 1930, pp. 2-5, Folder 366, Box 44, Series 601, RG 1, RF, RAC.

¹² Grant, November 2, 1928, 1, attached to his 3rd annual report on the Health Station, Folder 2736, Box 219, Series 3, RG 5, RF, RAC.

¹³ Ting-an Li, “The Sixth Annual Report of the Health Station,” submitted to John B. Grant, August 15, 1931, p. 5, Folder 2739, Box 219, Series 3, RG 5, RF, RAC.

¹⁴ T.A. Li, “Summary Report on Rural Public Health Practice in China,” *Chinese Medical Journal* 48 (October 1934), pp. 1086-1090.

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- ¹⁵ Grant, "A Proposal for a Department of Hygiene for Peking Union Medical College," p. 30.
- ¹⁶ Sidney D. Gamble, *Ting Hsien: A North China Rural Community*. Pala Alto, California: Stanford University Press, 1968; Charles W. Hayford, *To the People: James Yen and Village China*. New York: Columbia University Press, 1990; Mary Bullock, *An American Transplant*, chapter 7; and C.C. Chen, *Medicine in Rural China: A Personal Account*. Berkeley: University of California Press, 1989, chapter 3.
- ¹⁷ "First Quarterly Report Ending September 30, 1929, Rural Health Demonstration, Kao-Chiao," p. 19.
- ¹⁸ *Ibid.*, 7.
- ¹⁹ "Traveling Clinic of Kao-Chiao," Folder 2742, Box 220, Series 3, RG 5, RF, with pictures attached.
- ²⁰ "Sixth Quarterly Report Ending December 31, 1930, Kao Chiao Rural Health Demonstration Station, Bureau of Public Health, City Government of Greater Shanghai," Folder 2743, Box 220, Series 3, RG 5, RF.
- ²¹ T.A. Li, "Summary Report on Rural Public Health Practice in China," and J.B. Grant and T.M. Peng, "Survey of Urban Public Health Practice in China," *The Chinese Medical Journal* 48 (October 1934), pp. 1074-1079.
- ²² T.A. Li, "Summary Report on Rural Public Health Practice in China," p. 1090.
- ²³ J.B. Grant and T.M. Peng, "Survey of Urban Public Health Practice in China," pp. 1075-1078.
- ²⁴ *Ibid.*, 1078.
- ²⁵ "Public Health in Peking," p. 2, attachment in J.B. Grant, "Plans for Public Health Work in China 1925," Folder 532, Box 76, RG IV 2B9, CMB Inc. Chinese medical scientists (e.g. Jing Baoshan, Huang Zifang) frequently cited this alleged Gladstone statement in their advocacy of public health in publications.
- ²⁶ "Rural Public Health," p. 1, attachment in J.B. Grant, "Plans for Public Health Work in China 1925."
- ²⁷ John B. Grant, "State Medicine: A Logical Policy for China," *National Medical Journal of China*, 14 (February 1928), pp. 65-80.
- ²⁸ Grant, "State Medicine," pp. 76-78.
- ²⁹ Grant, "State Medicine," p. 79.
- ³⁰ Xi Gao, "Between the State and the Private Sphere: The Chinese State Medicine Movement, 1930-1949." In Liping Bu, Darwin Stapleton, and Ka-che Yip, editors, *Science, Public Health and the State in Modern Asia*. London, England and New York: Routledge, 2012.