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Introduction

Sam Willner

This volume contains four articles representing very different approaches and perspectives in the history of public health, illustrating the richness and great variety of the research field. We would like to express our sincere thanks to the authors contributing to an interesting volume of *Hygiea*.

Kari Tove Elvbakken and *Kari Ludvigsen* present a case study from Norway 1800-1940 discussing the relations between the medical profession and the state health authorities with regard to the development in hygiene and psychiatry, and how these two medical fields contributed to the professionalization of medicine and health administration.

Alberto Tanturri discusses how the efforts to engage the clergy in smallpox vaccination in Southern Italy in early Nineteenth Century often were met by skepticism and distrust by the parish priests. Tanturri's text could be extra interesting from a contemporary Swedish perspective, where the parish priests of the Lutheran state church were the major agents in the extensive smallpox vaccination program.

Jiong Tu presents the current Chinese health care insurance reform, and discusses how it serves as a mechanism of state control and governance and produces inequality by excluding large groups of citizens, such as the rural-to-urban migrant workers. These effects are interestingly illuminated by the presentation of some individual cases.

Finally *Michelle Monachino* and *Paulo Moreira* discusses the actual and potential contribution of the private business sector to national and international mental health promotion and governance through a new approach to Corporate Social Responsibility (CSR), by presenting a case study from the pharmaceutical industry.

Medical professional practices, university disciplines and the state

A case study from Norwegian hygiene and psychiatry 1800–1940

Kari Tove Elvbakken and Kari Ludvigsen

Introduction

In this article, we will explore the development of the hygiene and psychiatry disciplines within medicine and the changing relations between these fields of professional practice, university medicine and the state health authorities. We concentrate on the period from the early 1800s to the Second World War and address the following questions: What were the relations between actors in public health and mental asylums, the medical disciplines of hygiene and psychiatry, and the health authorities? How did the fields of hygiene and psychiatry contribute to the professionalization of medicine and to the emerging health administration, using Norway as a case?

The role of medicine in the processes of modernization and state building during the 1800s has been widely discussed.¹ Historical-sociological perspectives have inspired studies of the relations between professionalization and the European state-building processes² and analyses of medical professionalization in Norway add to this literature.³ The political scientist Vibeke Erichsen introduced the term profession

1 Alain Desrosières: “How to make things which hold together: social science, statistics and the state”, in P. Wagner, B. Wittrock and R. Whitley (eds), *Discourses on Society: vol. XV*, (Dordrecht, 1990); Michael Foucault: “About the Concept of the ‘Dangerous Individual’ in 19th Century Legal Psychiatry”, *International Journal of Law and Psychiatry*, (1978),1, 1–18

2 Andrew Abbott: *The System of Professions, An Essay on the Division of Expert Labour*, (Chicago, 1988); Michael Burrage, Konrad Jarausch and Hannes Siegrist (1990): “An actor-based framework for the study of the professions”, in Burrage, M and R. Torstendahl (eds.): *Professions in Theory and History, rethinking the study of the professions*, (London, 1980); Terry Johnson: “Governmentality and the institutionalization of expertise”, in T Johnson, G. Larkin and M. Saks (eds): *Health Professions and the State in Europe*, (London 1995), 7–24.

3 Jan Froestad: *Faglige diskurser, intersektorielle premisstrømmer og variasjoner i offentlig politikk. Døveundervisning og handikapomsorg i Skandinavia på 1800-tallet*, Dr.polit thesis,

state to label Norwegian development after 1945, during which there was a close integration of medical expertise into a health sector dominated by institutionally isolated policy definition.⁴ She argues that this development must be understood in light of the 19th century processes by which medicine became integrated into the state at all levels and how the profession achieved important roles in health policy. Ole Berg coined the terms medicracy to characterize the changing influence of health authorities that was at its strongest in the decades after 1945, and semi-medicracy to label the latter part of the 19th century.⁵ Her studies emphasize that physicians entered the Norwegian ministries and that public health dominated before hospitals took over as the core site for medical practice. Until the early 20th century, public positions were strongholds for Norwegian physicians and it was only after 1945 that clinical, somatic medicine became the foundation for the hospital-based medical elite, with close ties to the health authorities.⁶

This article aims to develop these analyses further by nuancing the notion of the professionalizing of medicine as a uniform process with a common knowledge base and common field of practice. We argue that our understanding of medical professionalization, and of the profession's contribution to the state, will benefit from comparing the relations between different segments of the medical profession, and focusing the role of practice, the scientific disciplines and the state. Such analysis will gain from studies that conceptualize medicine as composed of different and changing segments, with varying scopes of practice and methods, clients, socialization and career paths, identities and relations to the government, the university and the broader society.⁷

We will pursue this by examining the relations between two developing medical practices, namely academic actors and groups of actors within the health authorities during the 1800s and the first half of the 1900s. The analysis is based on our earlier works on Norwegian 19th century medical segments of hygiene and psychiatry.⁸ By

Department of Administration and Organization Theory, University of Bergen, 1995; Tor Halvorsen: *Sektorinteresser eller profesjonsinteresser*, Report, TMV series 10, 1995.

4 Vibeke Erichsen, V. (ed.): *Profesjonsmakt. På sporet av en norsk helsepolitisk tradisjon*, (Oslo, 1996); Vibeke Erichsen: «Health care reform in Norway: the end of the 'profession state'»? *J Health Polit Policy Law*, (1995) 20(3): 719–37.

5 Ole Berg: «Den evangske orden og dens forvitring», *Mikael*, 2013, 10: 149–97.

6 Ole Berg (1986): «Verdier og interesser - Den norske lægeforenings framvekst og utvikling», in Larsen, Ø. et al. (eds): *Legene og samfunnet*, Oslo: Den norske lægeforening Erichsen, V. (1996) (ed.): *Profesjonsmakt. På sporet av en norsk helsepolitisk tradisjon*, (Oslo, 1986) Haave, P. (2007): «Da legene skulle autoriseres», *Tidsskr Nor Lægefören* 24, 127: 3267–71.

7 Rue Bucher and Anselm Strauss: “Professions in Process”, *American Journal of Sociology*, (1961), 66, 325–34.

8 Kari Tove Elvbakken: *Offentlig kontroll av næringsmidler, institusjonalisering, apparat og tjenestemenn, dr.polit.thesis*, (Department of Administration and Organisation Theory, University of Bergen, 1997), Kari Tove Elvbakken: *Hygiene som vitenskap, fra politikk til teknikk*, paper 35, Department of Administration and Organisation Theory, University of Bergen (1995); Kari

extending the empirical analysis and broadening of the theoretical framework, it is possible to grasp distinct patterns of relations and further develop our understanding of the inter-dependent processes of medical professionalization and the development of public health administration. We study relations between actors in these segments and the health authorities, focusing professional contribution to policy formulation and institution building, but also the use of professional competence in state bureaucracy. We show how segments of medicine played various roles and gained authority and legitimacy to medical knowledge and practice before clinical hospital medicine became the core of medicine, and before the “profession state” was established.

To capture these changing relations, we will use analytic tools for studying various actor groups in professionalization processes. Burrage, Jarausch and Siegerist have argued that to understand the political and societal conditions for professionalization processes, groups of actors in the process of professionalizing, their actions and their relations must all be analysed.⁹ For our purposes, two groups of actors are particularly important, that is, actors in practice and actors in academia. The American sociologist Philip Elliott argued that professional practise in a particular field can provide power and trust that transcends the field’s scope of practice. Thus, it is important to be open to differences between peripheral and central fields of medicine when it comes to groups of actors. Different areas of professional practice and core knowledge give access to different client groups.¹⁰ Analyses should consider the clients, reference groups and contributions to policy, as well as the knowledge within different segments of a profession.

We pursue this notion by analysing the relations between groups of actors within the medical profession and the knowledge resources that they were able to offer political authorities. Our aim is to conceptualize the background for the profession’s position and legitimacy. We argue that the medical profession must be understood as an amalgamation of segments that may contribute to the authorities with varying knowledge and methods.¹¹ First, we briefly present background information on the medical profession and the health authorities in Norway. Second, we present the cases of hygiene and psychiatry as fields of practice, and the development of medical disciplines relating to these fields. Then, we explore the relations between hygiene, psychiatry and the health administration, and discuss the contributions of these

Ludvigsen: *Kunnskap og politikk i norsk sinnssykevesen 1820-1920*, dr. polit. thesis, Department of Administration and Organisation Theory, University of Bergen, (1998). Kari Tove Elvbakken and Kari Ludvigsen: “Hygiene og psykiatri- medisinske disipliner i statens tjeneste”, *Norsk statsvitenskapelig tidsskrift* (2003), 1, 19: 3–27.

9 Michael Burrage, Konrad Jarausch and Hannes Siegrist: “An actor-based framework for the study of professions” in Burrage, M. and R. Torstendahl (eds): *Professions in Theory and History*, (London, 1990)

10 Phillip Elliott: *The Sociology of the Professions*, (London and Basingstoke, 1972).

11 Rue Bucher and Anselm Strauss: *ibid.* (1961) p. 326.

medical segments to the development of health authorities and the professionalization of medicine.

Norwegian medicine: practice, faculty and ministry

Medicine professionalized in the 1800s and early 1900s and grew enormously. These processes varied between countries and specializations, and the emergence of disciplines took different forms, as did the systems of health administration.¹²

After the Napoleonic Wars, Denmark lost Norway to Sweden and a union between these two countries lasted from 1814 to 1905, when Norway became independent. However, during the years of the union, Sweden accepted that Norway kept the 1814-constitution, inspired by the French and American constitutions. That formed the legal framework for the raising of a Norwegian state bureaucracy. During the last decades of the 1800s, the Norwegian state-building process was strong, within a relatively democratic-minded context. . Among these state-building strategies was the practice of sending scholars abroad to learn from other states and scientific institutions.

Until the early 1800s, most Norwegian physicians were educated in Copenhagen, since the first Norwegian university was established in 1811. The University of Oslo¹³ with its Faculties of Law, Theology and Medicine educated civil servants for the new state. The Faculty of Medicine opened with three professorships in 1814¹⁴ and this number grew slowly during the 1800s. By 1866, four new professorships were appointed; after 1895, seven professorships were added, most of these branched from the one of surgery.¹⁵ These professors held their positions for decades. They were clinicians, teachers and institution builders, who conducted research, engaged in scientific activity and represented the medical elite until the late 19th century.¹⁶

During the first half of the 1800s, opportunities for clinical instruction were limited to a few institutions, such as the military hospital, an obstetric ward and morgues. Professors of medicine were the driving force behind the National Hospital, which provided an arena for physician clinical education from its establishment in 1826.

12 Andrew Abbott: *ibid.* (1988); Tony Becher, *Academic Tribes and Territories. Intellectual Enquiry and the Cultures of Disciplines*, (Milton Keynes, 1990)

13 The Norwegian capital, Oslo, was named Christiania from 1670 to 1877, Kristiania from 1877 to 1925 and Oslo subsequently. We use Oslo throughout this article.

14 Isak Kobro: «Universitet og medisinske fagmiljø», in I. Reichborn Kjennerud, , F. Grøn and J. Kobro, *Medisinens historie i Norge*, (Oslo, 1936.)

15 Kari Tove Elvbakken and Kari Ludvigsen, *Ibid.* (2003).

16 Ole Berg: “Verdier og interesser” (1986), 158–9; Per Haave: «Legene», in Slagstad, R. and O. Messel (eds), *Profesjonshistorier*, 277–311, (Oslo, 2014).

Norway had few physicians at the beginning of the 1800s; the number grew significantly during that century but few had their main practice in hospitals.¹⁷ Local authorities and private organizations built somatic hospitals; this expansion of hospitals was consistent with the increasing urbanization at the end of the 1800s. Local authorities also ran a number of mental asylums. In the mid-1800s, mental illness legislation made funding for mental health institutions a state issue and the government established four state asylums by 1902. The first decades of the 20th century saw an increase in smaller, county-based asylums. Beginning in the 1850s, state mental asylums provided positions for medically trained staff as directors and assistant doctors.

A growing segment of physicians ran private practices through the 1800s, at which time their vocation acquired the character of a liberal, middle-class occupation.¹⁸ Haave points to the fact that the number of private practice physicians grew faster than the number of hospital physicians in the early 1900s.¹⁹ Positions for the public employment of physicians grew after the Poor Law was enacted in 1845, and the 1860 Public Health Act required all municipalities to have health commissions, which were headed by a state-employed district physician or, in cities, the state physician.²⁰ Despite the state employment of physicians, the professional standing of doctors was quite low before the 1880s. The state-employed district doctors in the municipalities were essential to the health authorities until the 1940s.

The emergence of the Norwegian health administration can be linked to a temporary Sanitary Collegium for Norway and Denmark, which was temporarily established in 1803. In 1815, (in the years of the union with Sweden) an office for medical questions was set up within one of the Norwegian ministries.²¹ From that time, the professors of medicine were obliged to assist the ministry in medical issues. In 1833, professor of hygiene Frederik Holst proposed a programme for a permanent health commission of medical experts to advise the authorities.²² Commencing in 1845, the Ministry of the Interior decided upon issues of health and was allowed to call on two medical experts as consultants.²³ In 1848, one of the professors took over this consulting position and an advisory committee for medical issues, reporting to the ministry, was set up. Parliament allowed the hiring of a medical expert as chief civil servant for the health administration in 1857 and the former asylum doctor Ludvig Dahl (1826–1890) was appointed as the first medical director.

17 Øyvind Larsen: «Holdninger til helseproblemer», «Leger i Norge» and «Å være lege», in Ø. Larsen, O. Berg and F. Hodne, *Legene og samfunnet*, (Oslo, 1986).

18 Ole Berg, *ibid.* (1986), 172.

19 Per Haave, *ibid.* (2014)

20 Aina Schiøtz: *Folkets helse, landets styrke, Det norske helsevesenet 400 år*, (Oslo: 2003)

21 Anders Svalestuen: “Helsevesenet 1814–1940 En administrasjonshistorisk oversikt», *Norsk Arkivforum* (1988), 8, 7.

22 Edgeir Benum: *Sentraladministrasjonens historie, 1845–1884* (Oslo: 1979).

23 Andres Svalestuen, (1988): *ibid.* 24–28.

In 1891, the Directorate of medicine was separated from the ministry, with few resources and limited duties, and the directorate remained outside the ministry until 1940. From 1891 to 1938, four physicians held the position of director: two recruited from positions as asylum doctors and two were hygienists. The directorate attached several medical competencies. Among these, beginning in 1893, the Chief Medical Officer in Oslo provided assistance in questions of hygiene; from 1908, a state chemist was employed at the university.²⁴ A state serum institute opened in 1916, which grew into the state public health institute, which opened in 1929 and housed the university department of hygiene. This system emphasizes the close connections between the ministry, university and practice fields of psychiatry and public health.

The case of hygiene

Hygiene and sanitary problems in the cities

Like other European countries in the first decades of the 1800s, Norway was affected by epidemics of typhus and cholera. Rooted in Middle-Age strategies, cholera commissions were set up during outbreaks.²⁵ During the 1830s, this strategy was implemented in some Norwegian cities. Experiences with such epidemics are considered important for leading to the development of the first legislation on public health in Norway in 1860, which was also inspired by legislation abroad, especially in Britain. City and district physicians employed by the state led the boards of health and were responsible for sanitation. The activities and resources, such as competencies, of the boards varied and changed over time.²⁶

In the second half of the 1800s, public health faced challenges related to urbanization and industrialization, and hygiene became mainly a city issue. Although Norwegian cities were relatively small, they saw pronounced growth.²⁷ Housing, especially for workers, was often terrible, and food and water supplies and the disposal of refuse were inadequate. Meat and milk could cause disease and contaminated food contributed to high infant mortality rates. Meat was still butchered in the often chaotic and foul-smelling marketplaces of the growing cities, as has been described in Stockholm.²⁸

24 Kari Tove Elvbakken: *Ibid.* (1997).

25 Carlo Cippola: *Miasmas and Disease, Public Health and the Environment in the Pre-Industrial Age*, (New haven and London, 1992).

26 Anne Lise Seip: *ibid.* (1984) p 229.

27 Egil Ertresvaag: "By, byvekst og helse", in Elvbakken, KT and G Riise (eds), *Byen og helsearbeidet*. (Bergen, 2003).

28 Yvonne Hirdman: *Matfrågan, Mat som mål och medel i Stockholm 1870–1920*, (Stockholm, 1983)

Beginning in the 1850s, the water supply and sewer systems were improved. As in other European cities, market halls opened in Norwegian cities to ensure the orderly and hygienic sale of food.²⁹ Towards the end of the 19th century, hygiene in schools became a focus of attention, especially in the Norwegian cities.³⁰ In the 1880s, efforts were made to control the sale of milk to avoid adulteration and fraud, and to reduce the increasing infant mortality rate, especially among infants of unmarried and poor mothers. This was one of the many topics on the agenda for the boards of health and the practice of hygiene.

Measures dealing with leprosy were also initiated. Legislation enacted in 1885 allowed for the internment of those sick with leprosy in hospitals, followed by tuberculosis legislation in 1900. Many physicians also advocated for healthy habits. As in other European countries, health education became part of medical practice.³¹ Local district doctors, as heads of the boards of health, had an obligation to produce annual reports on the situation in their districts.

Hygiene, knowledge and the university

Internationally, hygiene was a subject within academic medicine from the early 1800s and the first international congress of hygiene was held in 1851. The concept of hygiene was synonymous with state medicine or *politica medica* internationally, illustrating the connections to the state. At the Norwegian university, hygiene received the fourth professorship of medicine in 1824; until 1940, only four professors held this chair.

Frederik Holst (1791–1871), formerly the chief health officer in Oslo, became the first professor in medical policy (state medicine), pharmacology and toxicology. Holst took his exams in Copenhagen in 1815 and in 1817 he was the first to defend a doctoral thesis at the newly established Norwegian university.³² Holst played an important role in the development of medical science and health administration until the 1860s; he was also engaged in establishing the first Norwegian-language medical journal and a Norwegian Medical Society.

Holst represented a scientific and academic line.³³ He can be placed into the European surveying tradition within medicine, which was hygiene's first main methodology.³⁴ From the 1830s, studies demonstrated close links between illness and

29 Kari Tove Elvbakken: *Ibid.* (1997).

30 This concerned school buildings, with issues of light placement, school meals and air quality.

31 Aina Schiøtz: *ibid* (2003); Eva Palmblad, *Medicinen som samhällslära* (Daidalos., 1990)

32 F. G. Gade: Fredrik Holst, in E. Jansen, E. : *Norsk biografisk leksikon*, (Oslo, 1934).

33 Ole Berg: *ibid.* (1986)

34 Kari Tove Elvbakken, *Ibid.* (1995).

mortality rates and the standard of living within different classes.³⁵ Holst used the census as a basis for similar discussions about the situation in Norway. With grants from the government, he studied medical institutions, among them prisons and mental health institutions, in Ireland, England, France and Germany, and initiated reforms when he returned to Norway. Holst argued for the establishment of a National Hospital, chaired and sat on a series of public commissions, and proposed new legislation in different fields.³⁶

In 1865, Ernst Ferdinand Lochmann (1820–1891) was appointed as the second professor of hygiene. He was inspired by the radical German physician, Rudolf Virchow.³⁷ Like Holst, he was broadly oriented towards medical theory. In his later years, he opposed the specialization of medicine and was critical of the increasing dominance of laboratory medicine that began in the 1880s.

The paradigm shift represented by bacteriology from the 1880s contributed to considerable changes within medicine. This influenced the discipline of hygiene, changing its methodological approach. The laboratory and microscope became vital tools. However, the surveying of sanitary conditions and disease, mortality rates and epidemiological methods were nonetheless central. This new paradigm changed public health strategies against epidemic diseases, including reintroducing the old strategies of confinement against epidemics.

In 1893, a new age in medicine was initiated when Frederik Holst's grandson Axel Holst (1860–1931) became the third professor of hygiene and bacteriology. He came to the university from a position at the Board of Health in Oslo.³⁸ His doctoral thesis was on bacteriology but he was a typical hygienist of the time. For example, he surveyed the housing and hygiene conditions of the working classes in Oslo in the 1890s. He combined his professorship with service to the state and city health authorities and, as did his colleagues in the international hygiene discipline, he published scientifically and for the public throughout his career. Holst visited modern laboratories abroad such as Koch's laboratory in Berlin and the Pasteur Institute in Paris and attended a number of international conferences.

Internationally, nutrition was an important topic in the field of hygiene and Axel Holst participated in a vital international research network. In 1907, he published an article on ship beriberi, which is regarded one of the most important in identifying the cause of scurvy.³⁹

35 Georg Rosen: "The Evolution of Social Medicine", in Freeman, H., S. Levine and L. Reeder (eds): *Handbook of Medical Sociology*, (New Jersey, 1972).

36 Ole Berg: *ibid.* (1986)157–8.

37. Eivind Falkum and Øyvind Larsen : *Helseomsorgens vilkår Linjer i medisinsk sosialhistorie*, (Oslo, 1981).

38 Kari Tove Elvbakken, *Ibid.* (1995).

39 Axel Holstand Theodor Frølich : "Experimental studies relating to 'ship beri-beri' and scurvy. II. On the etiology of scurvy", *Journal of Hygiene*, (1907), 7(5):634–71.

The close relations between city health efforts and the university discipline of hygiene during this period are demonstrated by the career paths and co-operation between the state physician, the board of health, and the university department. Chemical analyses to serve the medical authorities were performed at the department beginning in 1907, which also strengthened the relations between the health authorities and the discipline of hygiene.⁴⁰ The Department of Hygiene housed personnel such as the chief physician for epidemics and laboratory services.

Carl Schiøtz (1877–1938) followed as the fourth professor of hygiene in 1932, after leaving a position as head of the School Health Services in Oslo. His doctoral degree, earned in 1918, was an analysis of the weight and height measurements of 10,000 schoolchildren. Schiøtz became well known, even abroad, for designing the Oslo breakfast, a meal to be served to all children in the morning before school.⁴¹ Schiøtz changed the discipline of hygiene to include measurements of children's bodies, followed by actions such as providing extra fruit and vegetables or holiday visits to the countryside for those who needed to gain weight.⁴²

Starting in the 1920s, and during the depression years of the 1930s, many countries experienced enormous problems and many cities launched programmes to support and feed the poor. The Norwegian government turned to the Faculty of Medicine and the Department of Physiology in 1927 to design a minimum diet needed for survival. Many European physiologists worked on the same question. In 1927 and 1933, professor of physiology Einar Langfeldt (1884–1966) devised lists of the minimal food necessary to sustain life. Beginning in the early 1930s, opposing views on minimum standards led to a deep split in the Medical Society, and at the university between the conservative physiologists and the more progressive hygienists.⁴³ The Department of Hygiene and socialist physicians performed the first Norwegian survey of the diet of the working classes.⁴⁴

During the 1930s, physiology aimed at finding the minimum amounts of energy, nutrients, vitamins and minerals needed to sustain life. At the same time, the hygiene perspective focused on the optimum amounts of nutrients as the starting point, arguing that even poor people required a variety of foods and drink. Controversies between the perspectives of physiology and hygiene or social medicine were not unique to the Norwegian situation; this also occurred in Britain, for instance.

40 Kari Tove Elvbakke: *ibid.* (1997).

41 Carl Schiøtz: "Om en fullstendig omlegning av skolebespisningen i Oslo", *Nordisk hygienisk tidsskrift*, (1927), 1–33.

42 Kari Tove Elvbakken, *ibid.* (1995).

43 Several have written about these conflicts within the Medical Society: Unni Kjærnes: "Ernæringspolitikk mellom helse og matforsyning", in: Elvbakken, K.T., S. Fjær and T.Ø. Jensen (eds): *Mellom påbud og påvirkning. Forebyggingsstradisjoner, institusjoner, forebyggingspolitikk*, (Oslo, 1994).

44 Karl Evang and Otto Galtung Hansen: *Norsk kosthold i små hjem, virkelighet og fremtidsmål*, (Oslo, 1937).

The field of hygiene was central within academic and public medicine in the 1800s and the early 1900s. Professors represented changing perspectives on public health, changing methods and scientific perspectives. The professors were scientists and institution builders. Before bacteriology made the laboratory central, statistics and public institutions were the core. Beginning in the 1930s, body measurements became crucial. Norwegian hygiene related to the European survey tradition with contact to foreign medical and health administrations, and surveys became a crucial tool for the health authorities. This implied close co-operation with the government and that hygiene was at the core of medicine. The career paths of the professors led from the capital's board of health to university professorships. In turn, the professors were called back to serve on health commissions and committees.

The case of psychiatry

Practice and the growth of asylums

Public mental asylums became a field of practice for doctors employed by local or central authorities during the 19th and early 20th centuries in Norway. These institutions are considered important for understanding mental illness and the development of psychiatry as a field of medical practice.⁴⁵ As the poor population gradually became differentiated the mentally insane became defined as a distinct category. Until the mid-19th century, mental insanity as a societal problem lay within the criminal system and was associated with poverty relief. According to the criminal law of the time, people declared insane were not to be punished, and during the 18th century, some Norwegian cities established places to care for the mentally insane as part of the poor relief system. However, the majority of the mentally insane were still cared for by relatives.

Norwegian poverty policy reforms during the early 1800s can be seen as part of mercantilist strategies, where questions of health became part of the state's interest and the population became regarded a state resource.⁴⁶ Medical actors initiated reform plans for the handling of mental insanity, inspired by European reforms. To professor of hygiene Frederik Holst care for the insane was part of his engagement in state medicine. During his travels abroad, he visited mental asylums as well as hospitals and prisons. In the late 1820s, he carried out the first Norwegian census of the mentally insane and suggested a system of institutions differentiating between the curable and incurable mentally disturbed, based on medical principles. These

⁴⁵ Kari Ludvigsen: *Ibid.* (1998); Svein-Atle Skålevåg: *Fra normalitetens historie. Sinnssykdom 1870–1920*, Dr. art. thesis, University of Bergen (2003).p. 67.

⁴⁶ Anne-Lise Seip: *ibid.* (1984), 235.

comprehensive plans were not put into practice, but over the next two decades, some of the larger cities hired physicians to reorganize their institutions based on new ideas for the treatment of the mentally ill. Thus, municipal mental hospitals became a new field of practice for doctors, albeit on a small scale.⁴⁷

During the second half of the 19th century, the number of institutions for the mentally ill grew and became increasingly important fields of practice for physicians employed by the state or municipal authorities. Holst's idea of making treatment of the mentally ill a state responsibility was also proposed later by Herman Wedel Major (1814–1854), a physician at Oslo's municipal mental hospital. Major initiated comprehensive reforms in the care of the mentally ill, including the 1848 legislation on the public treatment of the mentally ill and the planning of state-run psychiatric asylums.⁴⁸ The first of these, Gaustad asyl, opened near Oslo in 1855 as a prestigious project. Until 1902, three other state-run asylums were built. Then some of the old asylums in the cities were authorized according to the mental health act, and continued their activities with medical doctors in director positions.

The public asylums became an arena for specialized medical practice, inspired by leading European developments. The asylum directors needed expertise in the treatment of mental illness, from asylum work and studies abroad. They were responsible for admitting and discharging patients, observation, diagnosis and direction of treatment. The right patient classification was considered an important therapeutic device, combined with somatic and psychic remedies and work therapy.⁴⁹ Diagnostic classification systems also separated asylum clients from other groups in need of public care. Despite attempts to base the asylums on medical principles, the role of poor relief was important in defining the clientele.⁵⁰ However, the state asylums also had to accept the admittance of the criminally insane, contrary to the intentions of the legislation and against protests from doctors.

In the late 19th century, the demand for asylum services increased. Asylum doctors were optimistic about potential therapeutic outcomes until the 1870s. At that time, the ambition to cure patients was increasingly challenged by financial problems and a growing pressure to fill up the wards⁵¹ asylum doctors were also challenged on their right to admit patients, yet strove to maintain the asylums as medical institutions.⁵²

47 Per Isdahl: "Historien til et øyeblikk. Herman Wedel Major og Oslo hospital", in Abrahamsen, P. (ed.), *Fra dollhus til moderne psykiatri. Oslo Hospital 1538–1988*, (Oslo, 1988).

48 Kari Ludvigsen, *ibid.* (1998).

49 Ole Rømer Sandberg: *Klinisk femtenaarsberetning fra Gaustad Asyl*. (Kristiania, 1872)

50 Kjersti Ericsson: *Den tvetydige omsorgen. Sinnssykevesenets utvikling – et sosialpolitisk eksempel*, (Oslo, 1974); Jan Bjarne Bøe: *De utsatte. Psykiatriske pasienter i privatpleie på Jæren, 1950–1970*, (Bergen: 1993).

51 *Ibid.*, pp 174–82; Svein-Atle Skålevåg: *System i galskapen - teori og terapi i norske sinnssykeasyl, 1855–1915* (Master thesis in History, University of Bergen, 1998).

52 Jan Goldstein: *Console and classify: the French psychiatric profession in the nineteenth century*, (Cambridge, 1987); Kari Ludvigsen, *ibid.* (1998), pp. 143, 159–62.

Towards the turn of the century, critical attention arising from public debate and a public inquiry about the conditions of the mentally ill at Gaustad asyl added additional challenges.

The 1848 legislation defined public institutions for the mentally ill as arenas for the development and exchange of knowledge on mental illness. Mental illness physicians pursued special education abroad, often with state scholarships and with an obligation to establish and develop medical institutions at home. However, scientific activity changed and decreased in the 1880s. Reports from public asylums became briefer and statistics replaced descriptions of medical histories and treatment. The asylums lacked both results and the courage to persevere with therapeutic innovation as the demand for their space grew. Asylums were increasingly filled with the chronically ill and the asylum doctors became administrators of large institutions with decreasing status. The number of somatic hospitals grew and was followed with increased optimism about curing somatic diseases.⁵³ In 1907, mental asylum doctors organized a psychiatric section of the medical association, and thus became engaged in mental health policy.⁵⁴

After the turn of the century, a reformed funding system led to the expansion in asylum building initiated and run by the counties.⁵⁵ New principles of hygiene and medical care marked the asylums established from 1900 to 1926. The number of asylum beds grew quickly, from 1500 in 1894 to 2900 in 1912. In 1926, there were 23 asylums with 5368 beds.⁵⁶ The period up to 1940 has been labelled the “nursing period” of mental institutions in Norway, with increased emphasis placed on educated care in mental hospitals.⁵⁷ Order and regularity of daily life were important, just like hygiene, fresh air and farm work. Although new somatic therapies were tested, including barbiturates and electrotherapy, observation of patients in guarded wardrooms combined with farm work remained important.

Mental illness, knowledge and the university

Internationally, psychiatry as a medical discipline originated in asylums for the mentally ill and in university psychiatry programmes, especially in the German

53 Kari Ludvigsen, *ibid.* (1998).

54 Per Haave: «Etterkrigstidens psykiatriske helsetjeneste og arkivet etter den sentrale helseforvaltningen», *Arkivmagasinet* (1994) 2, 7–12.

55 Kari Ludvigsen, *ibid.* (1998), pp. 217–8.

56 Per Haave: *Ambisjon og handling. Sanderud sykehus og norsk psykiatri i et historisk perspektiv*, (Oslo, 2008), p. 46.

57 Helge Waal: *Psykiatriske sykehus- muligheter og begrensninger*, (Oslo, 1978).

states.⁵⁸ In Norway, mental illness was not a mandatory topic for medical students until the 1890s, but some of the professors were interested in mental illness. Frederik Holst's work to reform mental health care has been described. In the 1820s and 1830s, mental insanity was a primary lecture theme. Interest in insanity can be linked to the consultative role of the authorities, but also to their engagement in broad health matters.⁵⁹

Gaustad asyl was intended to provide doctors and medical students with clinical and theoretical knowledge of mental illness. Starting in the 1850s, the development of scientific knowledge and instruction was funded by the state mental health budget, anchored primarily at Gaustad and supported by the medical faculty. The faculty saw the education of asylum doctors and the teaching of mental illness as responsibilities of the authorities. The asylum director Ludvig Dahl (1826–1890) taught students theoretical and clinical pathology and therapy.⁶⁰ From 1868, lessons were also given at Oslo's municipal mental asylum and at the national hospital from 1880. The new director Axel Lindboe (1846–1911) took over in 1883. Teaching at Gaustad still included lessons and clinical demonstrations and Lindboe was formally responsible for this education until 1912. However, the system gradually changed from 1895 onwards.

Controversies over competence in questions of mental illness arose in the 1860s. Disputes between mental asylum doctors and faculty professors concerning competence in forensic questions became particularly crucial.⁶¹ This may have led to a distancing between the medical faculty and the doctors who specialized in mental illness. The asylum directors were responsible for large institutions with budgets that took up a substantial portion of public medical expenditures. Additionally, the medical definition of asylums presented important obstacles to patient admissions. Although the 1848 legislation permitted asylum patients who were declared insane, it did not provide for the admittance of voluntary patients. Adherence to this legislation was seen as barring interesting cases, particularly patients with nervous diseases and milder mental afflictions.

Beginning in the 1880s, asylum doctors demanded an independent psychiatric clinic, outside the mental health system, to develop knowledge on a broader spectrum of mental health. Until the independent university clinic opened in 1926, the mental asylums and a few newly established hospital departments for the insane served as the basis for clinical psychiatric knowledge, along with new laboratories.

58 Roy Porter: *The Greatest Benefit to Mankind – A Medical History of Humanity from Antiquity to the Present*, (London, 1997); Edward Shorter: *A History of Psychiatry*, (New York, 1997), 100.

59 Kari Ludvigsen : *ibid.* (1998); Svein Atle Skålevåg, *ibid.* (1999): 180.

60 Anne Kirsten Austad and Ørnulv Ødegaard : *Gaustad sykehus gjennom hundre år*, (Oslo:1957), 152.

61 Kari Ludvigsen, *ibid.* (1998), 233.

In the late 1880s, due to international developments, scientific attention shifted from curing to pathological-anatomical studies, eugenics, neurology and experimental psychology in particular.⁶² In turn, this shifted attention to the prevention of mental illness and efforts to cure milder forms of disease. The strengthening of psychiatry education for medical students gained support from medical and government actors starting in the 1890s, with links to reforms in criminal law and the mental health system. Within the faculty, psychology and neurology struggled over academic positions in the 1890s, at a time when faculty expansion was branching into new psychiatry teaching positions.

In 1889, the faculty funded a scholarship in mental illness for Harald Holm (1852–1926), who was appointed head at Oslo's mental asylum in 1887 and who defended his dissertation on pathological anatomy in 1893. When the faculty proposed a teaching position in psychiatry in 1895, the ministry resisted and initiatives to organize education in mental illness were led by other medical actors. Christopher Leegaard (1851–1921), professor in neurology and head of the new department of neurology at the national hospital from 1895, argued strongly for university positions. He had taught neurology to public physicians at the municipal mental asylum and saw psychiatry as part of neurology. He competed with Holm over a teaching position in 1896; Holm was given the position and he taught psychiatry on the faculty until 1905.

Teaching at Gaustad by the hospital leaders continued in the late 1890s, but the faculty was however resistant to this. The struggle between the faculty and authorities over psychiatry teaching continued until 1915, when Ragnar Vogt (1870–1943) was appointed the first professor of psychiatry. Vogt held a scholarship to study neurology, experimental psychology and psychiatry in Germany and Denmark and earned his doctorate in 1901. He was an assistant doctor at Gaustad and then its director from 1911. He took over teaching when Holm became head of a new municipal asylum in 1905. Few students attended the courses until 1907, when psychiatry became mandatory. He published his lectures.⁶³ In 1909, positions at the faculty and the national hospital were combined into a single position for Vogt, who was also to be a consultant for the authorities.

Vogt's combination of positions was the subject of dispute over the organizing and funding of psychiatry education. The faculty were reluctant to pay for teaching and saw the clinic as the health authority's responsibility. In 1914, Vogt was appointed professor and assistant physician at Gaustad, he continued to serve the ministry as a consultant. In 1918, psychiatry received the status as a medical specialty. When the Oslo psychiatric clinic opened in 1926, Vogt was its first head physician and professor until he retired in 1940.

62 Kari Ludvigsen, *ibid.* (1998) 239-250.

62 Example: Ragnar Vogt: *Psykiatriens grundtræk. Første del* (Kristiania, 1905).

Psychiatric expertise was recognized as important for the prevention of crime and dangerous behaviour after a legislative reform around 1900. Vogt saw psychiatry as an area of expertise for solving social problems such as crime, prostitution, substance abuse, child welfare and mental deficiency. Insights into psychiatry and tools for classifying social problems were essential for advising the educational system and social services. The role of psychiatric expertise in prevention and the need for physicians to have mental health knowledge were important to the academic status of psychiatry. Vogt's programme linked the recognition of psychiatry as an academic medical specialty to their claim of expertise in surveying and monitoring citizens. Thus, the need for expertise to solve and prevent social problems became an important foundation for academic psychiatry in Norway.⁶⁴

Hygiene and psychiatry – practice and university

Hygiene and psychiatry were fields of public practice for physicians outside of the somatic hospitals. Publicly employed physicians, hygienists and mental health doctors performed important functions for the state. The duties of hygienists consisted of tending to hygiene and surveying health conditions in cities and across the countryside, employed by the local or central administration. Psychiatry provided a medical rationale for mental or behavioural deviation. Asylum doctors conducted interventions in the difficult area between medical treatment and the state's need to control deviant groups. Hygienists contributed to the securing of health and order in the cities.

Norwegian physicians have been described as professional cosmopolitans, oriented towards international scientific communities, publishing internationally and participating at conferences.⁶⁵ Government grants often fund these travels, with the obligation to study medical conditions and institutions abroad and develop plans for Norway's medical institutions inspired by the experiences. Professors and state medical personnel took part in both general and more specialized international conferences starting in the mid-1850s, in the fields of hygiene, state medicine and psychiatry.

The Faculty of Medicine experienced considerable growth during the last decades of the 19th century, including branching into new disciplines and professorships. The field of hygiene received an early professorship and dealt with important state issues. As in other European countries, efforts to build medical institutions, legislation and health administration were important issues within the field of hygiene, and the discipline dealt with problems that threatened social order. When bacteriology made

⁶⁴ Kari Ludvigsen, *ibid.* (1998).

⁶⁵ Ulf Torgersen: *Profesjon og offentlig sektor*, (Oslo, 1994).

its breakthrough, this knowledge became part of the field of hygiene, underscoring the connection between hygiene and the state. The status of the field of hygiene first started changing when clinical medicine expanded, especially after 1945.

As a medical discipline in Norway, psychiatry received a professorship almost a century after that for the field of hygiene. Although the state institutions for the mentally ill provided arenas for research, and asylum doctors were active in publications, relations between the university and mental asylum doctors were marked by struggles over competence and resources. Asylum doctors, however, provided the health authorities with important information, through surveying and monitoring the population and the living conditions for the mentally ill, estimating the need for public care and planning public actions on these issues. The asylum directors were mental health experts and civil servants. Their roles as officials and their important competence within the state gave them status when curing was unsuccessful and the prestigious image of the asylums was tarnished.

Ministry and medicine

The Faculty of Medicine, along with the Faculties of Theology and Law, played important roles in the process of state building in Norway.⁶⁶ Studies of the medical profession often point to close connections between the authorities and the Faculty of Medicine.⁶⁷ University medicine dominance is linked to the professor's role as advisor to the authorities and positions on the city boards of health. What were the specific relations between the practice fields and knowledge bases of hygiene and mental asylum doctors and the medical authorities?

Both hygiene professors and mental asylum doctors had close relations with and served the health authorities. Medical statistics was a crucial part of the hygiene discipline, or state medicine, and represented a field of knowledge that was highly important to the state. This can be further highlighted by considering the close relations between the health authorities in Oslo and the faculty. Both Frederik and Axel Holst came to the university from Oslo's boards of health. Scientific work related to city public health was published in journals, both foreign and domestic. Career paths also went other ways. Assistants at the department of hygiene wrote doctoral theses and were employed by the city health authorities. State physicians gave lectures and demonstrations at the university when needed.

Legislation on the care of the poor and mentally ill began in 1848, emphasizing state and medical responsibility for the mental asylums. The government accredited institutions and appointed asylum inspection commissions. The state authorized and

⁶⁶ Dag Østerberg: "Universitetets funksjonalitet. En vurdering", in Wyller, Egil A. (ed.), *Universitetets ide gjennom tidene og i dag*, (Oslo, 1991)

⁶⁷ Ole Berg, *ibid.* (1986); Vibeke Erichsen: *ibid.* (1995)

employed asylum doctors who diagnosed mental illnesses, inspected private care facilities and made reports on asylum operations to the government. The asylum doctors carried responsibility for a large portion of the state health budget. Medical doctors with knowledge of mental health represented expertise for the health authorities. The government, the faculty and the asylum doctors shared a common interest in surveying mental illness in the population. These surveys became fundamental for the planning of the location, building and running of the state asylums, for which the asylum doctors took a leading role in the planning processes. Municipal asylum doctors made similar reports and served the government on commissions and committees.⁶⁸ In 1848, Herman Major was appointed government consultant for mental health care. After his death in 1854, the new director at Gaustad became inspector and advisor for mental health for the government.⁶⁹

Despite these facts, there were no university positions in psychiatry until the 1890s, before which psychiatry was voluntary for medical students and the health authorities considered asylum doctors' competence important. In addition, from 1875 to 1918, asylum doctors dominated the position as director of health. In 1918, the position was taken over by Harald Gram (1875–1929), assistant professor at the Department of hygiene and chief medical officer of epidemic diseases. Subsequently, in the 1920s, the psychiatric expert and asylum director Karl Wefring took over.

Knowledge of hygiene and mental asylums was important in the state-building process in Norway. Medicine and health authorities saw the importance of population statistics for supervising the health situation and planning for medical institution building. Career paths can be identified from the state asylums to the ministry and the directorate, as well as from Oslo's boards of health to a professorship in hygiene.

Expertise for public health and social order

We started out by pointing to the fact that analyses of the relations between medicine and the state have often been based on a uniform picture of medicine. We wanted to discuss this issue, considering medicine as composed of different disciplines, each of which might have groups of actors with varying relations to the university and to the authorities. We see medicine as composed of different groups of actors, with varying relations with academia and the authorities, and we distinguish between actors in practice, university and health authorities.

We have studied actors related to two fields of medicine – two links between practice, university and health authorities – and have called attention to the bond

68 Kari Ludvigsen, *ibid.* (1998): pp. 133-35.

69 Kari Ludvigsen, *ibid.* (1998): pp. 102-6.

between the authorities and the representatives of practical and scientific actor groups within hygiene and mental health. Mental and public health physicians provided valuable knowledge to the state. Surveying, classifying and compiling statistics were a crucial part of the expertise of physicians in public and mental health. Professors of hygiene and the government shared an interest in statistics and institutions to deal with the threat of plague and chaos. In the asylums, classification based on medical knowledge systems, and on economic, social and practical criteria, was important. Knowledge of the prevalence of mental illness provided a basis for planning public budgets and building mental health institutions. Psychiatrists and hygienists had close relations with the government through practice, research and current issues. Health authorities used expertise from sections of medicine that today are no longer part of this field's core.

Studies of the relations between medicine and the state in Norway have largely concentrated on the role of actors at the university and of clinical and somatic medicine. We aimed instead at nuancing the understanding of the relations between medicine and the state in Norway through an analysis that emphasizes the variable roles and influence of medical practice fields and knowledge bases over time. Our discussion highlights the relevance of analytical perspectives that study various segments and groups within a profession to gain a clearer understanding of their changing roles and sources of legitimacy.

Our objectives have been elaborated through analysis of the medical fields of hygiene and mental illness. In particular, we considered the specific and changing relations between the medical practices, the scientific disciplines and the health administration. Based on this analysis, we argue that medical fields other than somatic, clinical medicine became generally important medical authorities in the state up to 1945. This also implies that there may have been variation over time regarding which fields make up the core of medical practice, as might have the competencies used in health policy. Characteristics related to the knowledge and fields of practice in hygiene and psychiatry, boards of health and asylums influenced the authority of the medical doctors in academia and in health administration. Practice for securing a healthy population, through monitoring and categorization, implied close relations with the authorities and became the foundation for career paths. Thus, authority of the Norwegian medical profession was achieved from knowledge and practice that were crucial for building institutions and expertise and maintaining a healthy population and society.

Studying the relations between actor groups related to different disciplines and with varying fields of practice, methods and scientific disciplines can contribute a nuanced picture of the professionalization of medicine as a unitary process. We argue that the officials related to public health and mental health institutions offered solutions to pressing problems of social order, and became important for the expert position of medicine in the state. Hygiene and psychiatry contributed to the

strengthening of medical authority and served as sources of legitimacy, not only for hygienists and psychiatrists, but also for physicians in general.

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Reference List

- Abbott, Andrew: *The System of Professions, An Essay on the Division of Expert Labour*, (Chicago, 1988).
- Austad, Anne Kirsten and Ørnulv Ødegaard: *Gaustad sykehus gjennom hundre år*, (Oslo, 1956).
- Becher, Tony: *Academic Tribes and Territories. Intellectual Enquiry and the Cultures of Disciplines*, (Milton Keynes, 1989).
- Benum, Edgeir: *Sentraladministrasjonens historie,; 1845–1884* (Oslo, 1979).
- Berg, Ole: «Verdier og interesser - Den norske lægeforenings framvekst og utvikling», in Larsen, Øivind. et al. (eds): *Legene og samfunnet*, (Oslo, 1986).
- Berg, Ole: «Den evangske orden og dens forvitring», *Mikael*, (2013), 10: 149–97.
- Bucher, Rue and Anselm Strauss: “Professions in Process”, *American Journal of Sociology*, 1961, 66, 325–34.
- Burrage, Michael, Konrad Jarasch and Hannes Siegrist: “An actor-based framework for the study of the professions”, in Burrage, M and R. Torstendahl (eds.): *Professions in Theory and History, rethinking the study of the professions*, (London, 1990).
- Bøe, Jan Bjarne: *De utsatte. Psykiatriske pasienter i privatpleie på Jæren, 1950–1970*, (Bergen, 1993).
- Cippola, Carlo: *Miasmas and Disease, Public Health and the Environment in the Pre-Industrial Age*, (New Haven, London, 1992).
- Desrosières, Alain. “How to make things which hold together: social science, statistics and the state”, in P. Wagner, B. Wittrock and R. Whitley (eds.), *Discourses on Society*: vol. XV, (Dordrecht, 1991).
- Elliott, Phillip: *The Sociology of the Professions*, (London, Basingstoke, 1972).
- Elvbakken, Kari Tove: *Hygiene som vitenskap, fra politikk til teknikk*, paper 35, (Department of administration and Organization Theory, University of Bergen, 1995).
- Elvbakken, Kari Tove: *Offentlig kontroll av næringsmidler, institusjonalisering, apparat og tjenestemenn*, dr.polit. thesis, (Department of administration and Organization Theory, University of Bergen, 1997)
- Elvbakken, Kari Tove and Kari Ludvigsen: “Hygiene og psykiatri- medisinske disipliner i statens tjeneste”, *Norsk statsvitenskapelig tidsskrift* (2003) 1, 19: 3-27.
- Erichsen, Vibeke: “Health care reform in Norway: the end of the ‘profession state’?” *Journal of Health Politics, Policy and Law*, (1995), 20(3): 719–37.
- Erichsen, Vibeke (ed): *Profesjonsmakt. På sporet av en norsk helsepolitisk tradisjon*, (Oslo, 1996).
- Ericsson, Kjersti: *Den tvetydige omsorgen. Sinnssykevesenets utvikling – et sosialpolitisk eksempel*, (Oslo, 1974).

- Ertresvaag, Egil: "By, byvekst og helse", in Kari Tove Elvbakken and Grete Riise (eds): *Byen og helsearbeidet*. (Bergen, 2003).
- Evang, Karl and Otto Galtung Hansen: *Norsk kosthold i små hjem, virkelighet og fremtidsmål*, (Oslo, 1937)
- Falkum, Eivind and Øivind Larsen: *Helseomsorgens vilkår Linjer i medisinsk sosialhistorie*, (Oslo, 1981).
- Foucault, Michael: About the Concept of the 'Dangerous Individual' in 19th Century Legal Psychiatry, *International Journal of Law and Psychiatry*, (1978), 1, 1–18.
- Froestad, Jan: *Faglige diskurser, intersektorielle premisstrømmer og variasjoner i offentlig politikk. Døveundervisning og handikapomsorg i Skandinavia på 1800-tallet*, Dr.polit.thesis, (Department of Administration and Organization Theory, University of Bergen, 1995).
- Goldstein, Jan: *Console and classify: the French psychiatric profession in the nineteenth century*, (Cambridge, 1987).
- Halvorsen, Tor: *Sektorinteresser eller profesjonsinteresser*, Report, TMV series 10, (Oslo, 1995).
- Hirdman, Yvonne: *Matfrågan, Mat som mål och medel i Stockholm 1870–1920*, (Stockholm, 1983).
- Holst, Axel and Theodor Frølich: "Experimental studies relating to 'ship beri-beri' and scurvy. II. On the etiology of scurvy", *Journal of Hygiene*, (1907), 7(5):634–71.
- Haave, Per: Etterkrigstidens psykiatriske helsetjeneste og arkivet etter den sentrale helseforvaltningen, *Arkivmagasinet*, (1994), 2, 7–12
- Haave, Per: Da legene skulle autoriseres, *Tidsskr Nor Lægeforen* (2007), 24, 127: 3267–71.
- Haave, Per: *Ambisjon og handling. Sanderud sykehus og norsk psykiatri i et historisk perspektiv*, (Oslo, 2008).
- Haave, Per: «Legene», in Slagstad, R. and O. Messel (eds): *Profesjonshistorier*, (Oslo, 2014), 277–311.
- Isdahl, Per: "Historien til et øyeblikk. Herman Wedel Major og Oslo hospital", in Abrahamsen, P. (ed.), *Fra dollhus til moderne psykiatri. Oslo Hospital 1538–1988*, Oslo, 1988.
- Johnson, Terry: "Governmentality and the institutionalization of expertise", in T. Johnson, G. Larkin and M. Saks (eds.): *Health Professions and the State in Europe*, (London and New York, 1995), 7–24.
- Kobro, Isak: «Universitet og medisinske fagmiljø», in Reichborn Kjennerud, I., F. Grøn and J. Kobro: *Medisinens historie i Norge*, (Oslo, 1936).
- Kjærnes, Unni: "Ernæringspolitikk mellom helse og matforsyning", in: Elvbakken, K.T., S. Fjær and T. Ø. Jensen (eds): *Mellom påbud og påvirkning. Forebyggingstradisjoner, institusjoner, forebyggingspolitikk*, (Oslo, 1994).

- Larsen, Øivind: «Holdninger til helseproblemer», «Leger i Norge» and «Å være lege», in Larsen, Øivind, Ole Berg and Fritz Hodne, *Legene og samfunnet*, (Oslo, 1986).
- Ludvigsen, Kari: *Kunnskap og politikk i norsk sinnssykevesen 1820-1920*, Dr. polit.thesis, (Department of Administration and Organisation Theory, University of Bergen, 1998).
- Palmblad, Eva: *Medicinen som samhällslära*, (Göteborg, 1990).
- Porter, Roy: *The Greatest Benefit to Mankind – A Medical History of Humanity from Antiquity to the Present*, (London, 1997).
- Rosen, Georg: “The Evolution of Social Medicine”, in Freeman, H., S. Levine and L. Reeder (eds.): *Handbook of Medical Sociology*, (New Jersey, 1972)
- Schiøtz, Aina: *Folkets helse, landets styrke, Det norske helsevesenet 400 år*, (Oslo, 2003).
- Schiøtz, Carl: Om en fullstendig omlegning av skolebespisningen i Oslo, *Nordisk hygienisk tidsskrift*, (1927), 1–33.
- Sandberg, Ole Rømer: ”Klinisk femtenaarsberetning fra Gaustad Asyl”. *Særskilt Aftryk af Norsk Magazin for Lægevidenskab*. (1872), I.b., 9-10 H.
- Seip, Anne Lise: *Sosialhjelpstaten blir til*, (Oslo, 1984)
- Shorter, E: *A History of Psychiatry*, (New York, 1996).
- Skålevåg, Svein Atle: *System i galskapen - teori og terapi i norske sinnssykeasyl, 1855–1915* (Masterthesis), (Department of History, University of Bergen, 1998.)
- Skålevåg, Svein Atle: *Fra normalitetens historie. Sinnssykdom 1870–1920*, Dr.art thesis, (Department of History, University of Bergen, 2003).
- Svalestuen, Anders: «Helsevesenet 1814–1940 En administrasjonshistorisk oversikt», *Norsk Arkivforum* (1988), 8, 7.
- Torgersen, Ulf: *Profesjon og offentlig sektor*, (Oslo, 1994)
- Waal, Helge: *Psykiatriske sykehus- muligheter og begrensninger*, (Oslo, 1978).
- Østerberg, Dag: “Universitetets funksjonalitet. En vurdering”, in Wyller, Egil A. (ed.), *Universitetets ide gjennom tidene og i dag*, (Oslo, 1991).

Clergy and Vaccination in Southern Italy in the Early Nineteenth Century

Alberto Tanturri

Introduction

Thirty years ago, in his introduction to the volume of *Annali di Storia d'Italia Einaudi* devoted to the theme *Malattia e medicina (Disease and Medicine)*, the Italian historian Franco Della Peruta expressed his wish that studies on the history of health would abandon the 'internal' approach that had been prevailing until then – which focused in particular on the events related to medical-biological theories and experimentations – to open up to the suggestions of social and institutional history. That was the only way historical reconstruction of diseases could avoid falling into a narrow medical perspective, to finally find its place in the concrete field of a social scenario well defined in its structure and characteristics¹. These methodological suggestions, only partially embraced in the studies of history of medicine published in the last decades, have inspired this survey devoted to the topic of clergy and vaccination in Southern Italy.

As a matter of fact, the theme seems to have been paid scarce attention by scholars, if we consider that in the last decades only two works have appeared that were specifically devoted to investigating the attitude of the clergy towards the new scientific discovery. The first study, published in 1983, was by the French historian Yves-Marie Bercé². He examined a wide number of cases from Austria to Northern Italy, France, Ireland and Belgium, and concluded that the Catholic clergy – both at the level of high prelates and of simple parish priests – gave, on the whole, an effective contribution to the diffusion of the Jennerian method. The second work, written by the Italian scholar Caterina Tisci, appeared in 2003, and focuses exclusively on

1 See Franco Della Peruta, *Presentazione*, in *Storia d'Italia, Annali 7. Malattia e medicina*, (Turin, 1984), pp. XIX–XX.

2 See Yves-Marie Bercé, “Le clergé et la diffusion de la vaccination”, *Revue d'histoire de l'Église de France*, 69 (1983), 87–106.

Southern Italy³. This too highlights “the effective function of cultural and social mediation” carried out by the clergy in order to accredit the Jennerian discovery among the population in the Kingdom of Naples.

As will be seen, these conclusions are thoroughly refuted in this work. The investigation that follows is divided into two parts. The first one will examine the legislative measures which marked the penetration of the Jennerian method in Southern Italy in the span between the carrying out of the first vaccinations and the year 1822, when the issue of *Regulations* redefined the picture of the institutions in charge of the diffusion of the vaccine. In the second part, the attitude of the clergy will be analysed in greater detail, in order to measure the degree of collaboration with the government’s efforts to spread vaccination among the population. Methodologically, historiographical analysis has been mainly based on a careful examination of legislation; however, since in this way the attitude of the clergy emerges only episodically and between the lines, an abundant amount of historical documents collected in several archives of Southern Italy has been analysed, too. The choice of extending the survey from the State Archive in Naples to the archives in the provinces was inspired by the belief that an analysis of the Neapolitan sources exclusively could result in misleading conclusions: from such sources – mainly consisting of laws, decrees, and administrative circulars – there emerges, in fact, a picture of a vaccination praxis coinciding with the one hoped for by the government, yet not necessarily corresponding to the reality of facts. Therefore, if we want to understand the role of the Southern clergy as regards the vaccine – not in its theoretical aspects (resulting from legislative regulation) but in its more concrete features – it is necessary to consult also the provincial archives. From their analysis a perspective emerges that is somehow different from the one upheld by the government, yet certainly more closely corresponding to the reality of the situation.

The Major Legislative Measures on Vaccination Issued between 1802 and 1822

The beginnings of vaccination in Southern Italy date back to 1801, when the British physician Joseph Marshall was appointed, together with his colleague John Walker, to join a British naval expedition to Egypt so as to vaccinate the members of the crew and, at the same time, to spread the new method of smallpox prevention among the British troops stationed in the Mediterranean⁴. After reaching Gibraltar, Minorca

3 See Caterina Tisci, “La vaccinazione antivaiolosa nel Regno di Napoli (1801–1809): il ruolo del clero”, *Medicina & Storia*, 3 (2003), 89–117.

4 Only a few years before (in 1796), Edward Jenner had attested as experimental evidence a fact commonly observed among the rural classes of Gloucestershire, demonstrating the efficacy

and Malta, the two doctors separated: while Walker continued into Egypt, Marshall headed to Palermo in order to vaccinate the sailors of the British ships quartered there⁵. During his stay in Sicily, however, thanks to the support of the Bourbon court – at the time temporarily installed in Palermo – Marshall extended these vaccinations to the local population, teaching the method to two colleagues, Giovanni Vivencio and Michele Troja, respectively *protomedico* (Chief Physician) and First Surgeon of the King⁶. From Sicily, Marshall reached Naples, spreading also there the first vaccinations which were widely promoted by means of public posters⁷. When the court returned to the continent, in June 1802, a Head Office for Vaccination was set up in Naples, formally presided by Michele Troja but in fact operated by vice-director Antonio Miglietta, who was destined to become one of the key protagonists of the diffusion of vaccination in the Kingdom⁸.

In a meeting of July 6th, 1802, the Head Office formulated a plan aimed to spread vaccination in the capital city and in the provinces that was acknowledged integrally

of the inoculation of cowpox as a form of prevention against smallpox. Jenner had then divulged the results of his research in the volume *An inquiry into the causes and effects of the variolæ vaccinae, a disease discovered in some of the Western counties of England, particularly Gloucestershire, and known by the name of the cow pox* (London, 1798).

5 On the vaccinations conducted in the British territories in the Mediterranean during the naval expedition to Egypt, more or less ample observations are available in various monographs, old and recent, rather heterogeneous in kind and value. Among these can be mentioned Francesco Calcagni, *A letter on the inoculation of the vaccina practised in Sicily*, (Philadelphia, 1807), in particular pp. 8fn, 14fn and 31; John Baron, *The life of Edward Jenner, with illustrations of his doctrines and selection from his correspondence*, I, (London, 1838), pp. 395–403; Paul Cassar, “Edward Jenner and the introduction of vaccination in Malta”, *Medical History Journal*, 13 (1969), 68–72; Yves-Marie Bercé, “Le clergé et la diffusion de la vaccination”, cit., pp. 88–89; Gianni Iacovelli, *Antonio Miglietta, il vero apostolo della vaccinia, e il vaiolo a Napoli tra ‘700 e ‘800*, in A. Tagarelli – A. Piro – W. Pasini, eds., *Il vaiolo e la vaccinazione in Italia*, (Villa Verucchio, 2004), II, p. 565; John Chircop, “Giusta la benefica intenzione del Re’: the Bourbon cowpox vaccination in Sicily”, *Hygiea internationalis. An Interdisciplinary Journal for the History of Public Health*, 9 (2010), pp. 158–159.

6 It seems almost superfluous to underline the power and prestige connected with the two positions held by the mentioned doctors. In particular, the chief physician was the head of the whole sanitary organisation of the country: see Luigi De Rosa, *Conflitti e squilibri nel Mezzogiorno tra Cinque e Ottocento*, (Bari-Rome, 1999), p. 126.

7 See Archivio di Stato [State Archives] of Naples (henceforth: ASN), *Ministero della Polizia Generale, Dispacci reali*, b. 134, dispatch No. 228 of June 23rd, 1801.

8 See ASN, *Ministero delle Finanze*, b. 2870, a letter by Michele Troja to the Minister of Finance, n.d. [but of December 1802]. On Miglietta there is very abundant bibliography. Among the most recent works, see in particular S. Arieti, *Miglietta Antonio*, in *Dizionario Biografico degli Italiani*, (Rome, 2010), vol. 74, 364–365; Gianni Iacovelli, *Antonio Miglietta, il vero apostolo della vaccinia, e il vaiolo a Napoli tra ‘700 e ‘800*, in A. Tagarelli – A. Piro – W. Pasini, eds., *Il vaiolo e la vaccinazione in Italia*, cit.; Lorenzo Carlino, *Cenni sull’opera di Antonio Miglietta e Cosimo De Giorgi in Terra d’Otranto*, *ibid.*, II, 551–559. About Troja, see Gianni Iacovelli, *Gli acquadotti di Cotugno. Medici pugliesi a Napoli tra Illuminismo e Restaurazione*, (Galatina, 1988), pp. 65–68 and *passim*.

and with no modifications in the dispatch of July 22nd of the same year⁹. The dispatch can be considered the true starting point of the history of vaccination in Southern Italy, and, at the same time, one of the most organic and elaborate measures on the matter issued during the first Bourbon Restoration. As far as Naples was concerned, the dispatch identified five sites, at due distance one from another, where every other day, for the whole morning, a physician and a surgeon would vaccinate without charge whoever presented themselves. On such occasions, the doctors were to also verify the course of the vaccinations already administered, and give appropriate instructions to the patients. The list of the vaccinated, with the indication of the outcome of each individual operation, would be presented to the sovereign, and successively published. In order to spread among the medical community the knowledge of the appropriate vaccination method, the dispatch also provided for the printing of a brochure. With regard to the provinces, the dispatch required the *presidi* (i.e. the highest district administrative authorities) to designate a number of physicians and surgeons equal to six for the small provinces, and to ten for the large provinces. They were to reside in Naples at the expense of their municipalities of origin for the necessary time to be trained in the new method under the guidance of doctors Vivenzio and Troja.

These solid premises were only partially confirmed by subsequent developments. In effect, despite the lack of official statistics on the number of the vaccinated, we can deduce from documentary evidence that in Naples vaccination became established to a certain extent whereas in the provincial territories its propagation was hampered almost everywhere. The positive outcome of vaccination in Naples is also attested through an autobiographical memoir by Antonio Miglietta, who attributed the merit of this result, on the one hand to the almost unanimous consensus granted to such practice on the part of the doctors of the capital city, and on the other to a terrible smallpox epidemic that raged between 1802 and 1803, thus prompting even the most reluctant to test the effectiveness of the new method¹⁰. Significantly different was the situation in the provinces, where things did not work the way they were supposed to. In 1806 Miglietta himself, outlining the status of the vaccination policy in this original phase, admitted that the government plan, as far as the provinces were concerned, had not been fully implemented, and that the vaccination posts outside the capital were still at a design stage¹¹. Something, therefore, had stalled. It is not difficult to deduce that, besides the vast number of opinions contrary

9 A copy of the plan is preserved in ASN, *Ministero dell'Interno*, II inventario, b. 2325, fasc. 165. The dispatch of July 22nd, 1802 can be found in ASN, *Ministero della Polizia Generale. Prima numerazione (1792 – 1819)*, b. 10, pp. 228–230.

10. See Antonio Miglietta, *Statistica vaccinica napoletana*, (Naples 1820), p. 3.

11 See ASN, *Ministero dell'Interno*, II inventario, b. 2325, fasc. 88: [Antonio Miglietta], *Prospetto sullo stato degli stabilimenti di vaccinazione, fondati in questo Regno sin dall'anno 1802*, enclosed in a letter of April 7th, 1806, by Miglietta himself to the Minister of the Interior.

to vaccination – which were to hinder its success also at a later period – the Bourbon initiative suffered from a remarkable weakness, inasmuch as the diffusion of Jenner's method did not rest on a solid and efficient administrative structure. There lacked a real health policy coordination centre, and the management of the treatment posts itself was often in the hands of confraternities, religious orders or other ecclesiastical institutions, thus slipping from the control of the government authorities.

With the French conquest of the Kingdom in February 1806, the practice of vaccination was given a more decisive impulse, this time supported by greater organisational efficiency. It is indeed significant to note that, after only one month since the establishment of the new government, it was decreed that public health was to be under the competence of the Ministry of the Interior, shifting thus under the latter's responsibility both the Health Tribunal and Superintendency of Naples, and the Health Tribunals or Deputations of the Kingdom¹². Vaccination practice could thus rely on a solid bureaucratic structure, consisting of one of the central branches of the state administration, which constituted the premise for a more determined implementation of the practice itself. With similar celerity, initial measures were ratified with the intent of promoting the diffusion of Jenner's method. First of all, the government began to advocate the drawing up of projects aimed at an effective spreading of vaccination. Between the end of 1806 and the first half of the following year, several plans were presented to the Ministry of the Interior, among which it is worthwhile mentioning, for the systematic nature and intelligence of its formulation, the project proposed by Giuseppe Caparrotti, a Calabrian doctor¹³. The plan envisaged, among other things, that smallpox patients be admitted into hospital wards specifically reserved for them, and that those who perished from the disease be buried preferably in cemeteries outside the town walls with no official funeral procession so that the parish priest could not demand any payment for the celebration of funeral services. This measure was clearly intended to bypass the well-known poor collaboration of the clergy in supporting Jenner's discovery among the members of their congregation – such poor collaboration resulting, one had the not groundless suspicion, from the priests' unwillingness to lose the earnings deriving from the frequent deaths that occurred during the epidemics.

The first articulated intervention in vaccination policy of the French Decade, and at the same time the basis and the point of reference for the ones that were to follow,

12 See Enrica Delle Donne, *L'organizzazione della salute pubblica dai napoleonidi alla Restaurazione*, in Antonio Cestaro – Antonio Lerra, eds., *Il Mezzogiorno e la Basilicata fra l'età giacobina e il Decennio francese*, Atti del Convegno di Maratea, 8–10 giugno 1990, (Venosa, 1992), II, p. 433. The decree in question is of March 31st, 1806.

13 See ASN, *Ministero dell'Interno*, II inventario, b. 2325, fasc. 53, *Piano di direzione di vaccinazione proposto dal dottor fisico e Regio professore di vaccinazione Giuseppe Caparrotti*, with no date but enclosed in a letter by Caparrotti himself to the Minister of the Interior (May 20th, 1807).

was the decree of May 20th, 1807¹⁴. The decree provided for the creation in Naples of a Central Committee for Vaccination – designed to replace the previously established Head Office for Vaccination – composed of ten members, among whom Antonio Miglietta, appointed as perpetual secretary, as also Domenico Cotugno (who was 71 years old at the time), one of the most renowned and illustrious representatives of Neapolitan medical culture¹⁵. The Central Committee – which was to have a facility for formal meetings, for its archive, and for vaccinations – had the task both of spreading the prophylactic system in Naples and of coordinating its propagation in the provincial territories. This first important legislative step was integrated by a number of other measures which rapidly followed one another. On June 6th, 1807, a ministerial circular to the Intendants reaffirmed the obligation to establish, in every provincial capital, a Provincial Committee for Vaccination (with suitable headquarters) and in every districtual capital a District Committee or, as an alternative, to appoint one or two physicians, in contact with the Provincial Committee, officially in charge of conducting the vaccinations in their territory of competence.

Furthermore, at the end of the same year, a *Piano di un regolamento* [Regulation Plan] was printed that illustrated those that, in the auspices of the Central Committee, had to be the tasks and features of the Provincial Committees, which had only been briefly sketched in the decree of May 20th, 1807 and in the above-mentioned supplementary circular¹⁶. In compliance with this *Plan*, the Committees had to assume various and differentiated responsibilities. First of all, they had the task to find and preserve the vaccine pus; furthermore, to provide for the training of the local health personnel about the manner of vaccinating; and finally to conduct information activities about the advantages of vaccination, on the one hand refuting hearsay intended to denigrate such practice, and on the other providing support for its usefulness and relevance through the parish priests. The members of the Central Committee too, therefore, had understood very well how important it was to engage

14 A copy of the decree is preserved in the Archivio di Stato [State Archives] of Bari (henceforth ASBa), *Sanità pubblica*, 2 (1806–1846), fasc. 15/II.

15 For an introduction to the life and works of Cotugno, see Loris Premuda, *Cotugno Domenico*, in *Dizionario Biografico degli Italiani*, (Rome, 1984), vol. 30, 480–483. Among the most recent bibliographical contributions, see in particular: A. Borrelli, ed., *Domenico Cotugno: documenti d'archivio 1766–1833*, (Naples, 1997); Id., *Istituzioni scientifiche, medicina e società. Biografia di Domenico Cotugno*, (Florence, 2000).

16 See Comitato Centrale di Vaccinazione [Central Committee for Vaccination], *Piano di un regolamento sulle funzioni de'Comitati provinciali di Vaccinazione del Regno di Napoli, stabilito dal Comitato centrale nella seduta del dì 4 ottobre 1807*, no typographical notes (a copy of the document is preserved at the Archivio di Stato [State Archives] of Campobasso, *Intendenza del Molise*, b. 1016, fasc. 144–II).

the parish clergy in spreading the new prophylactic method, in the light of the strong moral and intellectual ascendancy of this class on the mass of believers¹⁷.

At the time of the Second Restoration – consistently with the more general political trend that wished to avoid dismantling the reforms introduced during the French Decade and that preserved most of them – the new developments, also in the field of vaccination, were very few, at least at the beginning¹⁸. The first intervention was of a merely ‘nominal’ nature: in 1816 the Committees for Vaccination (as the term “committees” was perhaps considered too close to revolutionary argot) were renamed as Vaccination Commissions¹⁹.

This was followed by the important decree of November 6th, 1821²⁰, which implicitly rejected the proposal formulated by several representatives of the Southern medical class, namely indiscriminate compulsory vaccination²¹. In the light of the

17 On the set of tasks assigned to the clergy during the French Decade, see Michele Miele, “Il clero nel Regno di Napoli, 1806 – 1815”, *Quaderni storici*, 37 (1978), 284–313. No validation has been provided yet of the existence in Southern Italy of a form of collaboration imposed on the clergy by the lay authorities, which is instead attested in France, namely the request to avoid sounding death knells during smallpox epidemics. On this aspect, see, in the Archives Départementales de Meurthe-et-Moselle (Nancy), 50 J art. 28-4-8, a letter by the Minister of Religious Affairs to the bishop of Nancy, dated March 4th, 1803, in which the writer, urged by the Minister of the Interior, forwarded the request to the prelate, motivating it with the intent to keep away from the spirit of the sick, during epidemics, everything that could affect their imagination negatively and induce grievous premonitions.

18 About the substantial acknowledgement on the part of the restored Bourbons of the reforms introduced by the French, see Angelantonio Spagnoletti, *Storia del Regno delle Due Sicilie*, (Bologna, 1997), pp. 93–94. In the healthcare field, according to Gabriella Botti, the positive measures enforced in the French Decade “found confirmation and development in the reinstated Bourbon administration”: see Gabriella Botti, *Strutture sanitarie e malati nell’Ottocento borbonico*, in Angelo Massafra, ed., *Il Mezzogiorno preunitario. Economia, società e istituzioni*, (Bari, 1988), p. 1221.

19 See Antonio Miglietta, *Statistica vaccinica napoletana*, cit., p. 11. In the revolutionary and Napoleonic period, both the terms “comité” and “commission” are used to define bodies and institutions of public law. In the medical field, however, the term “comité” appears to have been employed more frequently (Comité de salubrité, Comité central de la vaccine...): see Michel Vovelle, *Le parole della Rivoluzione* (Italian translation), (Bologna, 2006), pp. 30–31.

20 The decree can be read in the Archivio di Stato [State Archives] of Teramo, *Intendenza borbonica, Salute pubblica*, b. 225/A, fasc. 80.

21 Inexplicably, several scholars assert that the decree of November 6th, 1821 introduced compulsory collective vaccination in the Kingdom: see Pietro Pierri, “Le vaccinazioni antivaiolose nel Regno delle due Sicilie”, *Archivio storico per le province napoletane*, 106 (1988) p. 410; Vittorio Donato Catapano, *Medicina a Napoli nella prima metà dell’Ottocento*, (Napoli, 1990), pp. 111–112; Lorenzo Carlino, *Cenni sull’opera di Antonio Miglietta e Cosimo De Giorgi in Terra d’Otranto*, in A. Tagarelli – A. Piro – W. Pasini, eds., *Il vaiolo e la vaccinazione in Italia*, cit., II, p. 551fn; Silvano Franco, *Il vaiolo in Terra di Lavoro*, *ibid.*, III, p. 982; Umberto Mendia, *Un esempio di medicina preventiva nel Decennio: la profilassi antivaiolosa*, in L. Iacuzio – L. Terzi, eds., *Studi e ricerche sul Decennio francese*, *Scrinia*, 3 (2006), p. 244fn. In fact, the decree in question sanctioned compulsory

disfavour that, especially among the poorest and least educated classes, continued to surround such practice, the introduction of compulsory vaccination was still considered impracticable. In addition to this, the political situation was extremely unfavorable for the proposal of a measure of this kind. It was, indeed, the aftermath of the insurrectional experience of 1820-21, and the trauma had been such as to render wholly inappropriate, in the eyes of the legislator, to impose a compulsory measure that could trigger widespread hostility towards the government, and perhaps also uncontrollable rebellious acts. For these reasons, the decree limited compulsory vaccination to some specific classes of subjects that were “regimented” and easily disciplinable or excluded, due to their condition, from concrete possibilities of opposition. Such were *in primis* the students of the civil, ecclesiastical, and military colleges, and then the foundlings, who were to be vaccinated within a month of their admission to the charity institution that accommodated them²². As for the rest of the subjects, the decree merely introduced simple forms of encouragement to undergo the operation. The decree required, for instance, that each parish priest should keep a register of all the vaccinated children within his parish; at the end of each year, during a public ceremony at the presence of the civil authorities, the name of a person out of every hundred vaccinated people would be drawn, and the person would then receive a prize of six ducats²³. To the same context pertains a norm according to which the non-vaccinated were to have neither the right to forms of donation from the State, nor would they have their petitions accepted by the public administration²⁴. The decree was completed by some measures more directly intended for the clergy. The parish priests were indeed assigned the duty to make people understand – through their catechistic teachings and homiletic allocutions –

vaccination for some specific (and limited) groups of individuals only. For completeness's sake, it must be added that, until 1821, collective compulsory vaccination was introduced in few European countries only, mainly in the German and Scandinavian areas, in the following chronological order: Principato of Lucca and Piombino 1806; Bavaria 1807; Denmark 1810; Norway 1811; Baden 1815; Kurhessen 1815; Sweden 1816; Württemberg 1818; Nassau 1818; Hannover 1821: see Yves-Marie Bercé, *L'introduzione de la vaccination antivariolique en Toscane, 1801–1815*, in I. Tognarini, ed., *La Toscana nell'età rivoluzionaria e napoleonica*, (Naples, 1985), p. 600; Edward Joshua Edwardes, *A concise history of small-pox and vaccination in Europe*, (London, 1902), p. 49. It should be further specified that in some of these cases compulsoriness was indirect. In 1810, Danish law, for instance, merely decreed that citizens who wished to be admitted to confirmation and marriage had to present a certificate of vaccination. Actual compulsoriness, on the other hand, was introduced instead by Swedish law, one of the most restrictive, in 1816. The law provided for a fine for those parents who did not have their children vaccinated by the age of two: see Peter Sköld, “The key to success: the role of the local government in the organization of smallpox vaccination in Sweden”, *Medical History*, 44 (2000), p. 207fn.

22 See *Giornale dell'Intendenza della Provincia di Aquila. Anno 1821*, (Aquila, n.d.), pp. 207–209 (art. 4 and 8).

23 See *Ibidem*, p. 208 (art. 5).

24 See *Ibidem*, p. 207 (art. 1).

the serious fault in which the congregation would incur if they neglected the obligation to vaccinate themselves and their children. In order to prevent forms of cynical venality (evidently anything but rare), it was furthermore decreed that those who perished from smallpox be buried, in a closed coffin and without funeral rites, in churches outside the residential settings²⁵.

Much larger scope had the following legislative measure, that is, the *Regolamenti per la pratica della vaccinazione ne' dominj del Regno delle Due Sicilie* [Regulations for the Practice of Vaccination in the Territories of the Kingdom of the Two Sicilies], issued on September 10th, 1822²⁶. These new *Regulations* redefined in detail the operative features of the central and peripheral institutions in charge of the diffusion of vaccination. As far as the Central Commission for Vaccination was concerned, there was, first of all, a new denomination: from then on, it would in fact be called Central Neapolitan Vaccination Institute²⁷ – differently, its original headquarters and, especially, its dependence on the Ministry of the Interior (as happened to all the bodies accountable for public health) would persist unchanged²⁸. As for its functions, the *Regulations*, besides confirming those that were already enforced, required a public meeting to be held at the beginning of every year, in which the secretary was to present the official statistics of the vaccinated in the previous year. On such an occasion, a special prize was to be awarded to the physician who had conducted the highest number of vaccinations (as long as they exceeded 2,000), and further rewards were to be granted to other doctors who had distinguished themselves by spreading such practice. It was also decreed that a public competition, open to national and foreign scholars, was to be held for the drafting of a scientific memoir on a theme inherent to vaccination to be indicated in the course of the meeting itself²⁹. The measures aiming to reinforce the diffusion of vaccination can be distinguished in those concerning the capital city and those regarding the provinces. As far as Naples was concerned, it was decreed that the Central Institution, which already had twelve ordinary vaccinators, was to have just as many supernumerary vaccinators³⁰. In all the city districts, furthermore, a site was to be designated (preferably in a suppressed monastery) to be dedicated to performing vaccinations, which had to always take place under the vigilance of the police commissioner (a detail from which one can grasp the problems of disorderly conduct often connected with the performance of

25 Ibidem (art. 3). This measure, of course, deprived the parish priests of remuneration for the celebration of funeral rites.

26 See *Giornale dell'Intendenza della Provincia di Aquila. Anno 1823*, (Aquila, n.d.), pp. 9–23.

27 See Ibidem, p. 10 (art. 1).

28 See Ibidem, pp. 11–12 (art. 3 and 4).

29 See Ibidem, pp. 14–15 (art. 7).

30 See Ibidem, p. 11 (art. 2).

vaccinations)³¹. With regard to the provinces, the *Regulations* provided for the creation of municipal Councils composed of the mayor, the parish priest (or priests), the municipal physicians and surgeons or – in the absence of the latter – the doctors who had been appointed as vaccinators³². The Councils were to meet at the end of every month to verify the progress of the vaccinations as well as to adopt the most urgent measures in case of epidemics³³. Municipal physicians and surgeons had the obligation to administer the vaccinations and to forward the list of the vaccinated to the municipal Chancellor monthly³⁴; in turn, the latter was to communicate these names to the Council, and through it to the parish priests, who had been assigned the task to verify their authenticity and to compile the register of the vaccinated, a responsibility that pertained to them in compliance with the decree of November 6th, 1821³⁵.

The Attitude of the Clergy towards Vaccination

As can be inferred from the legislative measures briefly surveyed above, since the beginnings of the diffusion of Jenner's method in Southern Italy, the clergy had been called upon to conduct a campaign of mediation aimed at making such practice more well-received among the masses, who were by instinct suspicious and hostile. In a letter to Jenner, Joseph Marshall recalls that in 1801 in Palermo, in the days of the public vaccination, one could observe processions of men, women, and children conducted through the streets by a priest carrying a cross to the vaccination posts³⁶.

However, notwithstanding the continuous and pressing attempts on the part of the government to engage the clergy in the vaccination campaigns with persuasive and sometimes even directly operational tasks (albeit, of course, in side-functions), the impression obtained from documentation is that the priests were not always observant of the functions asked of, or prescribed for, them. Examples in this respect abound. In 1808, for instance, the Intendant of the Department of Calabria Citeriore

31 See *Ibidem*, p. 13 (art. 5).

32 See *Ibidem*, pp. 18–19 (art. 13).

33 See *Ibidem*, p. 19 (art. 14).

34 See *Ibidem*, p. 17 (art. 11).

35 See *Ibidem*, p. 20 (art. 15).

36 See a letter by Joseph Marshall to Edward Jenner of January 26th, 1802, transcribed in John Baron, *The life of Edward Jenner, with illustrations of his doctrines and selection from his correspondence*, cit., I, p. 403. Marshall writes: “it was not unusual to see in the mornings of the public inoculation at the Hospital a procession of men, women and children, conducted through the streets by a priest carrying a cross, come to be inoculated.” Not without irony, the author of the letter observes that, with such a method, the population considered vaccination “a blessing sent from Heaven, though discovered by one heretic and practised by another” (*ibid.*).

said he was convinced that, to spread vaccination, one could very little rely on priests since they were for the most part ignorant, and therefore most likely not really persuaded of the usefulness of such practice³⁷. The following year, a report on the vaccination campaigns in the various provinces of the Kingdom denounced, in particular in the case of the Department of Terra di Bari, an extremely negligent attitude on the part of the clergy³⁸. In the same province, the Intendant, in a circular, reached the point of proposing, even if in rather generic terms, the donation of financial reward from the government to those priests who would distinguish themselves by their efforts at persuasion among the population about the usefulness of the vaccine³⁹. Much more drastic was the idea conceived by the Intendant of Principato Citeriore in 1807, who in a letter to the Minister of the Interior, while stating his belief that among the major obstacles to the diffusion of Jenner's method there was “the superstition fomented by ignorant priests”, proposed to remove from their ministry those parish priests whose parishioners refused to be vaccinated, or in whose parishes smallpox epidemics occurred⁴⁰. The proposal, which was acknowledged by the office holder of the Ministry and handed over for competence to the Minister of Religious Affairs, was rejected by the latter with measured but firm argumentations⁴¹. It did not seem fair, in his opinion, to punish the parish priests for the reluctance of parents to have their children vaccinated; once the priests had illustrated from the pulpit the advantages of such practice, they had no further obligation, nor could they be called to account for their parishioners’ inertia or aversion towards the vaccine. Proving to be healthily realistic, the Minister of Religious Affairs observed, furthermore, that “such an inveterate prejudice [...] cannot be eliminated through a sermon” (thus implicitly admitting that most priests had limited themselves to isolated addresses in favour of vaccination, without pursuing those long-lasting and committed efforts at persuasion which the legislator hoped for)⁴². In effect, if such a drastic proposal had been devised, it was precisely a sign that the parish priests, in general, did not cooperate in providing support for the vaccine among the population. The complaints of the administrators on the matter were indeed frequent. In 1809, the Intendant of Department of Capitanata, in a

37 See ASN, *Ministero dell’Interno*, II inventario, b. 2326, fasc. 32, a letter by the Intendant of Calabria Citeriore to the Minister of the Interior, dated February 21st, 1808.

38 See “Continuazione de’ dettagli su le vaccinazioni eseguite nelle province, e rapportate al Comitato Centrale”, *Opuscoli di vaccinazione*, 11–12 (1809), p. 136.

39 See ASBa, *Sanità pubblica*, 2 (1806–1846), fasc. 15/I, a circular of the Intendant to the justices of the peace, mayors and parish priests of the province, dated February 24th, 1809.

40 See ASN, *Ministero dell’Interno*, II inventario, b. 2325, fasc. 152, a letter by the Intendant of Calabria Citeriore to the Minister of the Interior, dated December 2nd, 1807.

41 See *Ibidem*, fasc. 176, a letter by the Minister of Religious Affairs to the Minister of the Interior, dated December 26th, 1807.

42 *Ibidem*.

circular, pointed his finger at those priests who, deaf to the pressing calls from the government, refused to explain to the population the usefulness of the new method of prevention⁴³. In 1814, in San Marzano, Principato Citeriore, a priest even went as far as to publicly discredit vaccination during Sunday mass, and to menace two physicians who were present in the church because they were 'guilty' of having tried to vaccinate a nephew of his⁴⁴.

There were exceptions, of course. In Giovinazzo, Terra di Bari, in 1808, the majority of the population resulted docile towards the practice of vaccination, a result achieved above all thanks to the patient efforts at persuasion pursued in particular by the bishop and the parish priests⁴⁵. In Cerignola, Capitanata, in 1810, the priests appeared very supportive with the physicians that administered the vaccinations; they illustrated the advantages of such practice to the population, and would sometimes perform the operations themselves⁴⁶. In Chieti, in 1812, the parish priests had often attacked from the pulpit the biases against the new method in which the congregation was imbued, albeit (as it seems) without significant results⁴⁷. These were, however, rather rare cases, as the prevailing attitude of the clergy showed – if not a conscious boycott of the government's requests – at least poor cooperation.

What were the reasons behind such a state of affairs? There were, in fact, many different factors which must therefore be analysed separately. First of all, elements of an ideological and doctrinal nature. The possibility of preventing a human disease by

43 See Archivio di Stato [State Archives] of Foggia (henceforth ASFg), *Intendenza e Governo di Capitanata – Sanità Pubblica*, bb. 8–9, fasc. 59, a circular by the Intendant to all the authorities of the province, dated May 31st, 1809.

44 See ASN, Ministero dell'Interno, II inventario, b. 2331, fasc. 131, a letter of the Central Committee for Vaccination to the Minister of the Interior, dated July 11th, 1814; Ibidem, letter by the Intendant of Principato Citeriore to the Minister of the Interior, dated July 25th, 1814, from which one concludes that the priest responsible for the circumstance, whose name was Giuseppe Pasquale, was punished with six days of detention.

45 See ASN, *Ministero dell'Interno*, II inventario, b. 2325, fasc. 164, minute of a letter by the Minister of the Interior to the Minister of Religious Affairs, dated July 11th, 1808.

46 See ASFg, *Intendenza e Governo di Capitanata – Sanità Pubblica*, b. 2, fasc. 17, a letter of the Cerignola Sub-Committee for Vaccination to the Intendant, dated March 31st, 1810. This one is the only case attested in the documentation of priests performing the vaccinations themselves. Also elsewhere, this seems to have occurred only in exceptional circumstances: Yves-Marie Bercé mentions this event only with reference to some centres in Alsace and few other rural villages in France: see Yves-Marie Bercé, *Le clergé et la diffusion de la vaccination*, cit., pp. 101–102. Peter Sköld, though considering the cooperation of the clergy in Sweden as one of the key factors that enabled a fast and widespread diffusion of Jenner's method in the Scandinavian country, admits that the cases of pastors personally performing the vaccinations were extremely few: see Peter Sköld, *The key to success: the role of the local government in the organization of smallpox vaccination in Sweden*, cit., p. 225fn.

47 See Archivio di Stato [State Archives] of Chieti, *Intendenza, Salute pubblica*, b. 114, fasc. 24, a letter of the Provincial Committee for Vaccination to the Intendant, dated February 7th, 1812.

means of material produced by an animal disease was based on the thesis of a fundamental analogy existing between the two. This was in contrast with the ontological alterity between human beings and beasts postulated by Catholicism. Moreover, was it licit – many priests wondered – to inoculate human beings with material from the brutes? Did it not mean risking contaminating with the temperament and instincts of the bovine species those who were thus treated? Was there not the risk to “Minotaur” (so to speak) human beings? This stance – to be honest, scarcely documented in a strictly Southern ambit yet most likely widespread in that geographical area too – was typical of some sectors of the clergy, but had also spread in a portion of the lay public opinion⁴⁸. In some European countries, this conviction was also supported by an effective propaganda campaign conducted through satirical prints that showed vaccinated subjects from whose limbs, small, monstrous bovines would spring⁴⁹. Critical voices against this imaginative thesis rose however within the ecclesiastical world itself. Is it not true, some prelates argued, that human beings drink cows’ milk and eat cow’s meat without these substances causing harm to them in any way? Therefore, there is no risk at all to be contaminated by bovines using their pus to prevent the onset of smallpox⁵⁰.

Equally insidious was another opinion that, at first sight, seemed even more grounded from a theological point of view. This opinion considered both health and disease as essentially deriving from God’s inscrutable will. Man had the obligation to accept either of these states, with gratefulness or resignation. Undergoing vaccination, with the aim of preventing a disease, was equivalent to usurping a prerogative of the Eternal One, that is, committing an arbitrary and immoral act⁵¹.

48 J. A. Dudgeon mentions the fact that, in England itself, “fears were expressed that this bestial procedure would lead to new and foul diseases, and that children vaccinated with cowpox would develop horns and the human character would undergo transformations”: see J. A. Dudgeon, “Development of smallpox vaccine in England in the eighteenth and nineteenth centuries”, *British Medical Journal*, 1 (1963), p. 1368. On the existence of similar fears in Sicily, see John Chircop, “Giusta la benefica intenzione del Re’: the Bourbon cowpox vaccination in Sicily”, cit., p. 172. The diffusion of this position also in the continental part of the Kingdom of the Two Sicilies can be indirectly deduced, among other things, from a brief account of this stance, with a confuting purpose, in a text by Piarist Serafino Gatti: see Serafino Gatti, “Lettera [...] ad un suo amico anti-vaccinista”, *Opuscoli di vaccinazione*, 4, n.d., 93–119.

49 See in particular James Gillray’s print entitled *The Cow-Pock, or the wonderful effects of the new inoculation* (1802), which displays an amusing collection of teratological metamorphoses while a painting portraying the Biblical episode of the adoration of the Golden Calf by the Hebrews allusively supervises them from a wall. The sketch was also reproduced on the cover of Stanley Williamson’s volume *The vaccination controversy: the rise, reign and fall of compulsory vaccination for smallpox*, (Liverpool, 2007).

50 See the pastoral letter by the archbishop of Turin, Giacinto Della Torre, dated July 26th, 1808, cited in Yves-Marie Bercé, *Le clergé et la diffusion de la vaccination*, cit., p. 96.

51 An analogous opinion had made its appearance also in the 18th century in opposition to the much more rudimental preventive method of human smallpox inoculation: see Arnold H.

That such a thesis was quite widespread among the Southern clergy is proven by a vast body of evidence. Suffice it here to mention, among others, a passionate appeal – dated 1809 – addressed to the Intendant of Capitanata by physician Luigi Sorge from Foggia, in which the doctor stigmatised the fact that several priests had instilled in their parishioners the idea that “the emergence of human smallpox and its slaughter were of God's will, something which cannot be heard but with a shudder and horror”⁵². However, the indignation of a provincial doctor (expressed, moreover, in a simple letter) was certainly not sufficient to refute an apparently deep-rooted conviction. In order to counter this conviction, the government resorted to circulating short and easy-to-read notes that, on the basis of theological arguments supported by appropriate quotations from the Scriptures, proved its groundlessness.

The most well-known of such notes is the *Omelia, in cui si parla dell'utile scoperta dell'innesto del vajuolo vaccino, fondata sul Vangelo de' dieci lebbrosi, recitata dal vescovo di Goldstat* [Homily about the useful discovery of the inoculation of cowpox, based on the Gospel of the ten lepers, recited by the bishop of Goldstat], an apocryphal text (the city of Goldstat does not exist, and its etymon – city of gold – highlights its allusively utopian nature) originally printed in Brescia in 1802, and then in subsequent editions in several other states of the peninsula⁵³. Its diffusion in the Kingdom of Naples was quite large for the standards of the time, if one considers that in 1806 the Royal Printing House printed two thousand copies of the document; that in many provinces it was published in the official Papers of the Intendancy; and that the Minister of Religious Affairs forwarded it to all bishops so that through the parish priests it could be publicly read to the congregation⁵⁴. With respect to its contents, the document cleverly relied on the passage of the Gospels about the ten

Rowbotham, “The “philosophes” and the propaganda for inoculation of smallpox in Eighteenth-Century France”, *University of California Publications in Modern Philology*, 18 (1935), p. 282.

52 See ASFg, *Intendenza e Governo di Capitanata – Sanità Pubblica*, bb. 8–9, fasc. 59, a letter by doctor Luigi Sorge to the Intendant, dated June 15th, 1809.

53 The complete title of the document is: *Omelia, in cui si parla dell'utile scoperta dell'innesto del vajuolo vaccino, fondata sul Vangelo de' dieci lebbrosi, recitata dal vescovo di Goldstat, e proposta, come di modello, ai parrochi del Regno di Napoli alla Direzione della Vaccinazione, in seguito al Sovrano Rescritto de' 9 agosto 1806*, (Naples, n.d.). The Brescia edition was followed by three further editions in 1804 (Bologna, Como and Milan), two in 1805 (Parma and Pistoia), two in 1806 (Carpi and Naples) and one in 1808 (Florence). According to Yves-Marie Bercé, its author was doctor Luigi Sacco (who mostly contributed to the spreading of the vaccine in Northern Italy), who was staying in Brescia exactly when the first edition of the *Omelia* was being published: see Yves-Marie Bercé, *Le clergé et la diffusion de la vaccination*, cit., p. 97. A more recent study by Alessandro Porro agrees with this opinion: see Alessandro Porro, *Strategie di educazione sanitaria nelle campagne di vaccinazione. Le varie edizioni dell'Omelia sopra il Vangelo della XIII domenica dopo la Pentecoste (1802–1808)*, in A. Tagarelli – A. Piro – W. Pasini, eds., *Il vaiolo e la vaccinazione in Italia*, cit., I, p. 374.

54 See ASN, Ministero dell'Interno, II inventario, b. 2325, fasc. 24, a letter by the Minister of the Interior to the Minister of Religious Affairs, dated October 10th, 1806.

lepers healed by Jesus, of whom only one showed his gratitude to the Redeemer⁵⁵. The appropriateness of the reference derived, among other things, from the easy analogy between smallpox and leprosy, both skin diseases. The anonymous author equated the behavior of the nine ungrateful lepers with the attitude of those who, to face a terrible disease, and despite having at hand a simple and effective remedy like vaccination (furthermore, certainly made available by the benevolent hand of Divine Providence), neglected to make use of it, thus exposing themselves and their children to the risk of contracting the disease. Those who abandoned themselves to fatalism saying “If God wants my child to die, May His will be done” committed an extremely serious error, because it was God himself who commanded human beings to do everything in their power to preserve their health⁵⁶. Demanding miracles from God to remedy one’s own inertia was the same as “tempting Providence”. Nor could one object sustaining that vaccination was a preventive and not a curative remedy, since specific Scriptural passages prescribed that man should honour the physician, take the medicines he recommended, and follow his prescriptions, including those of a prophylactic nature⁵⁷. Even without delving into the document, it is evident that it employed a clever argumentative method, inasmuch as it attacked this theory on its own grounds, namely theology and its Scriptural bases.

The deep-rootedness of a passive and fatalist attitude among the Southern clergy (and, consequently, among the population itself) is proven by the fact that the apocryphal Homily was not the only text that was spread to contrast it. Between 1807 and 1811, within the different provinces, brochures were diffused – whose authorship was attributed to ecclesiastics (whether real or fictitious it is not known) – which partly reposed the contents of the homily by the bishop of Goldstat and added new reflections⁵⁸. In spite of the different local origin of these texts, their argumentative structure was uniform, and ample passages even resulted identical. These documents all opened by attributing to Christianity the merit of having spread, for the first time in history, hospitals and assistance institutions, thus aiming to present the work of physicians as one of the most authentic manifestations of Christian charity. The texts described then the terrible effects of smallpox, illustrating

55 See Lk, 17, 11–19.

56 See *Omelia, in cui si parla dell’utile scoperta dell’innesto del vajuolo vaccino, fondata sul Vangelo de’dieci lebbrosi*, cit., p. 6.

57 The Biblical passage here largely quoted was Sir, 38, 1–15, perhaps the most reasoned apology of doctors and their role in the Scriptures. As for the duty to follow an adequate prophylaxis to avoid contracting the disease, the Omelia cited Sir, 18, 19 instead, this time in a somewhat captious manner and slightly out of context.

58 See Vincenzo Maria Greco, *Lettera familiare diretta ad un parroco amico [...] sopra l’inoculazione vaccina per uso di tutt’i parrochi dell’Archidiocesi di Cosenza*, (Cosenza, 1807); Vincenzo Girardi, “Lettera familiare diretta ad un parroco amico [...] sopra la inoculazione vaccina”, *Atti dell’Intendenza della provincia di Aquila per l’anno 1811*, (Aquila, n. d.), 191–198.

the different remedies devised by man to fight this devastating disease. After a hasty tribute to the advantages of human smallpox inoculation, the much greater reliability of vaccine inoculation was emphasised, and the readers (ecclesiastics and parish priests themselves) were exhorted to provide support for this method among their parishioners, with the same argumentations and corresponding Scriptural references already mentioned in the case of the homily by the bishop of Goldstat⁵⁹. From the corpus of these texts, there emerges 'in the backlight' the image of a clergy that, clinging to pretentious interpretations of the sacred texts, maintained (and conveyed to their congregations) a fatalist attitude that refused a priori to resort to a preventive method which, furthermore, they scarcely trusted. Under these conditions, the collaboration from the clergy advocated by the government was destined to clash against coldness and apathy.

The situation was further aggravated by the fact that several priests considered as unrelated to their ministry the task of providing support, among their congregations, for an instrument whose sole aim was the preservation of physical health⁶⁰. Was it not the duty of parish priests to concern themselves with the spiritual sphere only? How was it possible to conceive such a deviation from the duties that they had chosen to fulfill by being ordained? Here too there was in fact a misunderstanding. Even admitting that the priests showed a tepid attitude towards the government's plan of making them executors of the efforts at modernisation of Southern society, they had little consideration, if any, for a series of incontrovertible elements. The Mosaic Law, *in primis*, appeared to have been conceived to direct human beings toward eternal salvation, as also as intent on preserving the health of the body. The Redeemer himself, moreover, did not disdain to cure, along with the infirmities of the soul, those of the body too, even the most repulsive. Finally, the annals of ecclesiastical history were full of saints who had cultivated the study of medicine, and had devoted themselves to the care of the infirm.

A further factor, extremely different from those taken into consideration so far, which contributes to explaining the recalcitrant attitude of several priests towards the government's requests, could be attributed to mercenary motives. Many members of the clergy showed a tepid interest in Jenner's method because its diffusion, inasmuch as it reduced smallpox mortality, also reduced a source of income which, especially in the case of epidemics, was far from derisory, namely the oblations for the celebration of funeral rites. In this case, too, there is documentary evidence that attests the presence of this despicable form of venality among the Southern clergy. For all, it may be cited here the testimony furnished by doctor Giorgio Lisa from San Giovanni Rotondo, Department of Capitanata, who in 1809 accused the parish

59 See Vincenzo Girardi, "Lettera familiare diretta ad un parroco amico [...] sopra la inoculazione vaccina", cit., pp. 193–194.

60 See Yves-Marie Bercé, *Le clergé et la diffusion de la vaccination*, cit., p. 95.

priest of his town of doing nothing to provide support for vaccination among his congregation because if he had he would perhaps have lost income deriving from funerals⁶¹. On the other hand, it is not by chance that since 1807, as mentioned above, doctor Giuseppe Caparrotti had suggested to the government that the people who perished from smallpox should be buried without funeral rites, and that this suggestion was acknowledged, as seen, in the decree of November 6th, 1821.

In conclusion, it can be observed that there certainly were, among the Southern clergy (and in particular among the better educated) those who, armed with philanthropy and faith in progress, did everything in their power to propagate Jenner's method, cooperating with the physicians and executing the directives of the government. However, these were for the most part exceptions. The vast majority of the priests showed coldness and apathy, and looked at the new method with distrust, if not with blind hostility. What concurred to determine this attitude were questionable ideological and doctrinal reasons, narrow visions of the duties of priesthood, but also ignoble pecuniary motives. In any case, the poor cooperation furnished by the clergy can be deemed one of the most considerable obstacles to the penetration of Jenner's method into Southern society.

Conclusions

Until the 1820s, diffusion of vaccination practice in Southern Italy was, on the whole, rather modest. As shown in Table I, by 1827 (taking into consideration the number of vaccinations carried out since 1808) only 16.9% of the total population of the Kingdom had been vaccinated. To this figure we should, in effect, add the number of the vaccinated in the period 1802-1807 – about which no official data exist – and also the number of all the people vaccinated by physicians and surgeons privately, with payment or free of charge – since the official figures were based on the periodical communications received from the Vaccination Commissions of the single provinces which did not take into consideration private vaccinations. Even accounting for this, the actual figure is realistically not much higher than the one shown in the Table.

Various factors contribute to the explanation of such a poor outcome, whose detailed analysis is outside the scope of this work; be it sufficient to mention here that, as shown by a comparison of data from the single provinces, the trend shows a higher number of vaccinated people in the coastal or flat provinces such as Abruzzo Ulteriore I or Capitanata, and a decidedly lower figure in the impervious and mountainous internal areas characterised by almost impracticable means of communication.

61 See ASFg, Intendenza e Governo di Capitanata – Sanità Pubblica, b. 1, fasc. 8, a letter by doctor Giorgio Lisa to the Intendant, dated January 9th, 1809.

Apart from the territorial features and prevalent settlement types in the Kingdom – which certainly did not facilitate the work of the itinerant vaccinators – a relevant obstacle to the diffusion of the new discovery came indeed from the attitude of the clergy, mostly skeptical and apathetic if not openly hostile. Determining such a situation there were, on the one hand, theological and ecclesiological factors, and on the other, quite different (and more abject) reasons of a mercenary nature. The thesis of the effectiveness of the vaccine for human beings was based, in fact, on the idea of an ontological analogy between the bovine species and the human species, which was not compatible with the Catholic view. On a less elevated speculative level, vaccination was attributed the quality of mixing fluids coming from brutes with those of humans, thus transferring to the latter the temper and instincts of the bovine species – a belief not shared, it must however be said, by the most learned and enlightened sections of the clergy. From an ecclesiological point of view, moreover, many priests considered the task of dealing with, or worrying about, the physical health of their parishioners to be extraneous to their duties, thus forgetting (consciously or not) the vast thaumaturgic activity of the Redeemer Himself. As for resistances of an economic nature, suffice it here to mention that many priests were against vaccination simply because, ceasing the deaths caused by smallpox, they would lose a not inconsiderable source of additional income from the oblations for the celebration of funeral rites during epidemics.

Table I. Ratio between the number of vaccinated people and total population in 1827

PROVINCES	POPULATION IN 1827	TOTAL OF VACCINATED 1808-1827	PERCENTAGE
Naples	724,239	120,489	16.6
Terra di Lavoro	644,511	104,614	16.2
Principato Citeriore	466,693	121,429	26.0
Principato Ulteriore	362,299	57,738	15.9
Terra di Bari	410,708	51,902	12.6
Capitanata	292,906	62,630	21.4
Basilicata	463,914	47,311	10.2
Molise	331,401	47,537	14.3
Terra d'Otranto	346,895	55,822	16.1
Abruzzo Citeriore	275,264	53,119	19.3
Abruzzo Ulteriore I	180,725	42,734	23.6
Abruzzo Ulteriore II	269,826	40,451	15.0
Calabria Citeriore	369,457	73,791	20.0
Calabria Ulteriore I- II	565,993	80,849	14.3
TOTAL	5.704,831	960,416	16.9

Sources: Luigi SERRISTORI, *Statistica del Regno delle Due Sicilie (dominij di qua dal Faro)*, (Firenze, 1839); *Biblioteca vaccinica. Anno 1828, I parte del vol. XII*, (Napoli, 1828).

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References

- Arieti, Stefano, Miglietta Antonio, in *Dizionario Biografico degli Italiani*, Rome, 2010, vol. 74, 364-365.
- Baron, John, *The life of Edward Jenner, with illustrations of his doctrines and selection from his correspondence*, I, London, 1838.
- Bercé, Yves-Marie, “Le clergé et la diffusion de la vaccination”, *Revue d’histoire de l’Église de France*, 69 (1983), 87-106.
- Bercé, Yves-Marie, *L’introduzione de la vaccination antivariolique en Toscane, 1801-1815*, pp. 595-611 in Ivan Tognarini, ed., *La Toscana nell’età rivoluzionaria e napoleonica*, Naples, 1985.
- Biblioteca vaccinica*. Anno 1828, I parte del vol. XII, Naples, 1828.
- Borrelli, Antonio, ed., *Domenico Cotugno: documenti d’archivio 1766-1833*, Naples, 1997.
- Borrelli, Antonio, *Istituzioni scientifiche, medicina e società. Biografia di Domenico Cotugno*, Florence, 2000.
- Botti, Gabriella, *Strutture sanitarie e malati nell’Ottocento borbonico*, pp. 1221-1230 in Angelo Massafra, ed., *Il Mezzogiorno preunitario. Economia, società e istituzioni*, Bari, 1988.
- Calcagni, Francesco, *A letter on the inoculation of the vaccina practised in Sicily*, Philadelphia, 1807.
- Carlino, Lorenzo, *Cenni sull’opera di Antonio Miglietta e Cosimo De Giorgi in Terra d’Otranto*, pp. 551-559 in Antonio Tagarelli – Anna Piro – Walter Pasini, eds., *Il vaiolo e la vaccinazione in Italia*, Villa Verucchio, 2004, vol. II.
- Cassar, Paul, “Edward Jenner and the introduction of vaccination in Malta”, *Medical History Journal*, 13 (1969) 68-72.
- Catapano, Vittorio Donato, *Medicina a Napoli nella prima metà dell’Ottocento*, Naples, 1990.
- Chircop, John, “Giusta la benefica intenzione del Re’: the Bourbon cowpox vaccination in Sicily”, *Hygiea internationalis. An Interdisciplinary Journal for the History of Public Health*, 9 (2010), 155-181.
- “Continuazione de’ dettagli su le vaccinazioni eseguite nelle province, e rapportate al Comitato Centrale”, pp. 135-139 in *Opuscoli di vaccinazione*, 11-12 (1809).
- De Rosa, Luigi, *Conflitti e squilibri nel Mezzogiorno tra Cinque e Ottocento*, Bari-Rome, 1999.
- Della Peruta, Franco, *Presentazione*, pp. XIX-XX in *Storia d’Italia, Annali 7. Malattia e medicina*, Turin, 1984.
- Delle Donne, Enrica, *L’organizzazione della salute pubblica dai napoleonidi alla Restaurazione*, pp. 431-456 in Antonio Cestaro – Antonio Lerra, eds., *Il*

- Mezzogiorno e la Basilicata fra l'età giacobina e il Decennio francese, Atti del Convegno di Maratea, 8-10 giugno 1990. Venosa, 1992, vol. II.
- Dudgeon, John A., "Development of smallpox vaccine in England in the eighteenth and nineteenth centuries", *British Medical Journal*, 1 (1963), 1367-1372.
- Edwardes, Edward Joshua, *A concise history of small-pox and vaccination in Europe*, London, 1902.
- Franco, Silvano, Il vaiolo in Terra di Lavoro, pp. 979-1000 in Antonio Tagarelli – Anna Piro – Walter Pasini, eds., *Il vaiolo e la vaccinazione in Italia*, Villa Verucchio, 2004, vol. III.
- Gatti, Serafino, "Lettera [...] ad un suo amico anti-vaccinista", *Opuscoli di vaccinazione*, 4, n.d., 93-119.
- Giornale dell'Intendenza della Provincia di Aquila. Anno 1821, Aquila, n.d.
- Giornale dell'Intendenza della Provincia di Aquila. Anno 1823, Aquila, n.d.
- Girardi, Vincenzo, "Lettera familiare diretta ad un parroco amico [...] sopra la inoculazione vaccina", *Atti dell'Intendenza della provincia di Aquila per l'anno 1811*, (Aquila, n. d.), 191-198.
- Greco, Vincenzo Maria, *Lettera familiare diretta ad un parroco amico [...] sopra l'inoculazione vaccina per uso di tutt'i parrochi dell'Archidiocesi di Cosenza*, Cosenza, 1807.
- Iacovelli, Gianni, Antonio Miglietta, il vero apostolo della vaccinazione, e il vaiolo a Napoli tra '700 e '800, pp. 561-580 in Antonio Tagarelli – Anna Piro – Walter Pasini, eds., *Il vaiolo e la vaccinazione in Italia*, Villa Verucchio, 2004, vol. II.
- Iacovelli, Gianni, *Gli acquedotti di Cotugno. Medici pugliesi a Napoli tra Illuminismo e Restaurazione*, Galatina, 1988.
- Jenner, Edward, *An inquiry into the causes and effects of the variolæ vaccinæ, a disease discovered in some of the Western counties of England, particularly Gloucestershire, and known by the name of the cow pox*, London, 1798.
- Mendia, Umberto, Un esempio di medicina preventiva nel Decennio: la profilassi antivaiolosa, in Linda Iacuzio – Lorenzo Terzi, eds., *Studi e ricerche sul Decennio francese*, Scrinia, 3 (2006), 233-245.
- Miele, Michele, "Il clero nel Regno di Napoli, 1806-1815", *Quaderni storici*, 37 (1978), 284-313.
- Miglietta, Antonio, *Statistica vaccinica napoletana*, Naples 1820.
- Omelia, in cui si parla dell'utile scoperta dell'innesto del vaiuolo vaccino, fondata sul Vangelo de' dieci lebbrosi, recitata dal vescovo di Goldstat, e proposta, come di modello, ai parrochi del Regno di Napoli alla Direzione della Vaccinazione, in seguito al Sovrano Rescritto de' 9 agosto 1806, Naples, n.d.
- Pierrì, Pietro, "Le vaccinazioni antivaiolose nel Regno delle due Sicilie", *Archivio storico per le province napoletane*, 106 (1988), 409-418.
- Porro, Alessandro, *Strategie di educazione sanitaria nelle campagne di vaccinazione*.

- Le varie edizioni dell'Omelia sopra il Vangelo della XIII domenica dopo la Pentecoste (1802-1808), pp. 363-398 in Antonio Tagarelli – Anna Piro – Walter Pasini, eds., *Il vaiolo e la vaccinazione in Italia*, Villa Verucchio, 2004, vol. I.
- Premuda, Loris, Cotugno Domenico, in *Dizionario Biografico degli Italiani*, Rome, 1984, vol. 30, 480-483.
- Rowbotham, Arnold H., “The “philosophes” and the propaganda for inoculation of smallpox in Eighteenth- Century France”, *University of California Publications in Modern Philology*, 18 (1935), 265-290.
- Serristori, Luigi, *Statistica del Regno delle Due Sicilie (dominij di qua dal Faro)*, Florence, 1839.
- Sköld, Peter, “The key to success: the role of the local government in the organization of smallpox vaccination in Sweden”, *Medical History*, 44 (2000), 201-226.
- Spagnoletti, Angelantonio, *Storia del Regno delle Due Sicilie*, Bologna, 1997.
- Tisci, Caterina, “La vaccinazione antivaiolosa nel Regno di Napoli (1801-1809): il ruolo del clero”, *Medicina & Storia*, 3 (2003), 89-117.
- Vovelle, Michel, *Le parole della Rivoluzione* (Italian translation), Bologna, 2006.
- Williamson, Stanley, *The vaccination controversy: the rise, reign and fall of compulsory vaccination for smallpox*, Liverpool, 2007.

Health Insurance Regime as Differentiation and Discipline: The Chinese Health Insurance Reforms

Jiong Tu

Introduction

Health care in the Chinese official discourses is expressed as a right. At the First National Health Work Conference in 1950, soon after the founding of the People's Republic of China (in 1949), health care was declared as a right. It laid down healthcare guidelines oriented towards 'workers, peasants and soldiers'.¹ The constitution,² first promulgated in 1954 and later revised many times, denoted that the state should develop various medical and health care facilities to protect people's health (Article 21), that Chinese citizens should have the right to get material help from the state and society when they are old, sick, or lose their working ability, and that the state will develop social insurance, social aid, and medical and health care work to meet these rights of citizens (Article 45). In the collective era (from 1950s to 1970s), China had provided basic health care to most of its population. Health care then was consisted of health care for workers under the Labour Insurance Scheme (LIS, *laobao yiliao*), mainly funded by the welfare funds of enterprises, providing employees and their immediate family members with full or partial medical care coverage; public health care for government employees through the Government Insurance Scheme (GIS, *gongfei yiliao*), financed directly by governments at various levels, provided to people working in government and public institutions, including the staff of cultural, educational, health, and research institutes, and students at colleges and universities; and the rural Cooperative Medical Scheme (CMS, *hezuo yiliao*) for peasants, funded by contributions from participants and heavily subsidised by the rural collective welfare funds and government.

1 Shaoguang Wang, "China's Double Movement in Health Care," *Socialist Register*, 46 (2010), 240–61.

2 Central People's Government, PRC. *The Constitution of the People's Republic of China* (*Zhonghua renmin gongheguo xianfa*), Retrieved 2 June, 2013 (http://www.gov.cn/gongbao/content/2004/content_62714.htm).

However, things began to change with the advent of market reforms in the 1980s. The healthcare system underwent a transition, from fully state-run, financed care to more privately financed and delivered health care. The collective production system that supported rural health care was replaced by the household production system in the 1980s. The rural CMS and collective medical facilities could not be sustained anymore.³ Besides, the role of “work units” in providing health insurance to urban employees has been greatly weakened as they were required to become more efficient in the market. Many public employees “dove into the business sea” (*xiaohai*) or were laid off by their work units,⁴ becoming responsible for their own health care. Together with the collapse of rural cooperative medical insurance scheme, health insurance coverage in China has decreased to the minimum, leading to a rapid increase in direct out-of-pocket payment.⁵ The former universally available (basic) health services were no longer available to all. Many patients were left to shoulder their own health care expenses. Some even fell into poverty due to illness. In 2000, China was ranked close to the bottom (188th out of 191 member countries) in terms of the fairness of health care financing and ranked 141st in terms of the health system’s overall performance by the World Health Organisation.⁶

Only after the outbreak of SARS in 2003, China started to implement a new round of healthcare reform that is attempting to reverse the market character of earlier trajectories. The new healthcare reform reemphasises citizens’ entitlement to health care as a basic right. It denotes that the government should do its utmost to fulfil its duty in building the health system, in providing public health care, and in protecting

3 Since the early 1980s, the rural cooperative medical insurance system has collapsed, only 5.4% of China’s 940,000 villages had cooperative medical care in 1985 and 15% in 1994, though this figure was approximately 90% in the late 1970s. From Wu, Yanrui, “China’s Health Care Sector in Transition: Resources, Demand and Reforms,” *Health Policy*, 39: 2 (1997), 148.

4 From 1995 to 2002 alone, about 60 million employees were cut from state or collective enterprises. From Xing Ying, “Barefoot Lawyers and Rural Conflicts,” in Y. T. Hsing and C. K. Lee, eds., *Reclaiming Chinese Society: The New Social Activism*, (New York, 2010), p. 3.

5 In the mid-1990s, approximately 95 percent of rural residents were paying for their own care. Even with the government’s efforts to change the situation since the late 1990s, the Third National Health Service Research in 2003 still showed that about 65 percent of the population (45 percent of urban population, and 70 percent of rural population) did not have any insurance. From Colleen M Grogan, “Urban Economic Reform and Access to Health Care Coverage in the People’s Republic of China,” *Social Science & Medicine*, 41: 8 (1995), 1073–1084, and Xin Gu, *Towards Universal Coverage of Healthcare Insurance: The Strategic Choices and Institutional Frameworks of China’s New Healthcare Reform*. (Beijing, 2008), p. 60.

6 *World Health Report 2000*. Retrieved 20 December, 2010 (<http://www.who.int/whr/2000/en/>).

people's health rights.⁷ The official healthcare reform agenda was released in 2009,⁸ which aims to establish a state-sponsored health system that provides universal (basic) health care coverage. One of the main reform agendas is to set up a basic health insurance system that provides insurance for all. It includes health insurance for urban employees (introduced in 1998), jointly paid for by governments, employers and employees; health insurance for unemployed urban residents (since 2007), mainly paid for by residents and subsidised by governments; and a new cooperative medical insurance scheme for rural residents (since 2003), co-paid by governments and individuals. The government provides subsidies for the poor to take out medical insurance. There is also a medical aid system for patients with "major illness" or those facing financial difficulty. Commercial insurances are also encouraged to complement the state health insurances. Recent research shows that 95 percent of the Chinese population had some form of health insurance by the end of 2011, up from less than one-third in 2003.⁹

Situate in this grand transformation, this article analyses the function of China's new health insurance schemes. The article is based on the ethnographic research in Riverside County (pseudonym) of Sichuan Province from 2011 to 2012, involving semi-structured interviews and conversations with patients, health professionals, health administrators and officials, participant observation in medical institutions, and document research. In Riverside County, many patients have benefited from recent new insurance programmes. Health insurance programmes have also been proclaimed by local health professionals as the most, or even the only, successful part of the new healthcare reform. Nevertheless, this article holds a more critical view to analyse the function of health insurance as a mechanism of governance and differentiation.

From the perspective of governmentality, insurance can be considered as a "technology of risk"¹⁰ that organises people to share the burden of risks involved in life. Francois Ewald notes that insurance as "a distributive sharing of a collective burden" contains a social rule of justice and a principle of social solidarity, which is

7 See Talk by Gao Qiang (the Minister of the Ministry of Health) in 2005, "Developing Medical and Health Work, Making Contribution to Build a Socialist Harmonious Society" (Fazhan yiliao weisheng shiye, wei goujian shehuizhuyi hexieshehui zuo gongxian), *People's Net*. Retrieved 13 April, 2011 (<http://politics.people.com.cn/GB/1027/3590082.html>).

8 See the "Opinions of the CPC Central Committee and the State Council on Deepening the Health Care System Reform" (Zhonggong zhongyang guowuyuan guanyu shenhua yiyao weisheng tizhi gaige de yijian), 2009. Retrieved 27 January, 2011 (http://www.gov.cn/jrzq/2009-04/06/content_1278721.html).

9 Chen Gao, Fei Xu, and Gordon G. Liu, "Payment Reform and Changes in Health Care in China," *Social Science & Medicine*, 111 (2014), 10–16.

10 Francois Ewald, "Insurance and Risk," in G. Burchell, C. Gordon and P. Miller, eds., *The Foucault Effect: Studies in Governmentality with Two Lectures by and an Interview with Michel Foucault* (Chicago, 1991), p. 197.

different from the judicial idea of deciding accident compensation following an investigation of the cause of injury.¹¹ However, the new health insurance schemes in China contain contradictory and competing ideas. Health insurance is organised with the hope of improving social justice through the distribution of health care burden collectively. Yet the implementation of insurance schemes follows the judicial model. Insurance reimbursement is linked with the investigation of the cause of injury – the evaluation of whether the illness or injury was due to natural causes (in that case the insurance will cover the medical bill) or due to the behaviour of individuals (in that case the individual should bear the medical costs). The definition of “qualified” patients in the health insurance regime serves as the gatekeeper to safeguarding the insurance funds targeting the needy people, but it also produces new differentiation, discrimination, and inequality among patients. Health insurance policies combined with other state policies (for instance household registration, population control, and employment status) produce categories and qualifications that subject patients to a structure of selection and means-testing. It also provides the authority with new mechanisms of surveillance and control, and enables more efficient governance. Health insurance regimes form the basis of biopower and constitute the power/knowledge¹² in Foucauldian sense to monitor, shape and control the behaviour of individuals as well as the conduct of the population. This article explores how health insurance regimes constitute regulatory devices, enable the evaluation of the qualification and worthiness of patients, and correspondingly serve to extend the state control and surveillance of individuals and the population. In the process, it also produces new discriminations and inequalities among Chinese patients.

Health Insurance as Segregation: the Exclusion of Migrants

Rural-to-urban migrant workers have been widely researched in China. Migrant workers take the dangerous, difficult and dirty jobs that the urban residents are not willing to do. They have low social status and unequal access to public services in the city, and are referred to by scholars as the “second-class citizen”¹³. When migrants work in the city, only some well-functioned companies provide health insurance, which is co-contributed by workers and employers. Many migrants cannot get health

11 Francois Ewald, “Insurance and Risk,” in G. Burchell, C. Gordon and P. Miller, eds., *The Foucault Effect: Studies in Governmentality with Two Lectures by and an Interview with Michel Foucault* (Chicago, 1991), p. 206.

12 Michel Foucault, *Power/knowledge: Selected interviews and other writings, 1972–1977* (New York, 1980).

13 Dorothy Solinger, *Contesting Citizenship in Urban China: Peasant Migrants, the State, and the Logic of the Market* (Berkeley, 1999). M. King Whyte, *One Country, Two Societies: Rural-urban Inequality in Contemporary China* (Cambridge, 2010).

insurance in their working place and, as a result, confront serious health care exclusion. A 40-city survey conducted by State Council in 2004 shows that only 15 percent of migrant workers participate in social security schemes and only 10 percent have medical insurance.¹⁴ In the new healthcare reform, the state has developed health insurance for urban employees, insurance for unemployed urban residents, and cooperative medical scheme for rural residents, but no suitable insurance programme is available to migrant workers, many of who are peasants but work and live in the city. The health insurance system is coordinated within the jurisdiction territories of each municipality and is linked to people's household registration (*hukou*). The use of health insurance is restricted to assigned hospitals and pharmacies in places where people's *hukou* is located. If patients seek health care in other places, they either pay out-of-pocket or go to the assigned hospitals outside their municipality with a low reimbursement rate. The segregated and fragmented health insurance system cannot meet the demands of the increasingly mobile Chinese population. In 2012, the number of migrants in China was 236 million.¹⁵ In Riverside County, about one fourth of the population, over 250,000 people, annually migrate to seek job. The market economy creates these free floating workers, but the existing system does not provide a portable or national level medical scheme to protect them. By examining this marginal group in the current health system, this section tries to understand how the health insurance scheme shapes and facilitates a process of exclusion in health care governance.

The Migrant Worker Who Got a Brain Tumour

In September 2012, during my week-long observation in the rehabilitation department of a local public hospital, I met a brain tumour patient, a young migrant worker in his early 30s, who was being treated in the department. I talked with him over the week and got to know his story. In April 2012, the migrant worker had fainted at the construction site he worked at, in Henan province. His colleagues called the ambulance. In the hospital, the MRI scan showed a tumour in his brain. He got emergency treatment in Henan province, which cost him over 10,000 Yuan, several months of his salary. Soon after the emergency treatment, he migrated back to his home province Sichuan. He registered in *Huaxi* Hospital, the best hospital in the provincial capital. The main site of the hospital was full and could not accommodate any more patients, so he was accommodated in the hospital's newly-

14 Ching Kwan Lee and Yuan Shen, "The Paradox and Possibility for a Public Sociology of Labor in China," *Work and Occupations*, 36: 2 (2009), 110–125.

15 National Health and Family Planning Commission, PRC. "Summary of the 2013 Reports on the Development of China's Migrant Population" (<Zhongguo liudong renkou fazhan baogao 2013> neirong gaiyao), 2013. Retrieved 10 October, 2013 (<http://www.nhfpc.gov.cn/ldrks/s7847/201309/12e8cf0459de42c981c59e827b87a27c.shtml>).

built sub branch situated in the suburb. Doctors from the main hospital came to operate on him several days later. After the operation, he stayed in the hospital for about a month. Later on he was transferred to the Provincial Tumour Hospital, another top level hospital in the provincial capital, where he got regular medical checks and radiotherapy for two months. The tumour hospital was also full. The department he visited only had 50 beds, but there were more than 80 inpatients. “How expensive health care is in those big hospitals!” he exclaimed. The operation in *Huaxi* Hospital cost him more than 36,000 Yuan. Each time he visited the Tumour Hospital, the MRI scan would cost more than 2,000 Yuan and radiotherapy cost more than 4,000 Yuan, not to mention other expenses. The overall medical expenditure since his first hospitalisation had already surpassed 100,000 Yuan, a huge amount for most Chinese families, let alone for a peasant like himself. He had bought rural health insurance annually, but he predicted that he might only claim back about 20 to 30 percent of his expenditure. Most of his treatments were in places outside Riverside County (the Henan province where his tumour was diagnosed and the provincial capital where he got operation and radiotherapy). The insurance scheme encourages patients to seek health care in low level medical institutions before going to higher level hospitals by giving higher reimbursement rates for hospital care at the bottom level. In 2012, the reimbursement rate of rural CMS in Riverside County was 90 percent for medical expenditure beyond 100 Yuan in township level hospitals; 80 percent for costs that exceeded 200 Yuan in county level hospitals; 60 percent for expenditure beyond 600 Yuan in municipal level hospitals; 55 percent for costs beyond 700 Yuan in provincial level hospitals and appointed hospitals outside the province; and for treatment in other hospitals, the reimbursement rate was 45 percent for costs beyond 800 Yuan (see Table 1). The tumour patient would be reimbursed at the lowest rate for his treatment in Henan province and the provincial hospitals, because he did not know that he should have obtained a hospital transfer reference from his local county hospital first. Doctor Chen in the rehabilitation department commented that many patients in serious and emergency situations, like this tumour patient, would go directly to high level hospitals or hospitals near their work places, and therefore would not be able to obtain the transfer reference from their hometown hospital in the first place. Besides, the health insurance only covers the items on the name lists of drugs, treatments, and medical facilities. In the tumour patient’s case, many expensive drugs and tests were not covered by his insurance. The tumour patient’s prediction of 20 to 30 percent reimbursement is consistent with other patients’ experiences. In the field, I collected dozens of lists (displayed in local hospitals I visited) of patients who had received reimbursements between 2010 and 2012. Rural CMS patients on these lists, who had sought health care outside the local municipality, were generally reimbursed around, or less than, 30 percent of their overall medical expenditure.

Table 1. CMS Reimbursement at Different Levels of Hospitals in 2012

Hospital Level	Reimbursement for costs exceeded	Reimbursement rates	Reimbursement ceilings
Township hospitals	100 Yuan	90%	120,000 Yuan
County hospitals	200 Yuan	80%	120,000 Yuan
Appointed municipal hospitals	600 Yuan	60%	120,000 Yuan
Appointed provincial hospitals and appointed hospitals outside the province	700 Yuan	55%	120,000 Yuan
Other (non-appointed) hospitals outside the municipality	800 Yuan	45%	120,000 Yuan

Source: Collected by the author in Riverside County.

After treatment in the provincial capital, the migrant worker came back to Riverside County. He came to the local hospital daily for acupuncture and rehabilitation. During the week I observed at the hospital, the tumour patient constantly asked the doctors about his medical expenditure. In the long acupuncture process, he frequently lamented that only his elder brother was earning money to support the family since he got sick. His previous treatments had already cost more than 100,000 Yuan and he needed more money for the ongoing rehabilitation and further radiotherapy. Other patients in the same ward often gave him suggestions on what social assistance was available and how to apply from the government. I suggested that he should apply for the medical aid for major illnesses. He told me that he needed to wait until the Health Insurance Bureau approved his reimbursement, only then could he take the insurance reimbursement documents to apply for further medical aid from the Bureau of Civil Affairs. “I might get 2,000 to 4,000 [Yuan medical aid],” he predicted. The medical aid aims at helping poor families to counter major illnesses. Being mainly funded by the local level governments and supplemented with subsidies from the central government and social donations, the capacity of medical aid is limited. A report from the Riverside County Bureau of Civil Affairs showed that in 2010 it had given medical aid to 16,484 people in the urban area, which amounted to 3,466,800 Yuan. However, when this was distributed to individual patients, each patient received on average about 210 Yuan in aid. Since the setting up of rural CMS in Riverside (in 2005), the Bureau of Civil Affairs initiated a “second medical aid” for poor rural families to get up to 20,000 Yuan aid in cases of serious illnesses. The official data though, show that the total amount used in second aid was 138,000 Yuan in 2005, 600,000 Yuan in 2006, 1 million in 2007, and 1,137,015 Yuan in 2009. In 2006, the 600,000 Yuan aided only 136 patients, giving

less than 5,000 Yuan on average per patient. In 2009, the 1,137,015 Yuan aided 415 serious patients (whose medical fee surpassed 30,000 Yuan), but each patient on average only got about 2,700 Yuan in aid. A list of about 70 patients in a local town who got the “second medical aid” in 2008 showed that most of them only received 1,500 Yuan in aid, although all of these patients’ medical expenditure surpassed 20,000 Yuan. Without any special connection, the tumour patient had good reason to predict that he might only get a few thousands Yuan in aid, merely a drop in the bucket of the total expenses.

Bureaucratic Regulations, Social Separation and Exclusion

The tumour patient’s case reveals the many obstacles migrant workers face in general in order to get health care. These include a fragmented health insurance system, the *hukou* system that ties health care and other social services with people’s place of origin, overcrowded hospitals, exorbitant medical charges, low insurance reimbursement, complex and unclear policies, and so forth. The different insurance schemes that organise people together in the sharing of risks also produce separation among patients who are divided into different patient statuses. While people now have more access to social assistance, the rural population are still extremely vulnerable when facing major illnesses. Even for those who receive insurance reimbursement, the funding is frequently inadequate. Moreover, various rules and policies constitute a corpus of insurance knowledge, which people are not familiar with. The information billboards displayed around hospitals and insurance bureaus only provide a general introduction about health insurance policies. There is no detailed insurance regulation (such as insurance coverage item list, reimbursement procedures) available on-line or given to the public, and reimbursement policies change from year to year. The locals have to go to the insurance office to enquire in person. The migrant’s case also points towards the overly bureaucratic approach of insurance administration. Health insurance schemes are administered by several departments separately. Health insurance for urban employees and urban residents are administered by the Social Insurance Department at different levels of government under the Ministry of Human Resources and Social Security. The rural CMS is administered by the Rural Health Insurance Bureau under the Ministry of Health. Medical aid is under the administration of yet another department – the Ministry of Civil Affairs. The overly bureaucratic arrangement makes reimbursement procedures lengthy and complex. Patients have to pay medical fees out of pocket first, and get reimbursed after their treatment. The reimbursement process involves many procedures and a mass of paper work. After several months from his first hospitalisation, the migrant worker had not received any benefit. The over-

bureaucratic arrangements sometimes deter people from seeking proper health care and insurance benefits.

In China, the urban areas for a long time have been the privileged sites of medical services and facilities, which, however, are not available for migrant workers. Many literatures have recorded the poor access to proper health care for migrants in the urban areas, and the health risks of migrants, including psychological distress and mental health problems, infectious diseases, maternal health, occupational disease and injuries, and poor long-term health.¹⁶ The combination of health insurance schemes and the hukou system produces exclusions for migrant workers, disabling them from receiving affordable health care in the city. The return of migrants to their hometown to seek health care may overwhelm the newly-built rural insurance system.¹⁷ The movement of goods and labours in the market economy is not matched with the flexibility of social services. Public services continue the rigid separation between localities, between rural and urban areas, that has been in place since the collective era. These fragmentation and segregation impair labour mobility (which is fundamental to China's economic development) and social solidarity.

In early 2012, the central government released a series of new health reform targets for the following years, including giving migrant workers more equal access to medical services.¹⁸ Some local governments have experimented in supplying social security programmes for migrant workers but, without proposed funding mechanism, most local governments are not willing to provide migrants with appropriate public services that need to be supported by the local finance. Feng Xu argues that the governmental attitude towards migrant workers was not to “let” them “die”, but it was more about letting them “move” rather than making them “live”.¹⁹ My research on health care access suggests that migrant workers are either “let” to die

16 Juan Chen, “Internal Migration and Health: Re-examining the Healthy Migrant Phenomenon in China,” *Social Science & Medicine* 72: 8 (2011), 1294–1301. Therese Hesketh, Xuejun Ye, Lu Li and Hongmei Wang, “Health Status and Access to Health Care of Migrant Workers in China,” *Public Health Reports* 123: 2 (2008), 189–197. Xiaojiang Hu, Sarah Cook and Miguel A. Salazar, “Internal Migration and Health in China,” *The Lancet*, 372: 9651 (2008), 1717–1719. Yingchun Peng, Wenhui Chang, Haiqing Zhou, Hongpu Hu, and Wannian Liang, “Factors Associated with Health-seeking Behavior among Migrant Workers in Beijing, China,” *BMC Health Services Research*, 10:69 (2010).

17 Xiaojiang Hu, Sarah Cook and Miguel A. Salazar, “Internal Migration and Health in China,” *The Lancet*, 372: 9651 (2008), 1717–1719.

18 Central People's Government, PRC. “Guidance on Setting up Emergency Medical Aid System from General Office of the State Council of the People's Republic of China” (Guowuyuan bangongting guanyu jianli jibing yingji jiuzhu zhidu de zhidao yijian), 2013. Retrieved 2 March, 2013 (http://www.gov.cn/zwggk/2013-03/01/content_2342656.htm).

19 Feng Xu, “Governing China's Peasant Migrants: Building Xiaokang Socialism and Harmonious Society,” in E. Jeffreys, eds., *China's Governmentalities: Governing Change, Changing Government* (London, 2009), p. 40.

in the city²⁰ or expected to “move” back to their hometown to “live” (such as the tumour patient above). The labour of these young, healthy migrant workforces contribute to the improvement of living conditions in the urban areas and to the economic prosperity in China. The city also provides millions of migrant workers with a chance to earn more, and thus improves the lives of migrants and their families, but only when they are healthy. When illness comes, the city fails to provide them with protection. Referring to Foucault, Gay Becker writes that marginality reflects “the biopolitical division between those whose lives are managed with the goal of enhancement and those whose lives are judged as less worthy and who are allowed to die.”²¹ Lacking education and “quality” in the neoliberal market, migrant workers rely mainly, even solely, on their “healthy” bodies to support their lives in the city. When they become sick and (temporarily or permanently) lose their “productivity,” they become “valueless,” experience indifference, and are driven away from the city back to their hometowns in order to survive.

Health Insurance as Regulatory Technology

Health insurance schemes have specific regulations for the categorisation and qualification of patients. These regulatory rules vary from place to place, but generally there are several shared categories of illnesses or treatments that are not covered by the three main insurance schemes: injuries caused in traffic accident, medical accident, or other accident due to negligence;²² injuries caused by one’s drug-taking, fighting, or other illegal behaviour; treatment due to individual self-harm, suicide, alcoholism, etc.; medical treatment sought by oneself (a patient does not go to the

20 There are many media reports of “letting patients die” cases in China. A well-known incident occurred in 2012 when a migrant worker was left to die under a bridge, a spot where many migrant workers camped at night in Henan Province. The migrant worker had been ill for more than 20 days. A few days before his death, people called an ambulance. The emergency doctor came and examined him, found that his symptoms were normal, but asked him to go to the hospital for further checks. The patient refused. The ambulance then left, leaving the patient untreated. The worker died a few days later. See “Ambulance Failed to Save Dying Migrant, Zhengzhou Government Responded: Patient Refused to Go to Hospital” (Zhengzhou huiying mingong jietou binsi 120 jianerweijiu: huanzhe jujue jiuyi), 2012. Retrieved 19 February, 2013 (<http://www.chinanews.com/sh/2012/12-02/4374931.shtml>).

21 Gay Becker, “The Uninsured and the Politics of Containment in U.S. Health Care,” *Medical Anthropology*, 26: 4 (2007), 300.

22 This regulation is especially unfavourable for migrant workers. The rural CMS, the insurance most rural-to-urban migrant workers have, does not cover industry injuries – injuries caused during work, because it presumes that the industry injuries will be covered by the labour insurance. However, it ignores the large numbers of migrant workers, who take dangerous work in the city and have high possibility of getting injured during work, but frequently do not have labour insurance.

appointed hospital or does not get a transfer reference before going to a high level hospital); drugs or treatments outside insurance coverage; medical treatment for cases that are not in accordance with birth planning policies.²³ These regulations construct a “grid of abstract categories” that works as normative rules and judgements. They encourage people to be responsible subjects, not hurt themselves intentionally, and take responsibility themselves or seek compensation from the person who caused their injuries rather than rely on the public insurance. They also produce the “civic worthiness” of health care according to individual’s conduct. Injuries caused by irresponsible or “immoral” acts, such as fights, alcoholism, and criminalities, are “unworthy” of state covered health care. The individual is “objectively” evaluated by these criteria which constitute a punitive gaze, surveying individual behaviour, but frequently failing to acknowledge individual’s entitlement.

The “Unqualified” Patient under Population Control

In Riverside, I recorded many cases of insured people who were only partially-qualified or unqualified for health insurance coverage. The pre-marriage birth is one of the unqualified categories. One such case involved a 19-year-old who gave birth to a baby by caesarean in the county hospital in 2012. After the birth, the preterm baby was sent to the municipal hospital for intensive care. The overall medical costs of the mother and baby were over 10,000 Yuan, but neither of them could get any reimbursement, although the mother had joined the CMS. The CMS proclaims that it covers all the fees of a natural delivery and part of the costs of a caesarean. However, in order to get the benefit, the birth must take place in the appointed medical institution with a birth permit (*zhun shengzheng*). The birth permit is a certificate obtained by married couples to legitimate a birth, a policy related with the population control currently carried out in China. Only those who abide by state birth policies (married couples, one child in most cases) can obtain medical insurance reimbursement. The young mother, unmarried, could not get the birth permit. Her pregnancy thus became “undesired” and the baby was a result of an “unwanted birth” according to the state policy. The young mother was not entitled to insurance coverage for the birth. The baby, born out of marriage, would encounter more difficulties to obtain a *hukou*, without which he would not be able to get the newborn baby medical insurance. Thus, the baby had no coverage for his earlier treatment. Besides, the ethical environment in the local community has not changed as quickly as the economic development and sexual behaviour of young people. Premarital pregnancy is still highly stigmatised and frequently becomes the target of

23 The lists are based on the local health insurance reimbursement regulations and the internet search results about health care that is not covered by various insurance schemes.

gossip within a community.²⁴ The family, embarrassed by the “dishonoured” birth, could hardly speak out in the community, let alone fight for their insurance entitlement.

Population governance in China has relied on both the cruder disciplinary practices (sometimes coercive abortion) and more subtle controls such as the link of birth with health insurance and other welfare benefits. Birth control in China has been relaxed recently. The coercive elements in population control, although still occasionally exposed by the media, have been used much less frequently over the years.²⁵ The disciplinary techniques have become more subtle forms, which work to shape and guide individual conduct.²⁶ The state-initiated propaganda and policies that stigmatise and discriminate unmarried birth also serve the birth control. State policies, together with social norms, construct the standards of appropriate behaviour and a moral form of self-governance where an unmarried young woman is expected to control her own reproductive activities. The link of social welfare to birth behaviour materialises this control.²⁷ When an “illegal” birth occurs, the health insurance exposes the patient to new punitive regulatory techniques, adding embarrassment to the already embarrassed family. Health care thus facilitates the surveillance and control of the population.

Greenhalgh²⁸ suggests that China’s population-planning creates legal “non-persons” out of those born “out-of-quota.” The unplanned births give rise to “unplanned persons” who have no access to schools, village land, etc., and thus in essence creates “stratified citizenship.” In health care, these “unplanned babies” and women with “unplanned pregnancy/birth” are excluded from health care entitlement. Children and women, who come from more economically vulnerable families and need insurance reimbursement more than others, tend to be more

24 I first heard about this case through the gossip by a group of elderly women in a local community. Later I got more information about this case through interviews with several community members. But when discussing this case, all of them immediately lowered their voices.

25 Therese Hesketh, ‘China’s One-child Policy is Slowly Being Eased’. *The Guardian*. 2010. Retrieved 5 May, 2014 (<http://www.theguardian.com/commentisfree/2010/oct/24/china-one-child-policy-eased>).

26 Greenhalgh and Winckler (2005) find, in China’s population control, the neoliberal biopolitics emerge in the people’s effort to produce the ‘quality child’. They notes that the reproductive self-discipline is a kind of regulated freedom, guided by powerful logics of science and technology, the market, and the transnational consumer culture; it is produced by forces seeking to shape individual desires and behaviour to their own ends. Greenhalgh (2009) further notes that bio-governance in China aimed at the management of the vital characteristics of human populations, and exercised in the name of optimising individual and collective life, health, and welfare.

27 The link of social services with social-control mechanism has long been used by the party-state since the Maoist period.

28 Susan Greenhalgh, “Planned Births, Unplanned Persons: ‘Population’ in the Making of Chinese Modernity,” *American Ethnologist*, 30: 2 (2003), 196–215.

affected by these policy “penalties,” because they have less resources and connections to overcome policy obstacles. Health insurance produces a diffuse apparatus of power/knowledge with normative power that endorses certain values and behaviour while rejecting others that are not in accordance with the government’s aims. The health care right – the right to get insurance benefits here – is a matter ratified by the state, rather than a right given at birth. The actual entitlement is based on neither need nor right, but on rule abidance. Through the deployment of insurance regulatory, the individual and social body become more pliable and amenable. Insurance enables the beneficiary’s “voluntary” compliance. However, people also subtly negotiate their insurance entitlements.

Becoming Qualified Patients: Negotiate Insurance Reimbursement

Insurance qualifications form a controlled sphere of “normal” and “abnormal” illnesses. People respond by seeking to become the “qualified” or legitimate patients. Aunt Wen, a local resident in her 60s, broke her collarbone in May 2011, when she fell from her husband – Uncle Wen’s motorbike. Uncle and Aunt Wen recounted to me in detail how Aunt Wen was hospitalised and reimbursed:

Uncle Wen: We were opportunistic this time. When she broke her bone, we hadn’t bought health insurance yet. I went [to the community office] to ask whether health insurance was still for sale, he [the staff] told me it was. I asked that if I bought the insurance could I use it immediately, he said it could cover hospitalisation that happened from January this year. On the second day I bought insurance for both of us, and then we went to the hospital [laugh]...Later we got more than 60 percent reimbursement. Before reimbursement, they would come to investigate the case, inquiring how she got hurt. When we just went into hospital, I said she fell down from my motorbike, but falling down from motorbike wouldn’t be reimbursed, thus I said she fell down from the stair when going downstairs to shopping.

JT: How did you know motorbike accidents wouldn’t be covered?

Aunt Wen: They told us. When we just went into hospital, the other patients nearby [in the same ward] asked us how I broke my bone, we told them I fell off from motorbike, they told us we wouldn’t be reimbursed if we wrote falling off from motorbike. My eldest daughter hearing this immediately threw the [insurance claim] form she had already filled, she did business and was very “cunning.” Later she asked the doctor for another form. She said she forgot where the first one was. (Interview P11)

Aunt Wen was an urban resident and could join the health insurance for urban residents by paying an annual fee, which would cover hospital care for a year period (not for accumulation). In 2011, it cost 170 Yuan to join the insurance scheme. The health insurance specifies that the coverage scope of injuries directly caused by individual actions of the patients or others would not be covered, such as transport accidents. Instead of getting this information from the hospital or health professionals, Aunt Wen learnt this from other patients in the same ward, who frequently shared information with each other. Her family then made another excuse for her injury. Later on, the insurance bureau came to investigate Aunt Wen's case. Aunt Wen made up a detailed story about how she fell down from the stair outside her home when going out for shopping. In Aunt Wen's treatment, an expensive steel plate was installed to fix her broken bone. The whole medical expenditure was about 10,500 Yuan. Aunt Wen claimed back 6,700 Yuan from insurance, and thus paid only about 3,800 Yuan out of her own pocket. Aunt and Uncle Wen felt happy about this result and proclaimed that the insurance scheme was great. "You pay a little but get a lot," Uncle Wen commented. We all laughed when Uncle Wen said humorously that they were speculators who went to the hospital immediately after purchasing their health insurance. Patients like Uncle and Aunt Wen pragmatically took advantage of the state rules and adapted to the circumstance to gain benefits. The definition of "qualified" and "unqualified" patients is a subtle negotiation process that both the insurance bureau and the patient take part in, rather than simply a label allocated from above.

Nobody felt that it was "illegal" to "make the story up" and "take advantage of the policy," but rather, everyone felt happy for the result that Aunt Wen finally got reimbursed. Their "opportunistic" action was morally justified, considering that normal patients frequently suffered heavy burdens in the commercialised health care sector. As Ong and Zhang write, increasingly, in contemporary China, "individuals are obliged to exercise diligence, cunning, talents, and social skills to navigate ever-shifting networks of goods, relationships, knowledge, and institutions in the competition for wealth and personal advantage".²⁹ Individual patients rationally assess situations and act prudently. They negotiate quietly, and creatively challenge the official rules with their value framework and practical actions. These subversive, indirect actions by patients to circumvent or resist state rules are widespread. Although these daily "resistances" cannot directly change the rules, they do, to some extent, push back the policies that people think did not serve them well. They allow individuals to temporarily seize control of their own situations, and to secure health care access and benefits within the changing system.

29 Ong, Aihwa and Li Zhang, "Introduction: Privatizing China: Powers of the Self, Socialism from Afar," in *Privatizing China: Socialism from Afar* (Ithaca, 2008), p. 8.

Using Guanxi to Gain Benefits: the Unequal Insurance Reimbursement

People display an agentive ability to accommodate to existing policies. Local patients also widely use connections to obtain benefits from health insurance and aid programmes. Yet, these individual agentive efforts make insurance compensation and medical aid inconsistent. The “honest” and less connected patients may easily lose out. The cases of Mrs Lou and Mrs Huang below, demonstrate the huge difference in compensation for similar treatments in the same hospital:

Mrs Lou, a local resident in her 30s, broke her leg in 2011. She was taken into the TCM Hospital soon afterwards. The financial condition of Mrs Lou’s family was average. Her husband was working as a porter for a furniture store with a salary of just over 2,000 Yuan a month. Her son was studying in a local middle school. Mrs Lou was a worker in a local textile company, earning just over 1,000 Yuan per month. The company offered employees medical insurance, co-paid by the company and employees. However, Mrs Lou declined the insurance in order to save her portion (dozens Yuan a month) of contribution, because she knew her job was unstable and the insurance would not be lifelong if she left the company before the retirement age (55 years old). Moreover, she thought she was young and healthy and would not need medical insurance. As a result, when she got injured in 2011, she did not have any insurance. Luckily, her sister was working in a local health office. The sister helped Mrs Lou register under the name of a relative, who had rural CMS. This well-connected sister also found an acquaintance in the hospital and arranged an experienced senior doctor to operate for Mrs Lou. A steel plate was installed in Mrs Lou’s leg. She stayed in the hospital for 19 days. The whole hospitalisation cost over 20,000 Yuan, almost ten times her husband’s monthly salary. This huge amount of money was borrowed from relatives. Later, through her sister’s connections, she was reimbursed more than 10,000 Yuan, and thus only paid several thousand Yuan out-of-pocket. ‘It’s lucky we got the reimbursement, otherwise, we would be in a very difficult situation. We repaid the borrowed money after receiving the reimbursement’. She told me that now many people were like her, borrowing money for major surgery and repaying the debt after getting reimbursement. “The state policy is good, [it would be better] if there was less corruption at the bottom,” she concluded. (From Interview P6 and field notes)

68-year-old Mrs Huang broke her arm in 2010. She and her husband went to the TCM Hospital, and registered under the doctor who they had known for decades. Through this doctor, Mrs Huang was able to register as an inpatient with a hospital bed ready on the day. “If it was not for him, I would not be hospitalised that soon. I might have stayed in the [hospital] corridor waiting for a bed. There were no more beds available. Without connections or extra money, they would not have allowed me

to go into hospital,” Mrs Huang stated these words with gratitude to her doctor. Later on, in surgery, a steel plate was put in Mrs Huang’s arm, and she stayed in the TCM Hospital for over 20 days. Her total medical expenses were over 20,000 Yuan. Mrs Huang had rural CMS, but she claimed back less than 4,000 Yuan. “The [imported] steel plate couldn’t be reimbursed, the anaesthetic couldn’t be reimbursed, the bedding fees were not covered...” Mrs Huang counted to me in detail the items not covered in her case. Her husband, Mr Huang, told me that he learnt from the insurance bureau that injury (*shang*) received much less reimbursement compared with illness (*bing*). In Mrs Huang’s case, she had been injured. Mr Huang explained that the reimbursement process was related with *qing* (affection or relationship). “If we have a good relationship, I [the health insurance administrator] will reimburse you [the patient] for those drugs that are not specified by the insurance policy. If we don’t have good relationship, I won’t reimburse you for these items. You know our family’s condition. We didn’t have any connection, therefore claimed back only a little,” Mr Huang sighed. (From Interview P1, Interview P27, and field notes)

The differentiation of *shang* (injury) and *bing* (illness) is a simplification of insurance rules by local insurance officers. The different compensations on injury and illness are based on the division of health care responsibility. While many injuries are directly caused by patients or other individuals’ actions, illnesses in many cases are beyond one’s personal control. However, this differentiation is not in accordance with people’s concept and lived experience of illnesses which include all symptoms and injuries requiring medical care. The implementation of insurance policies thus frequently causes misunderstandings and doubts from patients. Individuals like Mrs Huang suspect that the disparities in insurance compensation among patients were due to *guanxi* connections. “No matter what you do, you need *guanxi* and *renqing* [relationship, affective tie] in this small county,” Mr Huang lamented. The staff at the insurance bureau have power to interpret policies according to individual cases. The interpretation and implementation by local administrators have certain arbitrariness and leave space for well-connected individuals to benefit more. In the cases above, Mrs Lou and Mrs Huang had similar injuries, were enrolled in the same hospital, had about the same overall medical expenditure (over 20,000 Yuan), used the same insurance scheme (the rural CMS), but were reimbursed greatly different amounts (more than 10,000 Yuan for Mrs Lou and less than 4,000 Yuan for Mrs Huang). The difference, without denying the impact of the official reimbursement rate that was slightly (5 percent) higher in 2011 than in 2010,³⁰ was largely because of Mrs Lou’s sister, who worked in a local health office and had insider knowledge about

30 Local official reimbursement rate of the rural CMS in the county level hospital was 60 percent for medical expenditure beyond 400 Yuan in 2010, and 65 percent for medical expenditure beyond 300 Yuan in 2011.

how the system worked. With good connections to the doctor, Mrs Lou's sister could ask the doctor to use more medicines that were covered by insurance; with good connections to the health insurance bureau, the items that were not specified by the insurance policy could also be reimbursed. The locals I met invariably agreed that knowing someone in the local medical "circle" was fundamental in getting reliable health care and favourable reimbursement. By using *guanxi*, Mrs Lou and Mrs Huang were enrolled in the overcrowded hospital in a timely fashion. With good connections, Mrs Lou could use a relative's insurance to receive higher compensation for health care; without connections, Mrs Huang, even with insurance, got a much lower compensation. Through connections, the state-subsidised health care became available for people who was not entitled but was well connected. For people like Mr and Mrs Huang though, resentment rose when they witnessed others benefit more while those in poor financial status and in need of help benefited much less. While on the surface it seemed that their low reimbursement was due to their mismatched reimbursement criteria, it was actually due to their lack of connections. Without connections to overcome official rules, Mr Huang felt discriminated against, and could only respond by complaining about local implementation and corruption. Even Mrs Lou, who personally benefited from health insurance, consciously criticised possible corruption at the bottom.

The new insurance scheme serves as a mechanism of control, making people more "governable." Yet the "governance" is always open to manoeuvre in local context. In health care access, patients draw upon different forms of capital to secure qualified health care and get insurance benefits. Patients' informal measures to accessing health care and their taking advantage of current policy were morally justified, which helped the "weak" patients benefit in the imperfect system. These actions constitute ordinary peoples' "creative compliance" in daily life when facing social structures that they cannot participate in or cannot reject directly. Agency, though, is always unequally distributed among people, who are embedded in specific social relationships and power structures. The frequent use of *guanxi* and *renqing* to take advantage of the "grey area" that is not specified by the policy, contributes to an abundance of arbitrary cases and potential corruption. The new health insurances, that should improve health care equality, contrarily create new injustice and predicaments. The locals question the varied insurance benefits and seek individual channels to overcome obstacles if possible, but can hardly argue against the system arrangement itself. They seek to meet the regulations and standards to become the "qualified" one who is entitled. They creatively use the rules and regulations that already exist in the system, adjusting themselves to strive for inclusion, creating a new dependency that leaves them vulnerable to arbitrary interpretation (by the local administrative agencies). In the process, they reproduce new inequality.

Discussion and Conclusion: the Making of Governable Subjects and the Reproduction of Inequality

Since the new healthcare reform in the 2000s, the Chinese government spending on health care has increased rapidly, especially in the area of health insurance. Health insurance allows for patients' medical fees to be partly covered. Recent research shows that, in the new health care reform, the total payment from health insurance programmes was estimated to account for over 50 percent of provider revenue, and over 25 percent of total health expenditure.³¹ However, this same research, alongside another recent study,³² shows that the new health insurance schemes have limited effect in reducing patients' health care burden. The rapid increase of overall medical expenditure, the low insurance reimbursement rate, the various regulations and mean-testing, to some extent, offset the effects of medical insurance.

Health insurance schemes are central in shaping people's experiences under the new healthcare reform. They function to integrate the formerly uninsured population, but also marginalise and exclude certain population. Insurance imposes various regulatory rules and criteria to individuals, and those patients who cannot meet or satisfy these criteria are marginalised. The normative categories of insurance recognise some patients' needs but remain blind to others'. Besides, insurance policies still contain rationalities and mechanisms produced in the collective period (that health care was determined by one's place of residence, *hukou* registration, employment status, etc.), which coexist and conflict with the rationalities of the market era. The over-bureaucratic insurance arrangement and reimbursement procedures exclude certain groups and discourage some patients from obtaining much needed medical aid.

The new health insurance schemes constitute biopower, subjecting patients to a structure of selection and means-testing. Governance is embedded in the health insurance regimes to shape and reshape the conduct of individuals and the population. Insurance policies not only generate "positive and productive forces for the compliance and regulation of the body,"³³ but also produce subtle, punitive techniques to refrain people from violating normative rules. The insurance bureau that determines the qualification of patients is "biobureaucracy,"³⁴ which exposes people to a set of knowledge, criteria and identifications. Although the

31 Chen Gao, Fei Xu, and Gordon G. Liu, "Payment Reform and Changes in Health Care in China," *Social Science & Medicine*, 111 (2014), 10–16.

32 Kai Liu, Qiaobing Wu and Junqiang Liu, "Examining the Association between Social Health Insurance Participation and Patients' Out-of-Pocket Payments in China: The Role of Institutional Arrangement," *Social Science & Medicine* 113 (2014), 95–103.

33 Martin Hewitt, "Bio-politics and Social Policy: Foucault's Account of Welfare," *Theory, Culture & Society*, 2: 1 (1983), 72.

34 Matthew Kohrman, *Bodies of Difference: Experiences of Disability and Institutional Advocacy in the Making of Modern China* (Berkeley, 2005).

deserving/undeserving distinction has a long history in the Chinese party-state's welfare allocation,³⁵ the new insurance schemes further categorise patients as being deserving or underserving, qualified or unqualified. There is also a clear division of state and individual responsibilities that it is an individual's responsibility for illnesses and injuries caused by suicide, accidents, fighting, alcohol consumption, criminal actions, etc. The insurance schemes underlie values of self-responsibility, that patients are required to conduct themselves in a responsible manner and to become qualified subjects. These new insurance schemes are thus used by the state as surveillance measures and disciplinary norms to control the population, birth, and individual conduct.

People are not simply passive in submitting to the established rules of insurance, but actively negotiate with these rules and creatively find ways to work around the regulations that attempt to structure and regulate their behaviour. Patients' *guanxi* work and creative problem-solving efforts unleash the subversive power towards system dominance and normalisation. However, many patients' negotiation ability is limited. They do not resist the structures and criteria of qualification, but refashion themselves to meet the criteria. People demand inclusion rather than claiming inalienable rights. Their successful negotiations have some immediate effects in obtaining benefits, but they can hardly penetrate into the system to make a change. Besides, the eligibility tests of claimants leave space for arbitrary interpretations, leading some people to benefit disproportionately. The criteria and rules are negotiated by those well connected to obtain special rights to health care benefits, while those less connected are further excluded. The inconsistent criteria and categories produce a deepening sense of injustice.

The definitions of eligibilities and qualifications will be an ongoing contention in the unfolding of the new healthcare reform among patients, health professionals, medical institutions, insurance bureaus, and various government departments that administer different insurance schemes. The rapidly mobilising Chinese population needs a renewing of the categories formed by the health insurance system, which are still bound by mechanisms that were formed in the collective era. The insurance benefits in the current healthcare reform still show the state's acknowledgement of individual needs and claims, which are "granted" rather than entitled. Health care that is not based on equal and inalienable rights would create further inequality. It cannot prevent individual existential needs being encroached upon by political and economic needs, and by officially sanctioned programmes (such as birth planning). The right to basic health care cannot depend on the considerations of eligibility or worthiness, but must be based upon the essential vulnerability of the human body, and on the fact that every individual has the right to life.

35 Janet Chen, *Guilty of Indigence: The Urban Poor in China, 1900–1953* (Princeton, 2012). Linda Wong, *Marginalization and Social Welfare in China* (London, 1998).

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References

- Becker, Gay, "The Uninsured and the Politics of Containment in U.S. Health Care," *Medical Anthropology*, 26: 4 (2007), 299–321.
- Chen, Juan, "Internal Migration and Health: Re-examining the Healthy Migrant Phenomenon in China," *Social Science & Medicine* 72: 8 (2011), 1294–1301.
- Chen, Janet, *Guilty of Indigence: The Urban Poor in China, 1900-1953*. Princeton, NJ: Princeton University Press, 2012.
- Ewald, Francois, "Insurance and Risk," pp. 197–210 in G. Burchell, C. Gordon and P. Miller, eds., *The Foucault Effect: Studies in Governmentality with Two Lectures by and an Interview with Michel Foucault*, Chicago: University of Chicago Press, 1991.
- Foucault, Michel. *Power/knowledge: Selected interviews and other writings, 1972–1977*. New York: Pantheon, 1980.
- Gao, Chen, Fei Xu, and Gordon G. Liu, "Payment Reform and Changes in Health Care in China," *Social Science & Medicine*, 111 (2014), 10–16.
- Greenhalgh, Susan, "Planned Births, Unplanned Persons: 'Population' in the Making of Chinese Modernity," *American Ethnologist*, 30: 2 (2003), 196–215.
- Greenhalgh, Susan, "The Chinese Biopolitical Facing the Twenty-first Century," *New Genetics and Society*, 28: 3 (2009), 205–222.
- Greenhalgh, Susan and Edwin A. Winckler, *Governing China's Population: From Leninist to Neoliberal Biopolitics*. Stanford, CA: Stanford University Press, 2005.
- Grogan, Colleen M, "Urban Economic Reform and Access to Health Care Coverage in the People's Republic of China," *Social Science & Medicine*, 41: 8 (1995), 1073–1084.
- Gu, Xin, *Towards Universal Coverage of Healthcare Insurance: The Strategic Choices and Institutional Frameworks of China's New Healthcare Reform (Zouxiang quanmin yibao: zhongguo xin yigai de zhanlue yu zhanshu)*. Beijing: China Labour and Social Security Publishing House, 2008.
- Hesketh, Therese, Xuejun Ye, Lu Li, and Hongmei Wang, "Health Status and Access to Health Care of Migrant Workers in China," *Public Health Reports* 123: 2 (2008), 189–197.
- Hewitt, Martin, "Bio-politics and Social Policy: Foucault's Account of Welfare," *Theory, Culture & Society*, 2: 1 (1983), 67–84.
- Hu, Xiaojiang, Sarah Cook and Miguel A. Salazar, "Internal Migration and Health in China," *The Lancet*, 372: 9651 (2008), 1717–1719.
- Kohrman, Matthew, *Bodies of Difference: Experiences of Disability and Institutional Advocacy in the Making of Modern China*. Berkeley: University of California Press, 2005.
- Lee, Ching Kwan and Yuan Shen, "The Paradox and Possibility for a Public Sociology of Labor in China," *Work and Occupations*, 36: 2 (2009), 110–125.

- Liu, Kai, Qiaobing Wu and Junqiang Liu, "Examining the Association between Social Health Insurance Participation and Patients' Out-of-Pocket Payments in China: The Role of Institutional Arrangement," *Social Science & Medicine* 113 (2014), 95–103.
- Ong, Aihwa and Li Zhang, "Introduction: Privatizing China: Powers of the Self, Socialism from Afar," pp. 1–20 in *Privatizing China: Socialism from Afar*. Ithaca, NY: Cornell University Press, 2008.
- Peng, Yingchun, Wenhua Chang, Haiqing Zhou, Hongpu Hu, and Wannian Liang, "Factors Associated with Health-seeking Behavior among Migrant Workers in Beijing, China," *BMC Health Services Research*, 10:69 (2010).
- Solinger, Dorothy, *Contesting Citizenship in Urban China: Peasant Migrants, the State, and the Logic of the Market*. Berkeley: University of California Press, 1999.
- Wang, Shaoguang, "China's Double Movement in Health Care," *Socialist Register*, 46 (2010), 240–261.
- Whyte, M. King, *One Country, Two Societies: Rural-urban Inequality in Contemporary China*. Cambridge, MA: Harvard University Press, 2010.
- Wong, Linda, *Marginalization and Social Welfare in China*. London: Routledge, 1998.
- Wu, Yanrui, "China's Health Care Sector in Transition: Resources, Demand and Reforms," *Health Policy*, 39: 2 (1997), 137–152.
- Xu, Feng, "Governing China's Peasant Migrants: Building Xiaokang Socialism and Harmonious Society," pp. 38–62 in E. Jeffreys, eds., *China's Governmentalities: Governing Change, Changing Government*, London: Routledge, 2009.
- Ying, Xing, "Barefoot Lawyers and Rural Conflicts," pp. 64–82 in Y. T. Hsing and C. K. Lee, eds., *Reclaiming Chinese Society: The New Social Activism*, New York: Routledge, 2010.

CSR: a catalyst for corporate contribution to global health governance?

A case study from the pharmaceutical industry

Michelle S. Monachino and Paulo K. Moreira

Introduction

Over the past twenty years international health and development agencies (WHO, 1997, 2005; UN, 2002; World Bank, 2002; WEF, 2011) have gradually advocated towards a participation of the private for-profit sector, and especially large multinational corporations (MNCs), in global population health promotion and disease prevention. Participation has been justified in terms of the socioeconomic agency of corporations in a globalized world, as well as connected to the positive and negative social, environmental and health externalities consequent to business manufacturing, distribution and marketing practices.

The framework advocating for a whole of society approach to public health finds its roots in the conceptualization of Social Determinants of Health (SDoH) put forward by WHO in the Ottawa Convention (1986), which, by clarifying the non healthcare-related causes of morbidity and mortality patterns -social, educational, trade and urban – set the basis for a gradual responsabilization of non-state private actors for health outcomes (Porter, 2006) further developed in the Adelaide (WHO, 1988) Sundsvall (WHO, 1991) and Jakarta conferences (WHO, 1997), to name a few. The paradigmatic shift that followed, seeing a change of focus from healthcare to health promotion, and from national public entities to non-state private actors, has been framed by Kickbush and de Leeuw (1999) as the second stage of public health: the global health governance (GHG) phase. In a GHG perspective businesses become institutions bearing responsibilities that transcend profit-making, as Rosneau and Czempiel (1992) clarify, “since the 1990s, mainstream international relations theory no longer considers private businesses as mere economic actors solely committed to their shareholders, but also as bearers of responsibilities towards a wider group of social stakeholders”, where the term governance alludes to an extension of the territory and players beyond formal governmental structures (Colebatch, 2009).

Secondly, businesses are identified as relevant participants in GHG for what concerns their direct influence on positive and negative externalities generated by business practices. If corporate responsibilities in what concerns labour conditions, human rights and the environment have so far been topics in the spotlight (Vogel, 2005), the call for a greater accountability of corporations for health outcomes is an issue that has gained increasing awareness in the last decade through the research of the North-American and European schools of public health (Freudenberg et al 2008, 2012, 2014; Wiist 2006, 2010; Lang 2007, 2010; Brezis and Wiist, 2011) and the advocacy of organizations such as Corporations and Health Watch, founded in 2007. Today, businesses are held responsible in a global public health perspective for what concerns: the production, distribution and allocation of goods and services; the branding and marketing strategies effecting consumer lifestyles; the lobbying of public health policies; and, ultimately, for the creation of wealth and consequently the allocation of power rights and resources along the supply and consumer chains that delineate prerequisites, choices, and access to health. In the book “Lethal but Legal” Freudenberg (2014) explains the toll that the tobacco, alimentary, automotive, alcohol and gun industries put on public health, arguing that the political and economical authority that MNCs have in contemporary societies makes their influence greater than that of national and international public health organizations, who can’t compete with corporation’s lobbying power, transnational reach and massive communication resources.

Held in a developing country at the verge of 21st century and aimed at reconsidering the Ottawa’s SDoHs in the light of “dramatic changes” introduced by urbanization and globalization of markets and communications (De Leeuw et al. 2006) the Jakarta Conference (WHO, 1997) was the first health promotion meeting to engage a GHG perspective. Whilst recognizing the SDoHs as valid, it clarified their shaping as no longer dependent on national health strategies, but defined by an ensemble of actors and mechanisms that transcend the healthcare, national and governmental spheres (Lee et al, 2004). For the first time the Jakarta Conference explicitly addressed the business sector as both a potential health-threatening and health-promoting agent and a key player in health, stating that the health determinants of the 21st century are to be tackled through a conjoint action of public and private sectors committed to promoting a social responsibility for health. The resulting declaration clarified business social responsibility for health as doing no harm: guaranteeing environmental health against the exploitation of resources and sparing citizens, consumers and employees from harmful products and irresponsible marketing strategies by applying equity-focused Health Impact Assessment (HIA) strategies (WHO, 1997). Further, the declaration included a set of positive recommendations, featuring the business responsibility to encourage intersectoral partnerships and investments in health promotion, as well as empower individuals and communities through the establishing of health enhancing environments. The

context pictured by the Jakarta Conference (1997) is further explored in the Bangkok declaration (WHO, 2005) in which dialogue and advocacy among governments, the civil society and the business sector are invoked as to address the threats posed by commerce's marketing, services and products. In the same period, also the UN addressed the issue stating that, although states are ultimately accountable for the right to access health, all members of society, including businesses, are accountable in the realization of such outcome (UN, 2000).

According to Buse and Lee (2005) the plea for the business sector to participate in global health governance has been answered with the adoption of three distinct approaches: self-regulation, which allows for a voluntary regulation of business practices, carried out by Corporate Social Responsibility (CSR) activities, Business Codes of Conduct (BCCs) and public-private partnerships (PPPs); co-regulation, by which objectives and responsibilities are negotiated among public and private actors; and participation in health governance, which results in the establishment of multi-stakeholder alliances at a policy-level. The realm of CSR, focus of this paper, can be framed as the ensemble of corporate-based initiatives aimed at addressing and balancing legal, ethical, economical, social and environmental concerns raised by a series of stakeholders with different interests and expectations concerning the nature and outcomes of corporate activity (Moon, 2007). As of today, the private business sector in general, and MNCs in specific, address, through CSR, a panoply of health promotion and disease prevention issues, not merely for what concerns employees but in relation to the health of local, national and global population (BSR, 2014; Monachino and Moreira, 2014). So far, corporate participation to GHG through CSR has been reviewed for what concerns its potentialities to: make resources available for otherwise under tackled causes or populations (Werner, 2009) and create relationships between businesses, institutional and civil actors for a multidimensional approach to health (Bunde-Birouste et al, 2010). CSR's alignment to social and health public policy objectives, on the contrary, has not been widely validated by literature, according to Margolis and Walsh (2004) and Fooks et al. (2011). More extensive is the literature concerning CSR's controversial aspects for GHG, which derive from a logic that contextualizes, at the same time, the will to answer to social and market objectives whose addressing is often difficult to distinguish (Buse and Lee, 2005), and leading to potential conflicts of interest, lobbying, blue-washing and confuting of scientific evidence (Babor, 2008; Friedman, 2009; Herrick, 2009; Dorfman et. al, 2012;).

This study starts from the assumption that CSR – notwithstanding the limitations deriving from the particularistic and profit-oriented nature of the firm – can be, under a series of conditions, a catalyst for corporate contribution to GHG and a means to link corporate and public national and international governance's objectives and efforts. As Margolis and Walsh (2004) point out, the ways in which CSR may impact corporations in terms of reputation, market differentiation and consumer and

employee retention, have been reviewed extensively, smaller attention, comparatively, has been given to exploring the actual and potential social and health inputs of CSR. The study proposes hence to analyse corporate actual and potential contribution to national and international mental health policy in terms of alignment of objectives, allocation of resources and establishment of linkages among different societal actors, influence on policy development, as well as to highlight the boundaries of CSR for GHG. The study engages as a case the Portuguese application of a global CSR campaign, launched in 2012 by a leading multi-national pharmaceutical, with the aim of improving adolescent access and education to health in 20 countries¹ across the globe. The company's Portuguese subsidiary, in collaboration with a local NGO working in the area of health intervention, adapted the global issue to the national reality, developing a project aimed at targeting adolescent mental health in vulnerable contexts.

Specific research objectives are set as to comprehend to what extent the CSR project: 1) aligns to international and national objectives for adolescent mental health, as expressed by the European Ministerial Action Plan on Mental Health (WHO, 2005) and the Portuguese National Health Plan (PNHP) 2007-2016; 2) allocates human and financial resources to comply with the set objectives; 3) manages to create business linkages with civil players and policy-makers in the field of mental health; as well as to 4) uncover unexplored potentialities and limits of the CSR project as identified by involved parties.

Methodology

This case study is based on the analysis of a CSR program, the Mental Health Program for Youngsters, currently taking place in Portugal and directed at improving adolescent mental health in vulnerable contexts. The program is part of a global CSR campaign launched in 2012 by a leading MNC pharmaceutical, addressing adolescent health in 20 countries worldwide. The study starts out with an analysis of the European and Portuguese approaches to mental health with a focus on adolescents, pinpointing set priorities and recommended actions contained in the European Ministerial Action Plan on Mental Health (WHO, 2005) and the Portuguese National Health Plan (PNHP) 2007-2016, briefly reviewing data on the burden of mental health struggles in Portugal, and reporting the partial assessments made so far on the European and Portuguese Plans for mental health. It continues with the description of the global CSR program and of its Portuguese application, the Mental Health Program for Youngsters, uncovering the overall rationale of the

¹ Australia, Brasil, Canada, Denmark, Germany, India, Korea, Netherlands, Norway, Portugal, Romania, Spain, Sweden, United Kingdom, United States of America and Zambia.

program and its evidence-basis, as well as clarifying, through the information contained in the project proposal, with which specific objectives the program was planned, designed and implemented and which are the competences of the various stakeholders involved. A distinct section is dedicated to collect the perspectives of stakeholders from the MNC, NGO and public sector concerning the program. Stakeholders from the MNC and the NGO were directly involved in the realization of the program, their point of view being of use to clarify the different priorities and expectations attributed to the program, as well as to uncover difficulties, success factors and gains from each side. Given that no actor from the public sector was actually involved in the realization of the CSR program a representative of the Portuguese department for mental health, the technical normative body of the Health Ministry responsible for implementing the NPMH, was heard on behalf of the public sector as to uncover reasons for lack of involvement as well as express opinions on the potentials and limits of CSR for public mental health policy. Stakeholder's perspectives were retrieved through semi-directive interviews carried out in the period January – June 2013. Interviews were recorded and analysed through content analysis.

Context: European and Portuguese approaches to mental health with a focus on adolescents

In 2005, the health ministers from 50 European countries met in Helsinki to attend the WHO European Ministerial Conference on Mental Health “Facing the Challenges, Building Solutions”. The meeting was aimed at establishing mental health as a priority across Europe, after pointing the high prevalence of mental health troubles affecting the region -100 million sufferers from depression and anxiety without counting troubles related to addictive alcohol consumption, bipolar, schizophrenia and panic disorders or Alzheimer- identifying the burden of disease as the second greatest in the region after cardiovascular illnesses, and pointing out the lack of adapted prevention and treatment responses across health systems (WHO, 2005). The resulting declaration pointed at the necessity for signatory countries to pursue the following objectives (i) give priority and visibility to the issue of mental health; (ii) develop, in consultation with relevant stakeholders, policies, plans and programs based on current knowledge, appropriate for life stages and directed at tackling stigma, discrimination and suicide; (iii) provide adequate funding to train workforce and implement policies and programs, (iv) ensuring a community-based and intersectoral perspective in the provision of services (WHO, 2005). Adolescents, together with infants and senior citizens, are identified as a priority population given their susceptibility to social, psychological and environmental threats to mental

health, caused by a biological and legal incapacity to fully defend or exert rights. The preservation of mental health for youths is framed as an investment, given that the furnishing of coping skills in young age are identified as determinants of a sound adult mental health. In adolescents particularly, mental struggles are not merely considered as potential threats for adult health, but also connected with risk-taking behaviors. For what concerns the specific necessities related to life stages, the Ministerial Conference's Action Plan (WHO, 2005) sets, as the responsibilities of institutions and the civil society, (a) the development of pertinent and evidence-based policies, for necessities related to life stages, cover: plans and programs; (b) the creation of mechanisms that guarantee involvement in decision-making processes; and (c) the development of community services allowing the conjoint participation of individuals, families, schools and day-care centers.

Preliminary results from the first national epidemiological study on mental health carried out in 2010 (WMHSI/CESOP, 2010) show that Portugal, with a an overall prevalence of 22,9%, is the country with the highest scores of mental troubling in the European Union. According to the National Health Observatory (Observatório Nacional de Saúde, 2012), mental troubles have been exacerbated by the socioeconomic crisis of 2008 and haven't yet reached their full incidence. As to respond to national struggles and in the aftermath of the signing of WHO's 2005 Action Plan, the Portuguese government published, with the resolution no. 49/2008 of the Council of Ministers, the National Plan for Mental Health (NMHP) for the timeframe 2007-2016. Adopting the context and priorities set by the WHO resolution; the NMHP frames mental health in terms of a primacy issue for national public health, stressing it should be addressed in a "timely and creative manner" by public and civil society institutions. Following the axis set at a European level the NPMH dedicates a separate section to children and adolescence mental health in what concerns the reorganization of psychiatric and mental health prevention and treatment services. The section dedicated to children and adolescence mental health acknowledges the weaknesses identified by WHO concerning the lack of adapted prevention and treatment as relevant to the Portuguese context, setting two operational objectives for the specific population: 1) to promote the issue at the population level and introduce mechanisms for primary, secondary and tertiary prevention; and 2) to increase quality and integration in mental care delivery throughout different levels of care and in collaboration with relevant actors.

Almost a decade after the formalization of the European Ministerial Conference of 2005, WHO's report on Adolescent Mental Health (WHO, 2012) points out that mental health in general, and adolescent mental health in particular, are still unsatisfactorily addressed areas of health intervention for what concerns political commitment and resources. Plans and programs are said to be carried out unsystematically, without the establishment of partnerships, bearing project-specific objectives, and destined to a small portion of the adolescent population, such as the

one in emergency and conflict situations, and not to the adolescent age group as a whole. According to the report policies for life stages have a tendency to focus on the protection of children or senior citizens, whilst adolescents health remains a smaller focus of attention due to a common misperception of the healthiness of the age group. On the contrary, the report shows that one-fifth of adolescents suffer from mental health problems, preponderantly anxiety and depression, triggered by poverty, social exclusion, peer rejection and family neglect. For what concerns the Portuguese context partial assessments of the NMHP implementation so far show that the reorganization of services is ongoing, with psychiatric hospitals definitively shut down and replaced by 20 population-specific mental health services, for adults, adolescents and infants. Lack of adequate funding in primary care, as well as scarcity of non-medical professionals for community service, are identified as non-compliance areas to date (Xavier et al., 2013).

The Health Program for Youngsters - Project Description

The Health Program for Youngsters is a global CSR campaign launched in 2012 by a leading multi-national pharmaceutical, with the aim of improving adolescent access and education to health in 20 countries across the globe. As stated by the project's website, the idea to launch a global CSR initiative was stirred by the acknowledgement that youngster health is a global issue and that the creation of a coherent and systematized CSR project would grant higher visibility to the cause than a number of national initiatives. Corporate headquarters drew on evidence from WHO and UNICEF reports; identifying the area of youth health as both relevant and under tackled within different health systems, thus pinpointing a gap for a corporate investment in an area with social impact. The launch of the program was sealed by the establishment of multilateral partnerships between the MNC and two transnationally renowned civil society institutions, the oldest and largest public health school in the world, and a charity with more than 70 years of experience of work in defense of infant and adolescent rights and dignity across 51 countries, as the guarantors of the project's scientific soundness and civil advocacy. National projects, carried out with domestic partners, are identified by local subsidiaries according to the major concerns pertaining to the adolescent population. Areas covered include road safety, hygiene, obesity, homelessness, cultural determinants, cardiovascular risk prevention, and reproductive and mental health.

The Portuguese version of the Health Program for Youngsters tackles mental health access and education in adolescents between 10 and 12 years of age, pertaining to social contexts identified as vulnerable to poverty, social exclusion and family neglect, and with scarce access to health. The Portuguese MNC branch made the choice of the area after consulting a professor from the Superior Institute of Health

Sciences in Lisbon working on mental health in youth, which indicated the cause of mental troubles in young adolescents as one relevant for the national population. The relevance of the area identified was then confirmed with the Portuguese secretary of state, which officially endorsed the initiative. Once the area of intervention decided, the company launched a bid to a number of local NGOs for the redaction of a project that would receive funding. Although the area of intervention being predefined, NGOs were left free to define the project's, population, timeframe and specific objectives; being the existence of clear and measurable indicators a priority condition for admission. After assessing feasibility, originality and indicators, the winner project was chosen. The awarded project proposal states as its aim to “intervene early, with children and youths aged 10 to 12 years, (...) because at a time when we are witnessing a growth in inequality among citizens, it is imperative to act in preventing personal and social maladjustment of young people in a way that avoids the costs to the individual and community” in a population “with little or no access to health and in vulnerable situations, with developmental alterations or behavioral problems, triggered mainly by self-concept, self-esteem and self-image problems”. Specific objectives are set as to increase self-esteem in target population by 30% (i) and increase the number of youths in target population trained in mental health by 30% (ii), throughout the timeframe of the project, set for the period 2012-2015. As supporting evidence, the project engages the resolution no. 49/2008 of the Council of Ministers, citing the need for mental health to be tackled contextually and adapted to specific groups and areas. Further, the project engages national literature on adolescent mental health in Portugal framing the occurrence and determinants of risk-taking behaviors (Matos et al. 1998; Matos and Carvalhosa 2001; 2002), and the relevance of the self-esteem construct for psycho-social adjustment as well as the establishment of healthy relationships and coping skills (Peixoto, Martins, Mata & Monteiro, 1996; Antunes, C. et. al., 2006; Emídio et. al. 2008) and contextualizes the perks of engaging a participatory perspective. Finally, the project quotes data from the European Science Foundation (Llopis and Anderson, 2006), which warns that 21% of Portuguese children live beneath the poverty line. As clarified by the proposal, the target population – circa 100 youngsters pertaining to 7 social neighborhoods in the Lisbon metropolitan area - was identified by the means of an after school support project already ongoing, which the NGO carried out in local community centers with the funding of the Ministry of Education and Social Solidarity. The health program for youngsters was thus intended to reinforce the ongoing activities with the children by adding two weekly hours dedicated to mental health education as to “complement/reinforce already existing resources, without duplicating or substituting their intervention, but becoming part of it”. In order to evaluate the improvement in self-esteem outcomes the project started by carrying out, on the target population, a CAP assessment study redacted in collaboration with sociologists from the University of Lisbon. The following phase (ongoing) contemplates the

implementation of thematic workshops focusing on topics identified through the assessment study, and training on mental health, both carried out through a peer, non-formal methodology. The project's concluding phase foresees, in 2015, the redaction of a manual of best practices, the realization of a number of short films, the holding of an holiday camp, and the carrying out of an assessment study to track changes. The awarded NGO is the one that has the main responsibility for the realization of the project's different activities: establishment of partnerships with community actors, selection of internal social workers, realization of thematic workshops, and contracting of additional and punctual resources, as it is the case for the sociology team employed to design the CAP study. The MNC contribution consists, on the other side, in full economic sponsoring, and in the participation of staff volunteers in the implementation of thematic workshops. Participants in the project and their parents are informed on the responsibilities of parties involved and source of sponsoring.

Stakeholders' perspectives

The MNC

According to the corporate responsible the Mental Health Program for Youngsters serves a tripartite goal, to further the company's core mission to promote access to health, to engage employees and foster motivation, and to proceed towards the establishment and strengthening of relationships with key stakeholders with whom interaction and collaboration isn't guaranteed by the normal portfolio of activities: employees, local communities, NGOs in the health field, and the government. The interviewee points out that, among others, the government is the priority stakeholder, given its regulatory function, and that commitments undertaken through CSR are aimed at showing business good will and increase business-government trust relationships. It is explained that the Mental Health Program for Youngsters was shaped as to be relevant and strictly aligned with public policy priorities, as to guarantee the existence of a social impact that would raise approval from public authorities and public opinion alike. The collaboration with the NGO, necessary to carry out the field work, was allowed through a procurement contract whose technical requirements were defined by the interviewee as complex; details of the project were then rounded through a series of informal business NGO meetings. According to the interviewee the target population could have been more extensive in number and geographical reach, but resources didn't allow a greater focus. Moreover, the local focus of the project, both the MNC and the project are based in the Lisbon metropolitan area, allows for direct involvement of employees and the

establishment of regular meetings to verify the progress and difficulties of the project. When questioned concerning the potentially controversial nature of the project –the MNC works on the neuroscience therapeutic area- the interviewee points out that the issue had been discussed at a company level, and then dismissed on the basis that the campaign is not related to any specific product, and that design and implementation of the project, which has a public health-basis rather than a clinical one, is carried out by an NGO who is not a normal business partner, guaranteeing neutrality.

The NGO

In the NGO's representative's perspective fundraising via the business sector has always been a means of project support, becoming a priority means of subsistence after that governmental funding of social entities has been cut down by the austerity measures. According to the interviewee, the injection of private for-profit investments via CSR introduced evident changes from traditional business charity funding; CSR financing is rigorous, subject to previously inexistent monitoring and assessment criteria, resembling a procurement contract rather than a donation. The representative points out that the NGO was invited by the MNC to participate in the bid for the CSR initiative by presenting a project fitting within the predefined area of adolescent mental health. Following the invitation the staff reunited internally as to verify the coherence of the initiative with the NGO's areas of intervention. After deciding that the collaboration would be fruitful, the project application was sent, and successively selected. According to the interviewee, the funding destined for the Mental Health Program for Youngsters allowed the formalization of a project responding to a need for mental tutoring identified in the realization of a previously existing after-school support program, where young participants experienced scholar absenteeism and failure. After verifying with all of the involved parties the possibility to complement the existing intervention of the after-school support program, the project was designed as to guarantee matching of needs and objectives. As the representative points out, major difficulties rose from the different standpoints and even language used by the social and business spheres, but that all complications were resolved by a "common will to approximate perspectives". Further, according to the interviewee, a key feature of collaboration was the deposition of full autonomy in project implementation to the NGO, condition that allowed the turning of business-like relations into trust-driven relations. No threats are disclosed concerning the fact that neuroscience is a business area of the sponsoring entity, under the explanation that the project is entirely carried out by the NGO staff - the sponsoring being acknowledged but not present in the daily development of the project - and that there is no superposition with youngsters' eventual parallel psychiatric accompaniments.

The public sector expert

A representative of the Portuguese department for mental health, the technical normative body of the Health Ministry responsible for implementing the NPMH, was heard on behalf of the public sector. The interviewee starts by framing the national approach to mental health as one aimed at implementing the NPMH with a distinct focus on adults, adolescents and children and by addressing primarily the reorganization of mental services, as to shift from a psychiatric hospital model towards community-based services. Further, the interviewee points out the comparatively smaller attention given by the department to the area of health promotion and prevention, in favor of the betterment of services. Questioned concerning the existence of linkages of the department with the private sector the interviewee clarifies the existence of protocols favoring the access on people with mental struggles to the job market, and points out the absence of partnerships arranged under the CSR frame. The interviewee further affirms that, although the business sector's involvement is welcome in theory, he is skeptic that CSR is a viable means to align public and private interests. When asked to argue such disbelief, the mental health representative expresses his wariness that the business sector's involvement is driven by goodwill and not vested interests -there are no "free meals"-. The existence of vested interests sets the basis for the design of deceptive initiatives, which appear as being aimed at addressing public health, but ultimately advantage private interests. As an example, the interviewee describes an alcohol industry-based CSR campaign presented to the department, which contemplated the creation of a "sober driver" figure among a group of friends. The campaign is misleading, as it doesn't aim at reducing harmful levels of consumption, but merely redirecting them towards other group members. Questioned in relation to the CSR program in analysis, the representative clarifies that not only the Portuguese department for mental health is not the public entity that endorsed the launch of the initiative, but that he ignores the existence of the CSR Mental Health Project as a whole. When informed of the project's specificities he posits the possibility of the initiative being motivated by the will to promote the company's antipsychotic drug, rather than making a social impact in adolescent health. In conclusion the interviewee affirms that to avoid the risk of misleading initiatives and set the basis for trust-riven collaborations striving for an alignment of public and private efforts there is a need for the establishment of mechanisms allowing governmental monitoring, assessing and when necessary sanctioning, of CSR pointing out that transparency can not be guaranteed without the possibility of enforcement.

Discussion of Results

Although the study being limited by the partiality of evidence gathered through one CSR program, which, additionally, has not reached its full conclusion at the time of redaction of the study, and by the fact that not all three stakeholders interviewed were involved in the planning, design and implementation of the program, the authors consider that the information collected is relevant to discuss perspectives on the actual and potential contributions of CSR to national and international health policy, incentives to policy development, as well as highlight boundaries and their relative boundaries, that are described below:

Contribution to national and international mental health policy

The Mental Health Program for Youngsters' project description, together with the critical insights provided by different stakeholders, prove that the CSR initiative is apt to contribute to national and international objectives for adolescent mental health. The Health Program for Youngsters manages to give visibility to the issue of adolescent mental health set as a priority by the European Ministerial Declaration on Mental Health (WHO, 2005), issue that, according to WHO (2012), was still unsatisfactorily addressed by policy worldwide at the time of the project's launch. Further, the project follows the priorities set by the European Ministerial Action Plan on Mental Health (WHO, 2005): is constructed in consultation with relevant stakeholders - the NGO for project design and implementation- engaging national and international mental health evidence-basis, and ensuring a community-based approach. The project, that engages a life stages-sensitive approach considers all the dimensions recommended for adolescent mental health: the provision of skills for coping mechanisms in adult life, the minimization of risk-taking behaviors, and finally, the involvement in decision-making processes, which is guaranteed by the participatory approach in which activities are shaped by social workers and adolescent alike and where learning is intended to be flexible and informal.

For what concerns the priorities set by the Portuguese government through the NPHM 2007-2016, reflecting the support given to the European Ministerial Action Plan on Mental Health (WHO, 2005), it can be said that the Mental Health Program for Youngsters not only aligns, but complements, the objectives set. In fact, although the plan sets the promotion of mental health for the population in general, and for children and adolescents specifically, as a national health priority, partial assessments (Xavier et. al, 2013) as well as the contribution of the public expert on the issue, have shown that the focus of public intervention has, in the first half of its implementation, been on the reorganization of services and the conversion of psychiatric hospitals in to community health services sensitive to life stages, whilst

highlighting the scarcer attention given to issues pertaining to disease prevention and health promotion. In this perspective the CSR Health Program for Youngsters aligns with both objectives set for adolescent mental health in the NMHP, to promote the issue by introducing mechanisms for prevention, and to increase quality and integration in care delivery throughout different levels and actors, complementing by allocating resources in areas that both the assessment and expert pinpoint as lacking. Although not disposing of precise information concerning the amount of economic and human resources allocated – being the information classified - the project allows to develop a project which targets a population that wouldn't otherwise dispose of means to access issues relevant for self-esteem and mental troubles, and does so by creating linkages between the MNC, the NGO and the ministerial projects whom it expands, without altering. This proves that CSR can represent a mean to overlap, integrate and enrich institutional or civil society projects, furnishing channels to allocate resources but also setting the basis for multi-sectoral coordination and integration efforts.

Contribution to health policy development

In addition to contributing to national and international policy for mental health by promoting the issue, aligning objectives and allocating resources the CSR Mental Health Program for Youngsters sets the basis for health policy development by contextualizing a new role of the private for-profit sector in supporting population health campaigns, setting benchmarks for CSR practices and creating privileged channels for stakeholder dialogue and engagement.

As proven by the case study CSR goes beyond the plea contained in the Jakarta Declaration (WHO, 1997) for businesses' to do no harm, introducing a channel by which the for-profit sector takes charge of its potential to participate in areas loosely or directly linked to core business, among which, population health. The proactive stance can be pinpointed in decision of the MNC to uptake a global health campaign with local adaptations as well as in the independent definition of the issue to address. In this respect the CSR program proves that MNCs are indeed operational and dynamic actors of in the GHG frameset, able to give rise to health campaigns and collaborative networks generated from the input of the MNC itself. Moreover, the commitment to initiatives that exceed what required from governments expands benchmarks for CSR practice and sets the basis for policy development on the role of the business sector and MNCs in GHG. Adolescent health is a relevant area socially, as supported by policy evidence-basis internationally, and the endorsement of scientific and civil society actors, both clarifying the existence of lacunae in public health policy, and a strategic issue for the MNC. Addressing a relevant gap allows the corporation a channel to access policy-makers, which, self-reportedly, are the key

stakeholders, as well as gain attention from non-governmental organizations advocating the issue. Further, the targeting of young populations, a common feature of CSR projects, is not only sensitive in terms of public opinion, but allows the corporation to establish links with the future public opinion, consumption and policy-making. Finally, the development of collaborative patterns with actors with whom interaction isn't guaranteed by the normal portfolio of activities, as it is the case for the NGO participating in the Mental Health for Youngsters Project, as well as other local partners of the project, is strategic for the MNC as it provides what Hamann and Acutt (2003) define as "complementary capabilities", such as social capital and local knowledge.

The CSR project gives momentum for stakeholder engagement and dialogue, partially in the planning phase and more extensively in the design and implementation phases that are, with the limitation of the issue definition, all responsibility of the NGO who took charge of defining specific objectives, identifying participants and choosing methodologies. The doubt may rise concerning the NGO's engagement in mental health for adolescent as being supply-driven, it is to say, influenced by the opportunity to receive a financing and constricted by the predefinition of the issue by the MNC. This doubt is refuted by the NGO representative, which clarifies that the internal evaluation of the CSR project's coherence with the NGO's areas of intervention, and the possibility to design the project independently, eliminated the risk of the civil society institution being influenced by its corporate partner. For what concerns the public sector, on the contrary, it is not possible to speak of an engagement. The endorsement given by the health secretary of state at the project's launch can not be considered as a form of involvement but rather as political formality, given that there is no mentioning of the potential role of MNCs in the PMHP, no participation in the design and implementation phases, and presumably, there will be no involvement for assessment. Even more interestingly, the representative heard from the mental health department, skeptical concerning the authenticity of CSR commitment to social good on a general basis has no knowledge of the taking place of the project in the sphere of competence of the department few kilometers away.

According to the interviewees actively involved, the CSR project allows for the creation of dialogue channels where needs and objectives are discussed and matched, as well as permitting the overcoming of difficulties that arise from the differences in interests and ways of pursuing and expressing them, allowing, as Moon (2007) describes it, the creation of new systems of governance that transcend market affiliation. According to Hamann and Acutt (2003) the commitment to social good and multi-stakeholder partnering through CSR is authentic as it allows, in the long period, the legitimization of corporate choices and actions, thus to lowering risks and costs of business operations. Finally, as clarified by the NGO representative, the collaboration engaged through the CSR project in analysis, differs from the ones

established in time through corporate philanthropic donations, as it is submitted to strict accompaniment, monitoring and assessment measures that translate in the minimization of risks of mismanagement and in an increased effectiveness.

Boundaries for CSR contribution to GHG

So far we have seen the aspects in which CSR commitment is a catalyst for MNCs contribution to national and international health policy as well as a potential driver for both CSR and health policy development. The case study in analysis has allowed to prove that CSR may be beneficial to public interest, whilst being strategic for the corporate sector, proving that, as WHO's director Margaret Chan expressed at the latest International Conference for Nutrition (Chan, 2014), economic and health objectives can converge. Nevertheless, it is fundamental not to take too much of a naïve stance, highlighting the boundaries inherent to CSR, as to guarantee that threats and controversies are made evident so that they can be acknowledged by non-corporate parties involved in alliances. Boundaries will be discussed according to the dimensions highlighted in the previous section: the proactive role of MNCs in new systems of governance such as GHG and the nature of multi-stakeholder partnerships.

As highlighted by Hamann and Acutt (2003) the notion of multi-stakeholder partnerships carried out through CSR seldom acknowledges the existence of power dynamics among parties, furthering a simple picture where partnerships and stakeholders are seen as “a collective endeavor, where all players are equal and conflicts of interest can be resolved by roundtables seeking consensus”. Additionally, the view that partnerships are sufficient to gain consensus reduces the need for the advocacy role of the civil society and the incentivizing and regulation task of the government, which can be pinpointed, together with consumer and public opinion boycott, as the roots of CSR. Further, the proactive stance assumed by CSR is not a guarantee that the plea to do no harm is interiorized. It may be merely bypassed in the pursuit of other commitments that, as the one in analysis, are beneficial for society and MNC at the same time. The fact that the for-profit sector proactively identifies the area of CSR intervention may result in projects that are either un-relevant, deemed as mere public relations or marketing efforts, or, as it is for the case study, are relevant, but are carried out without the concertation of all parties that could be potentially involved, for example, the distance from the national mental health department makes so that the initiative will remain project-specific and not be framed within a major regional or national frame. Moreover, as Fooks (2011) points out, the proactive choice to tackle relevant policy issues in sectors where corporate activity is strictly regulated, as it is the case for pharmaceuticals, may hinder vested interests such as the access to the policy-making arena with lobbying purposes, which could explain why

the secretary of state is informed upon the initiative and the national department for mental health isn't.

In conclusion it can be said that to minimize the risks associated to, and augment the potential for CSR to be a catalyst for social good and GHG in particular businesses should not be allowed to realize CSR projects autonomously or by partial partnerships where parties endorse but don't actively participate in design and implementation; responsibilities do not "lie" or are "placed" among a given actor, they are built and negotiated among parties, it is to say, they are collectively defined. The creation of incentives and regulation for CSR is a public sector's responsibility that, as of today, remains largely unattended within the Portuguese public sector. Portugal remains one of the few European countries where there is no national strategy on CSR apt to promote priorities, create mechanism to incentive stakeholder dialogue and intersectoral collaboration, or sets benchmarking and transparency criteria for CSR. The suggestion being that the government first, and civil society then, may have to take a clear stance as to formulate and promote their own priorities for CSR, securing that corporate participation be relevant, complementary and transparent to public objectives.

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Reference List

- Babor Thomas, “Alcohol research and the alcoholic beverage industry: issues, concerns and conflicts of interest” *Addiction*, 104: S1 (2008), 34–47.
- Brezis Mayer, Wiist H. William, “Vulnerability of Health to Market Forces”, *Medical Care*, 49: 3 (2011), 232-239.
- Bunde-Birouste Anne, Bull Nicholas and Brad McCarroll, “Moving beyond the ‘Lump-Sum’: football united and JP Morgan as a case study of partnership for positive social change”, *Cosmopolitan Civil Societies Journal*, 2: 2 (2010), 92–114.
- Buse Kent, Lee Kelley, Business and Global Health Governance, *Discussion paper n° 5*, Centre on Global Change and Health London School of Hygiene & Tropical Medicine, 2005.
- Caldas de Almeida José Miguel, Xavier Miguel, *Estudo Epidemiológico Nacional de Saude Mental – 1º Relatorio*, WMSI/CESOP, Lisboa, 2010.
- Chan Margaret, Opening address at the second international conference on nutrition, Rome, November 2014.
- Colebatch Hal Kempley, “Governance as a conceptual development in the analysis of policy”. *Critical Policy Studies*, 3: 1 (2009), 58-67.
- De Leeuw Evelyne, Tang Kwok Cho and Robert Beaglehole, “Ottawa to Bangkok — Health promotion's journey from principles to ‘glocal’ implementation”, *Health Promotion International*, 21: S1 (2006), 1-4.
- Dorfman Lori, Andrew Cheyne, Lissy C. Friedman, Asiya Wadud, Mark Gottlieb, “Soda and tobacco industry corporate social responsibility campaigns: how do they compare?”, *PLoS Medicine*, 9: 6 (2012), 1-7
- Fooks Gary, Anna Gilmore, Katherine Smith, Jeff Collin, Chris Holden and Kelley Lee, “Corporate social responsibility and access to policy elites: an analysis of tobacco industry documents”, *PLoS Medicine*, 8: 8 (2011), 1–12.
- Freudenberg Nicholas, Galea Sandro, “The Impact of Corporate Practices on Health: Implications for Health Policy”, *Journal of Public Health Policy*, 29 (2008), 86–104.
- Freudenberg Nicholas, “The manufacture of lifestyle: The role of corporations in unhealthy living”, *Journal of Public Health Policy*, 33 (2012), 244–256.
- Freudenberg Nicholas, *Lethal But Legal: Corporations, Consumption, and Protecting Public Health*, Oxford, 2014.
- Friedman Lissy, “Tobacco industry use of corporate social responsibility tactics as a sword and a shield on secondhand smoke issues” *Journal of Law, Medicine & Ethics*, 37 : 4 (2009), 819–27.
- Hamann Ralph, Acutt Nicola, “How should civil society (and the government) respond to 'corporate social responsibility'? A critique of business motivations and the potential for partnerships”, *Development Southern Africa*, 20: 2 (2003), 255-270.

- Herrick Claire, “Shifting blame/selling health: corporate social responsibility in the age of obesity” *Sociology of Health & Illness*, 31: 1 (2009), 51–65.
- Jané-Llopis E., Anderson P, *Mental health promotion and mental disorder prevention across European Member States: a collection of country stories*, Luxembourg, 2006.
- Kickbush Ilona, De Leeuw Evelyn, “Global public health: revisiting healthy public policy at the global level”, *Health Promotion International*, 14: 4 (1999), 285-288.
- Lang Timothy, Reyner Geof, “Overcoming policy cacophony on obesity: an ecological public health framework for policymakers”, *Obesity Review*, 8: S1 (2007), 165-181.
- Lang Timothy, “Corporate responsibility in public health: the government’s invitation to the food industry to fund social marketing on obesity is risky”, *British Medical Journal*, 341 (2010), 110-111.
- Lee Kelley, Buse Kent and Suzanne Fustukian, *Health policy in a globalising world*, Cambridge, 2002.
- Margolis Joshua, James Walsh, “Misery Loves Companies: Rethinking Social Initiatives by Business”, *Administrative Science Quarterly*, 48 (2003), 268–305.
- Matos Margarida Gaspar, Celeste Simões, Susana Fonseca Carvalhosa, Carla Reis, *A Saúde dos Adolescentes Portugueses*. Aventura Social & Saúde. Estudo Nacional da Rede Europeia HBSC/OMS. Faculdade de Motricidade Humana, Lisboa, 1998.
- Matos Margarida Gaspar, Susana Fonseca Carvalhosa, *Saúde mental e mal estar físico na idade escolar*. Aventura Social & Saúde, Lisboa, 2001.
- Matos Margarida Gaspar, *Saúde Mental e Bem Estar Físico na Idade Escolar*. Aventura Social & Saúde, Lisboa, 2002.
- Monachino Michelle S., Moreira Paulo K., “Corporate Social Responsibility and the health promotion debate: An international review on the potential role of corporations”, *International Journal of Healthcare Management*, 7: 1 (2014), 53-59.
- Moon Jeremy, “The Contribution of Corporate Social Responsibility to Sustainable Development”, *Sustainable Development*, 15 (2007), 296–306.
- Nishinaga Jesse, Lane Adam, and Jessica Davis Pluess, *A New CSR Frontier: Business and Population Health*, BSR Report, November 2013.
- Observatório Português dos Sistemas de Saúde, *Relatório de Primavera 2012 – Crise & Saúde, Um país em Sofrimento*, Coimbra 2012
- Porter Christine, “Ottawa to Bangkok: changing health promotion discourse”, *Health Promotion International*, 22: 1 (2007), 72-79.
- Peixoto Francisco José Brito, José Martins, Lourdes Mata, Vera Monteiro, “Adaptação da escala de auto-conceito para adolescentes de Susan Harter para a população portuguesa”, *Avaliação Psicológica: Formas e Contextos*, 4 (1996), 531-537.

- Presidencia do Conselho dos Ministros, *Resolução do Conselho dos Ministros 49/2008*, Portugal.
- Rosenau James, Czempiel Ernst-Otto, *Governance without Government: Order and Change in World Politics*. Cambridge. 1992.
- United Nations, Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health*, 2000.
- Vogel David, *The Market for Virtue*, Washington DC, 2005.
- Werner Wendy J., “Corporate social responsibility initiatives addressing social exclusion in Bangladesh”, *Journal of Health Population and Nutrition*, 27: 4 (2009), 545–62.
- Wiist William H., “Public Health and the Anticorporate Movement: Rationale and Recommendations”, *American Journal of Public Health*, 96: 8 (2006), 1370-1375.
- Wiist William H., *The bottom line or public health*, Oxford 2010.
- World Bank, *Corporate Social Responsibility and Sustainable Competitiveness*, 2002.
- World Economic Forum and the Harvard School of Public Health, *The Global Economic Burden of Non-Communicable Diseases*”, September 2011.
- World Health Organization, *The Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa, November 1986*.
- World Health Organization, “*Adelaide Recommendations on Healthy Public Policy*”, April 1988.
- World Health Organization, *Sundsvall Statement on Supportive Environments for Health*, June 1991.
- World Health Organization, *The Fourth International Conference on Health Promotion: New Players for a New Era - Leading Health Promotion into the 21st Century*, Jakarta, July 1997.
- World Health Organization, *The Bangkok Charter for Health Promotion in a Globalized World*, Bangkok, August 2005.
- World Health Organization, *Adolescent mental health: mapping actions of nongovernmental organizations and other international development organizations*, Geneva, 2012.
- World Health Organization Europe, *Mental Health Action Plan on Mental Health for Europe : facing the challenges, building solutions*, Helsinki, 2005.
- World Health Organization Europe, *Mental Health Declaration on Mental Health for Europe : facing the challenges, building solutions*, Helsinki, 2005.
- Xavier Miguel, Pedro Mateus, Alvaro Carvalho, “Portuguese Mental Health Plan : where are we now?”, *European Psychiatry*, 28: S1 (2013), 1.