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RESEARCH ARTICLE

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# Public Health and Private Charity in Northeast China, 1905–1945

**Abstract** Medical charity in northeast China evolved through the confluence of three processes: the foundation of state medicine, the legal and political transformation of private charities, and the militarized competition for influence between China and Japan. Following the plague of 1910, a series of Chinese regimes began building medical infrastructure in areas under their control, but their ultimate inability to establish a comprehensive public health program left private charities to fill the gaps. In contrast, the Japanese administered concessions in Kantō and along the South Manchuria Railway instituted a farsighted and multivalenced medical policy. The Japanese model did not merely tolerate medical charities, it reserved for them a very specific role in the larger strategic framework of healthcare provision. Under the client state of "Manzhouguo," the Japanese model further evolved to channel medical voluntarism into a hybrid state-charitable sector.

**Keywords** Manchuria, charity, medicine, epidemic disease, Japan, sovereignty, social engineering

## Introduction

In 1907, the Scottish physician Dugald Christie (1855–1936) addressed the Centenary Missionary Conference in Shanghai. Christie was a pioneer of medical mission in China's Northeast, and his speech championed medicine as "an essential and integral part of the Mission of the Church." His listeners were by and large already won over to his message. Medical charity was integral to mission work in China, so much so that many missionaries actually feared for the day that the Chinese government would make a real commitment to public health. Addressing precisely these concerns, Christie said that mission hospitals and medical schools should remain autonomous, even as they were "laying the

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foundations of what will one day be purely Chinese work."[1]

The questions surrounding medical charity in China would soon develop in ways that neither Christie nor his 1907 audience could have anticipated. Over the subsequent three decades, China experienced an explosion of foreign and native philanthropy. Christian missions were joined by a wide variety of new charitable institutions, all of which poured vast resources into public health and medical education programs. At the same time, the collapse of the imperial system, the factionalism of the new Republic, and growing compromises of Chinese territorial sovereignty left China as a patchwork of political entities that were unable to commit to public health, but also uneasy about allowing private charities to retain their earlier role.

This article examines the confluence of events and interests that shaped the foundation of public and private medicine in early twentieth century Northeast China. The question of how state and charitable institutions should interact, of obvious concern to Christie and his listeners in 1907, remained a key question over the subsequent decades, even as the actors themselves changed. This question had new urgency, as health became part of state responsibility and sovereignty, particularly in light of new medical internationalism, and of rising Japanese influence over the region. The private sphere negotiated a new relationship with the state, but also adapted to new realities: traditional charities expanded their operation, and were joined by new actors that were less the expressions of charity than the manifestations of a developmental state.[2]

## Medicine in Northeast China before 1910

Custodianship of the public good in late imperial China was shared between the state and private individuals. In practice, the two spheres were deeply integrated: it was often the same stratum of civic-minded local elites who supported social endeavors whether they did so in an official or private capacity. Official relief activities relied heavily on donations garnered from local elites, while charitable societies known as benevolent associations (*shantang*) worked with the blessing and cooperation of local officials. State and private came together in times of crisis to care for victims of famine or natural calamity, as well as to provide acts

[1] Dugald Christie, *Thirty Years in Moukden, 1883–1913: Being the Experiences and Recollections of Dugald Christie*, 220.

[2] Chalmers Johnson first coined the term "developmental state" in reference to the industrial reconstruction of postwar Japan. I use it here to refer to an earlier legacy of political legitimation based on the promise and institutions of economic and social development. See Chalmers Johnson, *MITI and the Japanese miracle: the growth of industrial policy, 1925–1975*; Meredith Woo-Cumings, ed., *The Developmental State*.

of compassion, such as sheltering widows and orphans, feeding the hungry, and burying the indigent dead.[3]

However, this conception of public welfare generally did not include what today might be called public health. On the whole, late imperial officialdom took relatively little interest in the systematic management of health: regulating medical care, ensuring public sanitation and combating epidemic disease. One important reason for this apparent disinterest was simply the state of scientific knowledge. Epidemic disease, for example, was attributed to crowds of angry spirits or the stagnation of unhealthy *qi*, rather than the transmission of pathogens. Officials and community leaders combated disease with religious ceremonies, but generally neglected taking steps such as effecting quarantine, closing the roads to infected migrants and ensuring the quality of water supply, primarily because the understanding of disease did not suggest that such measures were necessary. Benevolent associations that distributed medicine to the poor did so in order to alleviate suffering, rather than as a matter of public health.[4] Even reputed reformers such as Li Hongzhang (1823–1901) had to be won over to the idea that government should take any active role in the suppression of epidemic disease.[5]

Even after new conceptions and models of public health began to take root in China during the nineteenth century, broader medical reform was slow to materialize. The initial impetus came primarily from abroad. Following the American Protestant Peter Parker (1804–88), who opened his pioneering ophthalmological clinic in Canton in 1835, waves of medical missionaries began building ever larger and better-funded mission hospitals, clinics and medical schools in Chinese cities. Foreign administered sections of Shanghai, Tianjin and Amoy incorporated advances in urban planning that inspired a new role for the state in sanitation.[6] Like many of China's late nineteenth century reforms, the first medical innovations were carried out at the initiative of unusually energetic individuals such as Li Hongzhang, who founded the Beiyang Medical College in 1893. Ten years later, the general Yuan Shikai (1859–1916) threw his weight

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[3] T'ung-tsu Ch'ü, *Local Government in China under the Ch'ing*, 156–61; Vivienne Shue, "The Quality of Mercy Confucian Charity and the Mixed Metaphors of Modernity in Tianjin." On late imperial charities more generally, see Joanna F. Handlin Smith, "Benevolent Societies: The Reshaping of Charity during the Late Ming and Early Ch'ing," and Fuma Susumu, *Chūgoku zenkai zendō shi kenkyū*.

[4] On Chinese official attitudes towards health, see Cao Shuji, "Shuyi liuxing yu Huabei shehui de bianqian," and Carol Benedict, *Bubonic Plague in Nineteenth-Century China*. On religious ceremony as a communal response, Paul R Katz, *Demon Hordes and Burning Boats: The Cult of Marshal Wen in Late Imperial China*.

[5] Ruth Rogaski, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China*, 38, 134.

[6] Ibid.

behind a proposal to build a Medical Hospital for the Qing New Army. Yet as personal projects, these reforms were easily undone: once Li and Yuan were forced from power, many of the institutions that had flourished under their protection came to an abrupt end.[7] Writing in 1915, the China Medical Commission of the Rockefeller Foundation confirmed the poor results of two decades of fitful medical reform: "The hospitals under Chinese control, whether government or private, are with few exceptions ineffective, and they are chiefly of interest as demonstrating how small an impression high grade Western medicine has as yet made on China."[8]

The overall neglect of public medicine also held true for Chinese administrations in the Northeast. Institutional public health was almost non-existent in late-Qing Manchuria: few provisions for sanitation were made in the rapidly expanding cities, and medical care consisted of doctors of traditional medicine, who trained and practiced as individuals.[9] Where it existed, organized medical care was provided by foreign ventures. The Russian-run China Eastern Railway (CER) operated a string of twenty medical units, including seven hospitals along its northern track, and three on its southern, as well as a hospital in the Guandong city of Dal'nii (future site of Dairen). Although the railway hospitals did take Chinese patients (the CER history claims that by 1902, Russian hospitals had treated a total of 48,157 Chinese outpatient and 7,795 inpatient admissions), they existed primarily for the employees of the CER, and as we shall see, as a first line of epidemic defense of Russia itself.[10] The most notable private venture was the small mission hospital, which Christie founded in Mukden (Shenyang)[11] in 1884, followed by a medical college eight years later.[12]

Support for these smaller enterprises was unpredictable. Newly appointed during the Qing reforms of 1905, Viceroy Xu Shichang (1855–1939) and General Zhao Erxun (1844–1927), made sweeping plans to expand medical education, and promised Christie extensive support for his school and hospital.[13] However, this group of officials were themselves politically allied with Yuan Shikai, and

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[7] Lian-teh Wu, "Medical Progress in China since the Republic," 363–68.

[8] Rockefeller Foundation and China medical commission, *Medicine in China*, 53–55.

[9] Sun Hongjin, "Jindai Shenyang chengshi fazhan yu shehui bianqian (1898–1945)," 151.

[10] Chinese demand for Russian medical services was so great that the Guandong hospital closed all but its fourth-class ward to fee-paying Chinese patients. R.K.I. Quested, *"Matey" Imperialists? : The Tsarist Russians in Manchuria, 1895–1917*, 105–14.

[11] Many of the places discussed in this article have a number of names and pronunciations. The modern name will be given parenthetically in the first instance, and thereafter names will are given in the form they appear in the original source.

[12] Christie, *Thirty Years in Moukden*, 225–33.

[13] Both Xu and Zhao returned to political prominence with the return of Yuan Shikai in 1912. He Yimin, "Sichuan Province Reforms under Governor-General Xiliang," 136–56; Xu Jianping, "Zongdu Xiliang yu Dongbei bianjiang de kaifa."

like him, were dismissed after the death of the Empress Dowager in 1908. Xu Shichang's successor as viceroy, the Mongol Xiliang (1853–1917), expressed personal respect for Christie, but had little interest in implementing his vision of systemic medical reform. Christie in turn characterized Xiliang as "fine example of the best type of the old-fashioned Chinese official," that is to say, a well-intentioned gentleman who was nevertheless far outside of his depth on matters requiring technical competence.[14]

## The Arrival of Japanese State Medicine

Japan entered Manchuria as part of a broader shift in the political balance in northeast Asia. Since the 1880s, Russia and Japan had increasingly challenged Chinese hegemony over areas such as Korea and Mongolia, and each had sought to establish its own influence in the Qing's own homeland of Manchuria. After a decade of increasingly brutal conflict among the three powers, Japan prevailed, gaining a formal protectorate over Korea (which it annexed in 1910), as well as significant concessions elsewhere.[15] Manchuria remained Qing territory, but was deeply compromised. Having been thwarted in its attempt to annex the entire Liaodong Peninsula, Japan would settle for a special 99-year leasehold over the Kantō (Guandong) Territory at its tip, and possession of the Russian railway line as far north as Changchun. Russia retained the northern line, and a shaky authority over the railway boomtown of Haerbin.[16] The railway was itself a major concession, as it brought not only possession of the track itself, but also the right to develop and garrison adjacent lands. Alternately through the governorship of Kantō and the administration of the South Manchuria Railway (*Minami Mantetsu*), Japan vastly expanded the city and port of Dal'nii (renamed as Dairen), and aggressively developed its holdings in the region (see Fig. 1).

Japan came to Manchuria with three decades of experience in public health reform at home and in Korea. Following the demise of the shogun system in 1868, Japan had committed itself to the highly centralized and interventionist model of Prussian *Staatsmedizin*. The new Meiji government immediately enacted a series of reforms regulating the practice of medicine, requiring certification for practitioners, and establishing a network of hospitals. From 52

[14] Christie, *Thirty Years in Moukden*, 235.

[15] Specifically the Sino-Japanese War (1894–95), the Eight-Nation Boxer Suppression (1900) and the Russo-Japanese War (1904–1905).

[16] Russian rights outside of the special zone of the China Eastern Railway eroded quickly after 1906, and disappeared altogether after the formation of the Soviet Union. See R.K.I. Quested, *"Matey" Imperialists? : The Tsarist Russians in Manchuria, 1895–1917*, and Blaine R Chiasson, *Administering the Colonizer: Manchuria's Russians under Chinese Rule, 1918–1929*.

public hospitals in 1874 (the mandated minimum of one in each prefecture), the number of hospitals grew more than tenfold to 626 in 1882.

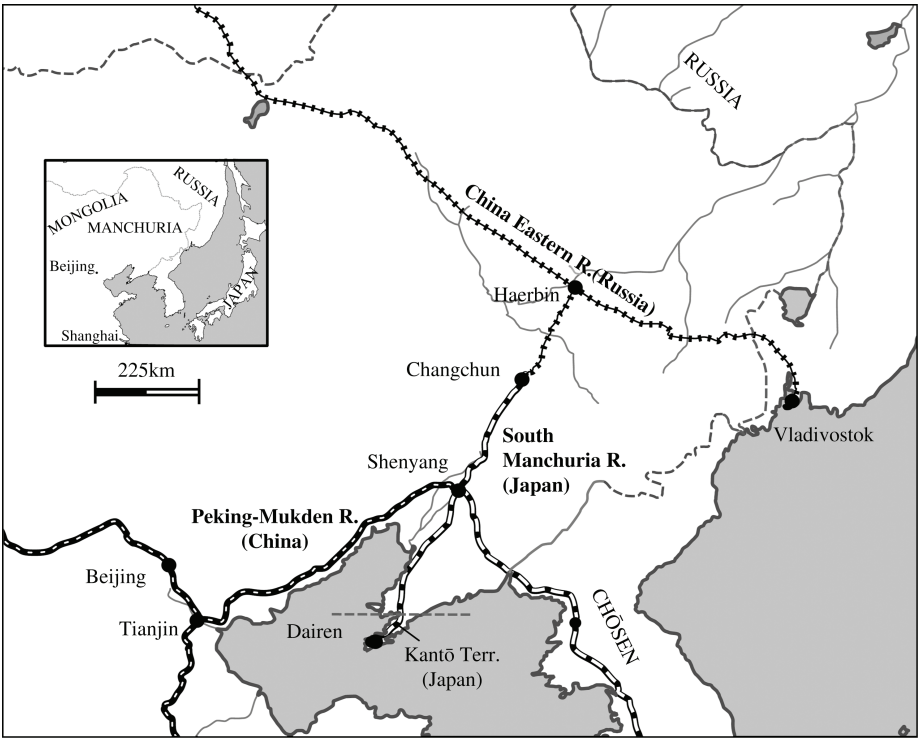


**Fig. 1** Manchurian Railways in 1920

Source: Map by author.

Japan's medical transformation reflected a variety of strategic goals. The network of provincial hospitals supported the new conscript army by training military doctors on a large scale. The shift of population to the industrializing cities, combined with the expansion of seaborne trade made the threat of epidemic disease a particular concern. The new Meiji government introduced mandatory smallpox inoculation in 1876, and responded to an 1885–86 outbreak of cholera (with a total death toll of 109,758) with a series of increasingly sophisticated quarantine measures. These culminated in the 1897 Infectious Disease Prevention Law, which established comprehensive standards for reporting and treating outbreaks, quarantining homes and neighborhoods, and disposing of infected bodies. A provision for eradicating rats was added in 1905, based on the experience of Japanese researchers such as the bacteriologist Kitasato Shibasaburō (1853–1931) during the 1894 plague in

Hong Kong.[17]

These efforts were aided by organizations like the Red Cross of Japan (RCJ), which straddled public and private, channeling citizen efforts into the state-led transformation of medical institutions, and providing central leadership over the medicalization of society. Formed in 1886, the RCJ operated under the honorary supervision of the Meiji imperial couple, which subsidized the society with an annual grant of 10,000 yen. The RCJ mobilized for battlefield aid and disaster relief, but also established more permanent enterprises, such as nurses' training centers and hospitals. The imperial house also lent the RCJ considerable political support, thus casting the organization as a model for patriotic civic action. The Meiji empress became a visible patron of the society, speaking on its behalf, and rolling bandages for troops during the war with China. Yet despite the RCJ's deep financial and social ties to the imperial couple, its organizers took pains to emphasize that "the Red Cross Society of Japan does not belong to the government but it is a private institution."[18]

Japanese medical reform in Chōsen (Korea) shared similar priorities, but was more circumspect in how it elicited popular participation. The pro-Japanese faction that came to power in 1894 had initiated a spate of public health measures, aimed largely at combating specific epidemic diseases, such as cholera, typhoid and smallpox. Under the 1905 protectorate, Japan took direct charge of public health and hygiene. Yet although the Japanese government introduced the same centrally managed trio of medical training, hospital construction and epidemic prevention that they had at home, these reforms had a radically different social significance in the colonial context. Editorial articles in the Japanese-language *Chōsen shinbun* overtly espoused funding colonial medicine in order to weaken the influence of Anglo-American medical missions. Moreover, the mobilization of mass support for medical reform was aimed at resident Japanese, rather than native Koreans. When the Red Cross of Chōsen was founded in 1908, only one thousand of the 9,000 inaugural members were Korean. That organization was absorbed into the Red Cross of Japan just one year later.[19]

Japan took a similarly farsighted but selective approach to establishing a medical infrastructure in Kantō. Even before 1905, Japanese living in Manchuria had already established a number of private clinics, as well as the Christian Seiai (Ch. Sheng'ai, Sacred Love) Hospital in Dal'nii. Victory over Russia cleared the

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[17] Fujio Ōtani, "One Hundred Years of Health Progress in Japan," 13–36; William Johnston, *The Modern Epidemic: A History of Tuberculosis in Japan*.

[18] Keiichi Kawamata, *The History of the Red Cross Society of Japan*, 41–45, 90, 117, 156.

[19] Lee Jong Chan and Chang Duk Kee, "The Institutionalization of Public Hygiene in Korea, 1876–1910"; "Manshū ni ikeru jizen jigyō" (Charitable social services in Manchuria), *Chōsen shinbun*, June 1, 1908; "Sekijūjikai sō kai" (General meeting of the Red Cross), *Chōsen shinbun*, September 1, 1908.

way for long-term planning and massive infrastructural investment. Official efforts were initially coordinated by the Mantetsu railway, which established its own Department of Hygiene (*eisei ka*), and began plans for the construction of the Dairen Hospital in 1907. At the same time, the Japanese administration actively integrated private efforts into its overall medical strategy. The Red Cross of Japan, which had operated field infirmaries during the wars with China and Russia, soon thereafter established a branch specifically for Manchuria. Private ventures such as the Seiai Hospital not only continued their operations, but began receiving charitable funds (*onshi*) directly from the imperial house in 1924. The Seiai would remain a major recipient of *onshi* funds for the next two decades.[20]

## Medicine in Northeast China: 1910 to 1932

Between 1911 and 1931, a string of official and private actors attempted to establish medical institutions in Northeast China. While an unquestioned success in absolute terms, these reforms lacked the strategic vision or coordinated implementation that characterized the Japanese efforts at home and abroad. The piecemeal nature of Chinese medical reforms reflected both the high degree of political division, and a lack of coordination between state and private medical initiatives. In contrast to the integration of state and private seen in organizations such as the Red Cross of Japan, Chinese medical charities arose in response to a vacuum of state services, and often found themselves either at odds with newly expanding state power, or being used as pawns in political infighting. It was only in the late 1920s, as the Japanese threat loomed on the horizon, that political leaders made a last-ditch attempt to unify the entire medical sector.

The first concerted Chinese attempt to build medical institutions in Manchuria was prompted by an outbreak of plague late in 1910. The mysterious and quickly fatal disease first appeared along the northern frontier in October, and by December, was being reported in Haerbin and Guanchengzi (Changchun). By January 1911, migrant laborers returning to north China for Spring Festival had carried it to Beijing and Tianjin. Their symptoms were identical: cramps and fever, coughing up blood, and skin lesions that identified the outbreak as pneumonic plague (but not the swellings or "buboes" that would have accompanied the less fatal bubonic plague). In the worst affected areas, the mortality rate could be staggeringly high. In Shuangchengzi, a crowded coolie

[20] Policy continuity among Japanese possessions was due largely to the influence of individuals like Gotō Shimpei, a medical doctor who shuttled between top-level posts in Japan, Taiwan, and the Mantetsu. Kantō directive 5, 1907 made Mantetsu responsible for health and sanitation, forestry and education. Manshikai, *Manshū kaihatsu 40 nenshi*; *Dairen Seiai iin sanjū shūnen shi*, 6–9.

settlement south of Haerbin, 4,000 people died in the course of two months. The eventual death toll may have reached 60,000.

Qing officials were clearly out of their depth. Having no technical understanding of epidemic disease, Xiliang appointed Christie honorary medical advisor to the government, and gave him wide berth to deal with the problem. But there was little that Christie could do. A massive quarantine was ineffective, not merely because the early stages of the disease presented no symptoms, but the Chinese government was unable to exercise authority over Japanese- and Russian-owned railways. Even the Chinese-run Mukden-Beijing line did not stop third-class carriage until January 14; well after the disease had established itself in both cities.[21]

In contrast, Russian and Japanese railway authorities took decisive action. The sprawling Russian empire had extensive experience with epidemic disease, and tsarist health authorities had effective quarantine and hygienic protocols to be followed during periods of actual outbreak. On their own authority, Russian railway directors in Haerbin sent teams of Cossack guards to enforce quarantine in the adjacent Chinese city of Fujiadian. The Cossacks took a particularly aggressive approach to their task, marking dwellings with suspected cases of plague and sealing both infected and healthy inhabitants inside.[22] Japanese authorities in Kantō had more time to formulate a response. As it became clear that the disease was spreading from north to south along the railway, Kantō authorities simply sealed off the southern terminus, and effected a strict quarantine of migrants, thus sparing the territory the worst of the outbreak.[23]

Once they came to realize the scale and potential political consequences of the crisis, Chinese officials reacted to demonstrate their competent stewardship of public health. Xiliang convened an international conference, the first of its kind in China, to discuss the origins, spread, and treatment of the outbreak. This highly choreographed event opened with much press and fanfare in Shenyang in April 1911, and invited the participation of such luminaries as the American Richard Strong (1872–1948), who was brought in from the Philippines to overshadow the influence of Russian and Japanese scientists. Presiding was a

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[21] Lian-teh Wu, "A Short History of the Manchurian Plague Prevention Service," 1; Christie, *Thirty Years in Moukden*, 225–38.

[22] Russian scientists also operated a network of laboratory outposts in the eastern empire. Investment in CER medical capacity was consistent with a disproportionate level of spending in Russian Central Asia. Alexander Melikishvili, "Genesis of the Anti-Plague System: The Tsarist Period," 19–31. R.K.I. Quested, *"Matey" Imperialists? : The Tsarist Russians in Manchuria, 1895–1917*, 105.

[23] A great deal of important work has been written on the 1911 plague, and China's response to it. See especially Mark Gamsa, "The Epidemic of Pneumonic Plague in Manchuria, 1910–1911"; Carl F Nathan, *Plague Prevention and Politics in Manchuria, 1910–1931*; Cheng Hu, "Quarantine Sovereignty, 1910–1911."

thirty-two-year-old Penang Chinese physician named Wu Liande (1879–1960). Anglophone and Cambridge-trained, Wu was also well connected to the dynasty, and had assisted in the founding of the Imperial Medical College in Tianjin. Despite his youth, Wu was given the place of prominence at the conference and the resulting publication, and was placed in charge of a new organization: the Manchurian Plague Prevention Service (MPPS).[24]

Even if the narrowly averted disaster of the plague finally convinced the Qing of the strategic importance of medical reform, the demise of the regime just a few months later removed the one actor that would have been capable of actually building an integrated public health infrastructure. As China devolved into internal strife, military power in the Northeast remained firmly in the hands of the so-called Fengtian clique, headed by militarist Zhang Zuolin (1875–1928). The region would not formally submit to central administration until 1928, after Zhang had been assassinated and replaced by his son Zhang Xueliang (1901–2001), and a new national government had been established in Nanjing. In between, the Northeast was effectively independent, but also deeply divided. In addition to seeking to expand his military power to the south, Zhang Zuolin often found his own interests to be at odds with those of the Fengtian (Liaoning) government, which particularly as regards legislative and commercial reforms.[25] In addition, the two railway powers retained military and civil authority over their respective lines and wielded significant influence over and through their expatriate populations.[26]

In the absence of an overarching health policy, Wu Liande and his MPPS became the face of modern medicine in northern Manchuria. Still centered in Haerbin, Wu used his extensive network of foreign contacts to propel the MPPS into a premier center of epidemic research and prevention, publishing in excess of a hundred academic papers, primarily but not exclusively on the topic of infectious disease. Despite the ongoing political disunity, Wu also became integral to the creation of national public health associations elsewhere in China,

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[24] Nathan, *Plague Prevention and Politics in Manchuria*, 38; Wu, "A Short History of the Manchurian Plague Prevention Service." The exclusion of Russian scientists continued into the life of the MPPS. R.K.I. Quested, *"Matey" Imperialists? : The Tsarist Russians in Manchuria, 1895–1917*, 200.

[25] For examples of development under the Fengtian regime, see Ronald Stanley Suleski, *Civil Government in Warlord China: Tradition, Modernization and Manchuria*; Elizabeth R VanderVen, *A School in Every Village: Educational Reform in a Northeast China County, 1904–31*; Qin Zhang, "Civil Justice in Early Twentieth-Century Northeast China: Fengtian Province, 1900–1928"; Sun Hongjin, "Jindai Shenyang chengshi fazhan yu shehui bianqian (1898–1945); and Yu Jiang, "State Building, Capitalism, and Development: State-Run Industrial Enterprises in Fengtian, 1920–1931."

[26] On Japanese exercise of informal power through liberal interpretation of consular authority, see Erik Esselstrom, *Crossing Empire's Edge: Foreign Ministry Policy and Japanese Expansionism in Northeast Asia*.

traveling frequently to medical conferences throughout Asia, becoming a key feature of a tightly networked international research community.[27]

But the brief to control epidemic also left MPPS as something of a niche player, since the focus on epidemic control restricted their range of activities. Wu enjoyed the sympathy of government officials, but the MPPS itself had no formal political status. As a result, the MPPS was left in an institutionally tenuous position. For most of its history, the MPPS was funded by an annual grant from the Manchurian Customs Office, and was reliant on the goodwill of individuals such as Zhao Erxun, who was reinstated as Governor General from 1911 to 1916. Before 1911, Wu had advocated a broad vision of medical reform, lobbying court officials to build hospitals, "where not only could students be efficiently trained, but soldiers could be properly cared for, and the graduate medical officers continue their practice, so as to be ready for all emergencies." Wu continued to advocate a broad public health mission in his capacity as the head of the MPPS, but the brief of his office forced him to focus disproportionately on the threat of plague. Through the MPPS, Wu was finally able to build his hospitals, but these were first and foremost plague research and quarantine facilities. The MPPS built six such hospitals, all at strategic points for the communication of disease: a central facility at the railway junction of Haerbin, along with smaller ones at strategic locations, such as the port city of Niuzhuang and the border crossings at Yilan, Lahasusu (Dongjing), Manzhouli, and Taiheihe. In short, the primary institutional identity of the MPPS remained that of an emergency response service, the quick containment of further outbreaks of disease during the 1910s and 1920s a quiet testament to its success.[28]

The MPPS was conspicuously absent from the city of Shenyang, which was not only the largest city in the Northeast, but also the center of an increasingly confident civilian elite, and later the military base of Zhang Zuolin. Fengtian municipal and provincial authorities had laid the foundation for health reforms early on, carrying out sanitary campaigns in the city as early as 1915. These efforts intensified after Zhang's rise to power, but were more precisely the work of reform-minded political figures such as Fengtian governor Wang Yongjiang (1872–1927). In 1923, Wang and Ruan Zhenduo (1893–1973), a Japanese-trained medical doctor who would later go on to hold prominent positions under the Manzhouguo[29] government, proposed the construction of a public hospital in

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[27] Lian-teh Wu, "How I Built Hospitals in China"; Nathan, *Plague Prevention and Politics in Manchuria*, 44. For Wu's activities on the national stage, see Liping Bu, "Social Darwinism, Public Health and Modernization in China, 1895–1925."

[28] Wu, "How I Built Hospitals in China."

[29] The name Manzhouguo translates literally as the "nation of Manchuria." Technically this name was only valid until 1934, when the state (in emulation of Japan) proclaimed itself the "Great Empire of Manchuria" (da Manzhou diguo). Chinese scholarship generally refers to it as the "false nation of Manchuria" (wei Manzhouguo).

Shenyang, and solicited 180,000 yuan for its construction. Zhang himself had relatively little to do with the Haerbin-based MPPS, and approached medical reform primarily for the health of his own military. In the aftermath of his wars with Wu Peifu, Zhang founded what would become the single largest medical facility in Manchuria, the 400-bed Northeastern Military Hospital (*Dongbei lujun yiyuan*), also in Shenyang. Completed in 1924, the Northeastern Military Hospital rivaled the MPPS Haerbin facility in patient capacity, but at 600,000 yuan, cost significantly more than all of Wu Liande's ventures combined. Like the MPPS plague hospitals, this facility did devote excess capacity to routine healthcare (see Table 1), but its primary purpose was strategic.[30]

**Table 1** Hospital Construction in Beijing and Northeast China

| | Year of construction | Cost (yuan) | Size |
|---|---|---|---|
| Haerbin (MPPS) | 1911 (expanded 1919, 1922, 1924) | Construction 70,000, expansions at 18,000, 30,000, 25,000 | 470 beds |
| Qiqihaer | 1911 | 30,000 silver taels | 60 beds |
| Manzhouli (MPPS) | 1912 (rebuilt 1923) | 40,000 taels, reconstruction 9,000 | 30 beds |
| Lahasusu (MPPS) | | 20,000 taels | 42 beds |
| Ilan (MPPS) | 1913 | 10,000 | 60 beds |
| Taiheihe (MPPS) | 1914 | 28,000 | 70 beds |
| Peking Central | 1918 | Approx. 300,000 | 150 beds |
| Niuzhuang (MPPS) | 1920 | 40,000 taels, quarantine block 30,000 | 45 beds, 400 quarantine |
| Fengtian Public Hospital | 1923 | 180,000 | 30 rooms |
| Northeastern Military | 1924 | 600,000<br>74,223 annual operating expenses | 400 beds |

Source: Wu "How I built Hospitals," 400–406. As of 1910, one silver tael was roughly 1.39 yuan. Sun Hongjin, "Jindai Shenyang," 154–55.

Missionary medicine continued to expand in Chinese Manchuria, but declined in relative importance. Christie remained the center of a medical mission that

[30] Ibid.; Sun, "Jindai Shenyang chengshi fazhan yu shehui bianqian," 107–10, 151–60; On the relationship between Wang Yongjiang and Zhang Zuolin, see Gavan McCormack, *Chang Tso-lin in Northeast China, 1911–1928: China, Japan, and the Manchurian Idea*, and Suleski, *Civil Government in Warlord China*.

provided care to the poor, while keeping an eye to building a medical infrastructure in the longer term. In 1912, Christie founded the Mukden Medical College, which grew from a staff of eight professors in 1914 to employ twenty-nine foreign and Chinese staff fifteen years later. This impressive growth was still far from adequate. In 1915, just as the Rockefeller Foundation was making plans to fund a major medical center in Beijing, William Welch (1850–1934), dean of the Johns Hopkins Medical School, bluntly assessed the real impact of the college, saying that the "future of medical education in China does not lie with the inferior type of medical school to which these devoted men are now giving so much of their time and energy."[31] By 1929, the college was still only able to admit one class every two years, and was no closer to becoming the "purely Chinese work" that Christie had optimistically suggested in 1907. Although Christie personally admired Wu Liande, praising his "able and energetic direction" of the MPPS, it seems that neither side ever proposed any form of institutional cooperation. Moreover, although the MMC enjoyed the goodwill of Chinese officials, and did receive occasional financial assistance (such as the 6,000 silver dollars it received from the Fengtian Provincial government in 1920), it still relied overwhelmingly on foreign donations for its financial existence.[32]

Medical charity in Manchuria was further shaped by the rapid expansion of the charitable sector across China. Urged on by the success of Christian missions, traditional Chinese charities began developing larger and more permanent institutions. One group called the Fengtian Tongshan (Mutual Benevolence) Society had originated as a traditional *shantang* in 1881, when two local officials began organizing free vaccinations for the poor. Within a few years, the Tongshan Society had grown into a network of workhouses and small clinics, and in 1925 they established their first hospital by taking over operations of the Chinese Red Cross Hospital in Fengtian.[33] At the same time, the new Chinese religions of the twentieth century founded their own charities as an expression of moral service, and in order to raise their public profile. The largest of these new charities was the World Red Swastika Society (WRSS), which was created by a spirit writing group called Daoyuan after a 1921 flood

[31] David S. Crawford, "Mukden Medical College (1911–1949): An Outpost of Edinburgh Medicine in Northeast China, Part 1: 1882–1917: Building the Foundations and Opening the College," 73–79; "Mukden Medical College (1911–1949): An Outpost of Edinburgh Medicine in Northeast China, Part 2: 1918–1949: Expansion, Occupation, Liberation and Merger," 179–84.

[32] Christie, *Thirty Years in Moukden*, 256–57; Crawford, "Mukden Medical College (1911–1949)."

[33] *Fengtian Tongshantang yaolan*; Jing Jie, "Jindai Fengtian Tongshantang jiuji shiye shulüe (1881–1931)"; *Manshū Shakai Jigyō Nenpo, Shōwa 9 Nendo*, 45–46.

of the Yellow River sent thousands of refugees to seek shelter in the nearby city of Ji'nan. Within a few years of its founding, the WRSS had expanded far beyond its original base, establishing branches across the country, and organizing famine and refugee relief on an industrial scale. During the late 1920s, the WRSS became particularly active in Manchuria, where they operated hospitals and soup kitchens, as well as conducting emergency disaster relief.[34]

The expansion of private charities prompted the introduction of legal measures aimed at bringing the sector under control, and integrating it into a state framework. Between 1928 and 1933, the newly formed Nanjing government introduced a spate of regulatory legislation that provided financial oversight, and reorganized existing groups according to a standard model. The centerpiece of this legislative effort was the 1929 Charitable Organization Supervision Regulation (*Jiandu cishan tuanti guize*), which forbade charitable organizations from engaging in religious mission, and precluded a wide net of undesirables—bankrupts, opium smokers, corrupt officials and political reactionaries—from holding positions of leadership. To ensure compliance, all charitable organizations would be required to register with the government. At the same time, the government expanded the scope of state welfare. In 1928, Nanjing published its "Outline of National Foundation" (*Jianguo dagang*), which stipulated that "care for children and the elderly, support for the poor, disaster relief, medicine, and other charitable activities should all fall under the management of local government." Private charities were to form a united front with these official efforts. In spite of the common view of the Nanjing government as axiomatically hostile to civil society, the intention of this legislation was not so much to destroy private charities, but to consolidate the provision of vital social services under government control.[35] Nor was it unique to Nanjing: other local governments had already made attempts to take direct control of private charities that in some cases even predated these measures.[36]

Although Fengtian made similar efforts to integrate medical charities into a single state sector, these arrived too late to bear fruit. Christie's Manchuria Medical College had been instructed to register with the Liaoning provincial

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[34] Thomas David DuBois, "The Salvation of Religion? Public Charity and the New Religions of the Early Republic."

[35] Zeng Guilin, "Minguo shiqi cishan lifa zhong de minjian canyu—yi Shanghao cishan tuanti lianhehui wei zhongxin kaocha."

[36] In June of 1928, the northern Anhui prefecture of Ningfu promulgated an ambitious proposal to fund and operate a system of charitable institutions, including orphanages and work homes, as well as hospitals and clinics for the poor. "Ning fu gongbu jiuji yuan tiaoli" (Ning Prefecture promulgates relief institution laws), *Shengjing shibao*, June 11, 1928.

government in 1926, two years before such legislation was enacted by Nanjing.[37] Three years later, Zhang Xueliang proposed absorbing the Manchurian Medical College into the newly founded Northeast University in Shenyang, in part to consolidate the provision of medical education, but also to counter the overwhelming influence of Japanese universities on the Manchurian professional elite. Although MMC leaders were sympathetic to the proposal, this plan (like much of Zhang Xueliang's long-term thinking) was derailed by the Japanese seizure of Manchuria in 1931.[38]

By any measure, these two decades of Chinese medical reform in the Northeast had produced very significant achievements. Manchuria in 1930 possessed a foundational infrastructure of hospitals, medical schools and sanitary facilities. Despite the continued existence of plague, cholera, and typhus, Manchuria never experienced another epidemic disaster on the scale of 1910–11. At the same time, the effort fell short of what it could have been. Despite good intentions, medicine in Manchuria remained fragmented by personal and institutional loyalties. The strategic vision for the sector as a whole, one that integrated the informal sector into a government-coordinated plan to provide medical services to a wide population, came too late to be of any use.

## Public and Private in Japanese Healthcare

In contrast, Japanese Kantō and SMR territories skillfully integrated a plurality of medical interests and strategies into a single program.[39] Relying on the Mantetsu railway, the Kantō administration, and a select body of medical charities, the Japanese administration was able to create and implement a central blueprint for the entire health sector. Private efforts, at least those of a certain sort, were from the outset given a specific place within this structure.

Consistent with the original 1907 framework, responsibility for healthcare in Japanese areas continued to rest primarily on the railway. In 1914, the Mantetsu formed its own Department of Sanitation, which was tasked with supplying buildings, machines and equipment for the provision of public health both inside

[37] Austin Fulton, *Through Earthquake, Wind and Fire: Church and Mission in Manchuria 1867–1950; the Work of the United Presbyterian Church, the United Free Church of Scotland, the Church of Scotland and the Presbyterian Church in Ireland with the Chinese Church in Manchuria*, 267.

[38] D S Crawford, "Mukden Medical College (1911–1949): An Outpost of Edinburgh Medicine in Northeast China, Part 2," 180; Wang Zhenqian, et al., *Dongbei daxue shigao*, 2–12; Jing Jie, "Jindai Fengtian Tongshantang jiuji shiye shulüe."

[39] Japanese medical research and education was nevertheless highly factionalized. Shiyung Liu, "The Ripples of Rivalry: The Spread of Modern Medicine from Japan to Its Colonies."

Kantō, and as needed along the railway itself. Even after the newly formed Kantō governments of Dairen and Ryojun (Lüshun) were given authority over public services within their own municipal areas the following year, the railway retained leadership over its existing network, and continued to expand its infrastructure of hospitals and clinics both by building new institutions, and by consolidating existing ones. Completed in 1908, the seven-story Dairen Hospital was the crown of the entire system, and over time expanded to include a network of branch institutions. Between 1911 and 1932, the Mantetsu built four new hospitals, received ownership of a fifth, and oversaw the expansion and reclassification of numerous clinics as hospitals.[40]

The railway also coordinated anti-epidemic measures and research. Like their Chinese counterparts, Mantetsu doctors remained vigilant against plague, establishing their own quarantine facilities in major ports and railway cities: Yingkou, Andong (1922), Fengtian, Sipingjie (1927), Dashiqiao (1932) and Changchun (1932, renamed as Xinjing/Shinkyō). (See Fig. 2) They also imported regulation regimes from Japan. Cholera had been a consistent problem in both Japan and Korea, and preventing spread of the disease was a high priority for the Japanese urban engineers who planned and expanded the city of Dairen.[41] The degree of central coordination is evident in the decisive shift of the Japanese medical system to focus on eradicating tuberculosis. Tuberculosis had long been common in Manchuria, but because the disease was not often fatal, neither Chinese nor Japanese health systems paid much attention to it until 1925, when the newly appointed head of the Mantetsu Health Bureau Kanai Shōji (1886–1967) announced that eradicating tuberculosis was to be a top priority. Kanai instituted a focused eradication campaign that required all cities with a population over 50,000 to enact prevention measures, and included the blueprint for a network of tuberculosis sanitoria.[42] Within Manchuria, it would appear that these anti-tuberculosis measures were entirely unique to areas under Japanese control.

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[40] Robert J. Perrins, "Doctors, Disease and Development: Engineering Colonial Public Health in Southern Manchuria, 1905–1931"; Manshikai, *Manshū kaihatsu 40 nenshi*, 498.

[41] Manshikai, *Manshū kaihatsu 40 nenshi*, 498; Japan had faced cholera during the 1890s, and developed the urban planning codes that were used in new cities such as Dalian, and retroactively in older cities such as Yingkou, which faced 50,000 cases in 1919. Robert J. Perrins, "Doctors, Disease and Development: Engineering Colonial Public Health in Southern Manchuria." On cholera prevention in Korea, see "Kaku senmonka no korerabyō yobōdan" (Expert opinions on cholera prevention), *Chōsen shinbun*, October 1, 1909. For a more complete picture of Japanese anti-plague measures in Manchuria, see Mantetsu chihōbu eiseika, *Shōwa hachi nen pesuto bōeki gaikyō*, 16–47.

[42] Japanese attention to tuberculosis derived from the explosion of the disease among young girls working in the textile factories of cities such as Osaka. Manshikai, *Manshū kaihatsu 40 nenshi*, 151–53.

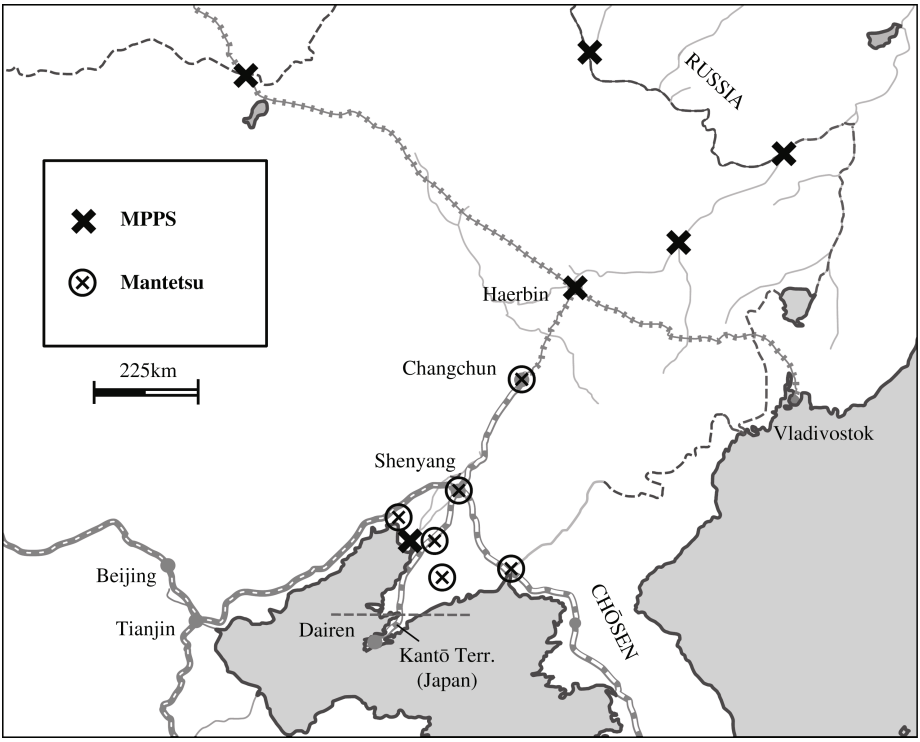


**Fig. 2** Distribution of MPPS (1931) and Mantetsu (1932) Plague Facilities
Source: Manshikai, *Manshū kaihatsu 40 nenshi*, 498; Wu "How I built Hospitals," 400–406. Map by author.

The Japanese healthcare system clearly prioritized certain elements of society. Throughout the entire Mantetsu-administered region, Japanese hospital admissions outnumbered Chinese by a factor of 4.3 in 1914, and 2.2 in 1929.[43] But race was not always a deciding factor. Even in the Christian Seiai Hospital, priority was given to those who could pay (see Table 2). A small but significant number of self-paying Chinese patients patronized the Seiai, no doubt in order to enjoy what they expected to be a superior level of hospital care. Access to subsidized health care across the territory was more strictly hierarchical. Japanese workers in strategic industries took priority, and Mantetsu workers and their families were particularly well cared for. The treatment of Chinese workers varied as a function of supply and demand. Despite the constant flow of Chinese migrants into Manchuria, Japanese industries frequently faced worker shortfalls. Labor was particularly scarce in major industrial centers such as major iron

[43] Minami Manshū Tetsudō Kabushiki Gaisha, *Minami Manshū Tetsudō Fuzokuchi Eisei Gaikyō, Shōwa 3 Nen*, 325.

mining and colliery center at Fushun. Not surprisingly, Fushun hospitals were the only ones in Manchuria in which Chinese patients were in the majority, the most common treatments being for the sort of external injuries (i.e., broken bones, lacerations) that workers would incur in an unsafe industrial environment. [44]

**Table 2** Seiai Hospital Admissions 1910–1930

| | Japanese self-paid | Japanese charitable | Foreign self-paid | Foreign charitable | Total |
|---|---|---|---|---|---|
| 1910 | 5,032 | 4,364 | 56 | 412 | 9,864 |
| 1915 | 8,820 | 3,356 | 92 | 460 | 12,728 |
| 1920 | 16,880 | 3,696 | 172 | 624 | 21,372 |
| 1925 | 19,674 | 6,196 | 882 | 288 | 27,040 |
| 1930 | 33,983 | 6,824 | 1,527 | 251 | 42,585 |

Source: *Dairen Seiai iin sanjū shūnenshi*, 91–93.

Japanese planners in Manchuria were keenly aware of the public relations value of medicine. The Mantetsu were especially eager to display their medical achievements to the outside world: they brought foreign scientists to tour state-of-the-art medical facilities, and produced all variety of promotional materials, ranging from scholarly journals to postcards of the Dalian Hospital itself. Japan directed its medical charm offensive at many different audiences: the international scientific and diplomatic communities, and prospective migrants from Japan. Japan was especially anxious to counter the influence of foreign medical missionaries among the Chinese. Public health, particularly that in a relief capacity, was intended to counter the pernicious missionary influence by blunting its most effective recruitment tool.[45]

Medical charities played a vital role in this softer edge of Japan's larger health strategy. Although many Mantetsu hospitals did provide some subsidized care, medical charity was often repackaged as a separate venture. In 1929, the Mantetsu Dairen Hospital established its own Tongshou Hospital, which specialized in subsidized medical care for Chinese patients, in the name of "Chinese-Japanese friendship and mutual benefit." The Christian Seiai Hospital

[44] Minami Manshu Tetsudō Kabushiki Gaisha chihōbo eiseika, ed., *Mantetsu Iin Iran*, 238–39. Hospital statistics derive from annually published social welfare surveys (*shakai jigyō chōsa*) available in *Shokuminchi shakai jigyō kankei shiryō shū*, *Manshū, Manshūkoku hen* (Collected historical materials on colonial social services, Manchuria and Manzhouguo).

[45] Popular press articles such as "O-Bei senkyoshi to hai Nichi ha" (European and American missionaries and the anti-Japan element) made this point explicitly. "*Chōsen shinbun*," March 1, 1909. See also note 17.

often provided free or cheap care to Japanese and Chinese poor, but was equally valuable as a public relations tool to express the humanity of Japanese administration. Charitable hospitals operated with a clear state mandate. The Seiai Hospital successfully registered as a juridical person (*hō jin*) in 1916, and continued to enjoy an annual subsidy. It continued to expand its operations. In 1919, Seiai founded a branch mental hospital in the suburb of Fujiantai, and in 1923 founded the Hongci (Great Kindness) hospital in Fushun to give free care to Chinese patients.[46]

The most notable and successful combination of public medicine and charitable public relations was the Manchuria Branch of the Red Cross of Japan (RCJ). In 1928, the RCJ maintained 15 branch offices in Manchuria, along with hospitals in Dairen and Fengtian, and 13 free or subsidized clinics. By 1933, their medical staff included 544 doctors, 160 dentists, 584 medical assistants, and 1,107 nurses. More than the Mantetsu, it was the Japanese Red Cross that filled the particular niche of providing basic medical care to a mass clientele. Not only did the RCJ participate in medical initiatives such as the campaign to eradicate tuberculosis, they also dispatched traveling medical teams to Kantō, Tieling and Andong: by 1928, these teams had provided free treatment to 1.167 million people.[47]

Chinese charities operated inside the Japanese-administered areas, under conditions ranging from overt support to benign neglect. As its name suggests, the World Red Swastika Society saw itself as being above national loyalties, and moved freely between Chinese and Japanese-administered areas. Yet towards the late 1920s, the network of branches in Manchuria began to express particularly strong ties to Japan, especially after the Daoyuan merged with a new Japanese religion called Ōmotokyō.[48] Similarly, the Fengtian Tongshan Society opened a free hospital within the Japanese railway zone of Shenyang in 1930, suggesting that they maintained good relations with both Japanese and Chinese authorities.[49] The Hongji Benevolent Society (*Hongji shantang*), yet another charity that originated in late Qing Manchuria, operated a string of soup kitchens and shelters

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[46] *Dairen Iin Gaiyō*, 99–101; Manshikai, *Manshū kaihatsu 40 nenshi*, 143, 168. The granting of juridical personhood conferred recognition of an institution's legal existence, but was also used as a gateway against organizations that the state found undesirable. See also note 51. On the development of law in Japan's continental possessions, see Thomas David DuBois, "Inauthentic Sovereignty: Law and Legal Institutions in Manchukuo."

[47] Manshikai, *Manshū kaihatsu 40 nenshi*, 167–68.

[48] Although Ōmotokyo itself was eventually outlawed by the Japanese government, its adherents included many of the most vocal advocates of Japanese expansion on the continent. Thomas David DuBois, "The Salvation of Religion? Public Charity and the New Religions of the Early Republic."

[49] Jing Jie, "Jindai Fengtian Tongshantang jiuji shiye shulüe (1881–1931)"; *Manshūkoku shakai jigyō gaiyō*, 45–46.

both inside and outside of Kantō, but specialized in medicine. The Hongji Benevolent Society registered with Japanese authorities as a legal person in 1928, and set up a hospital that same year.[50]

The Japanese medical system not only engaged the charitable sector, it in many ways engineered it. Working with the experience of establishing medical systems at home, as well as in Korea and Chinese Taiwan, Japanese authorities in Manchuria began with a clean slate and a clear blueprint. In contrast to Chinese areas, where charities arose in response to a lack of government action, the Japanese system engineered a role for private and semi-private actors. As they had a generation earlier in Japan, public organizations helped mobilized society for campaigns against epidemic disease. Like it did in colonial Korea, the Red Cross of Japan selectively mobilized a stratum of elites in Manchuria, while extending Japanese soft power through its image of modern medical humanitarianism. Although other charities, including Chinese ones, were ancillary to this effort, they were tolerated and even supported to the degree that they supported Japan's core goals.

## Manzhouguo and the Emergence of Nationalist Charity

Political changes after 1932 prompted a profound transformation of Japanese health strategies in Manchuria. Late in 1931, the Kantō Army easily expelled the Zhang Xueliang regime. The formation of the nominally independent state of Manzhouguo early the next year formalized Japanese control over the region, and opened the door for greater and more systematic investment, including an even more ambitious blueprint for public health. At the same time, aggression in Manchuria had irreparably alienated Japan from the international community. The 1933 Lytton Commission formally rejected the validity of the created state, prompting Japan to withdraw from the League of Nations, and to adopt an increasingly defensive and militaristic posture. As war with China in 1937, and the Allies in 1941, channeled the empire's resources and institutions to military needs, Manzhouguo consolidated health provision by absorbing the informal sector. This erased even the notional divide between public and private, and produced a hybrid sector of charitable institutions that were not just politically loyal, but actually operated as a branch of the government.

With the formation of Manzhouguo, Japanese officials prepared to expand the Kantō model of medical reform to the entire country. Most of the immediate changes, such as the 1933 law requiring practitioners to seek government certification, followed a pattern established in Japan's own early Meiji reforms.

[50] *Manshū Shakai Jigyō Yōran*, 212–16; *Manshū Shakai Jigyō Nenpo, Shōwa 9 Nendo*, 158–62.

Longer term reforms would build upon existing institutions, particularly the Mantetsu, which expanded its Medical College into a network of medical, pharmacy, and dental colleges, and founded a string of tuberculosis sanitoria, with a total of 724 beds. The most ambitious plan was set forward in 1934 by the newly established Manzhouguo Department of Welfare (*Minsheng bu*). This plan aimed to systemically expand the health infrastructure to underserved areas, beginning with the creation of a string of National Hospitals that would serve as the core of a public health infrastructure. As part of this larger vision, the Mantetsu opened ten new regional hospitals in 1934, and five more the subsequent year.[51]

The outbreak of war added urgency to health reforms, even as priorities shifted. A growing need for manpower accelerated the pace of medical transformation across the Japanese empire. As Japan embarked on a major push to ensure the health of its own civilian population, the Manzhouguo Department of Welfare followed suit, putting in motion an ambitious plan to build a network of 130 clinics, as well as a hospital in each city, county, and banner. Epidemic prevention took a similarly long view, such as the ten-year program to eradicate plague by 1953.[52]

As the empire shifted to a wartime footing, Manzhouguo aggressively pruned and consolidated the existing charitable sector. Foreign mission charities such as Christie's Mukden Medical College were gradually pressured to accept direct Japanese control. Sensing the growing hostility of Manzhouguo authorities, the college had already taken on a Japanese Christian as principal. But even this measure proved to be insufficient, following 1938 directive demanding that all private organizations register as juridical persons. Although the Manzhouguo registration requirement nominally resembled Chinese charity legislation of the 1920s, the inspiration of this particular regulation was the Religious Organizations Law (*shukyō dantai hō*) that was simultaneously being put in place in Japan.[53] Like the Chinese charity laws, the Japanese Religious Organizations Law worked by denying registration to suspect organizations, most notably those associated with Christian missions. The religions law was also sufficiently flexible as to police the ideology of leaders, allowing police or the military to replace troublesome individuals, or to take over an organization from within by replacing the entire

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[51] Manshikai, *Manshū kaihatsu 40 nenshi*, 135–41, 151–59; Manshū teikoku minseibu, *Minsei Nenkan 1934*, 448, 584–87.

[52] Banners remained in use as county-level administrative divisions in Mongol areas. Minami Manshu Tetsudō Kabushiki Gaisha chihō bo eiseika, ed., *Mantetsu Hoken Iran*.

[53] "Shūkyō ha hōjin no mondai" (The problem of legal personhood for religious organizations), *Yomiuri shinbun*, May 8, 1938; "Shūkyō dantai no konbon teki dai kaikaku" (Fundamental change to religious organizations), *Yomiuri shinbun*, July 21, 1938, December 3, 1938.

leadership en masse. Such was the eventual fate of the MMC, which remained intact (and was even renamed after Christie), but was placed under an entirely new board.[54]

At the same time, a favored circle of charities continued to enjoy significant state support. Many of Manzhouguo's political luminaries, including the emperor Puyi (1906–67), sat on the boards of favored charities. The Manzhouguo Red Swastika Society, which formed as a breakaway national organization, counted state ministers Xiqia (1883–1950), Zhang Jinghui (1871–1959), Yu Zhishan (1882–1951) and Sun Qichang (1885–1954) among its high-ranking members. The Manzhouguo RSS thrived: establishing a headquarters in the new capital, and more than tripling its number of branches, from 30 in 1931 to 99 ten years later.[55] The Hongji Benevolent Society, which became notorious for trafficking opium in 1930s Shanghai, clearly enjoyed a favored status under Japanese rule, and a great deal of official latitude in its operations in Manzhouguo.[56] Beyond political support, favored charities enjoyed financial support from a number of prestigious sources: conspicuous donations by Manzhouguo elites or the state itself, and most notably, the *onshi* donations that came directly from the Japanese imperial house. The Fengtian Tongshan Society received small but symbolically significant *onshi* donations as expressions of imperial favor. In contrast to the labored registration process endured by the MMC, this society submitted its papers on July 1, 1937, and received its approval within three weeks.[57] Even as the Manzhouguo government turned the screws on Anglo-American missionaries, the Japanese Christian Seiai Hospital received an annual *onshi* donation of 500 *yuan*, the largest sum given to any private charity.[58]

Manzhouguo did not merely shepherd its charitable sector, it pioneered a new type of national charity that would operate as a branch of government. The model for this new type of national charity was a group called the Spreading Welfare Society (*Puji hui*), which was established by order of the Ministry of Civil Affairs (*Minzheng bu*) on March 1, 1934, the date that the state of Manzhouguo formally named itself an empire. Unlike groups like the Manzhouguo Red Swastika Society, which already enjoyed high-level political support, the Spreading Welfare Society was directly tied to the newly crowned Emperor of

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[54] Crawford, "Mukden Medical College (1911–1949)"; Fulton, *Through Earthquake, Wind and Fire*, 275–81.

[55] DuBois, "The Salvation of Religion? Public Charity and the New Religions of the Early Republic," 105–6.

[56] Frederic E Wakeman, *The Shanghai Badlands: Wartime Terrorism and Urban Crime, 1937–1941*, 14; "Huazhong Hongjishantang sheli gangyao ji pandu shiliaoxuan.

[57] *Fengtian Tongshantang yaolan*, 65–66.

[58] *Manshū Shakai Jigyō Nenpo, Shōwa 9 Nendo*, 166; In contrast, the hospital's 1937 operating budget was well in excess of 200,000 *yuan*. *Dairen Ni Okeru Shakai Jigyō Dekiyō* (Overview of Dairen social services), Dairen, 1938.

Manchuria, who (in emulation of *onshi* from the Japanese emperor) seeded the society with a personal donation of one million *yuan*. Although the society worked with other semi-official organizations (such as the Concordia Society, *xiehe hui*) to promote Manzhouguo social initiatives, its primary activity was medical welfare. In conjunction with the Health Agency of the Department of Welfare, the society ran a home for old soldiers, and operated medical teams that visited temple festivals to provide free medical care to remote areas.[59]

In 1939, the Spreading Welfare Society formally merged with local branches of the Red Cross of Japan to form the Red Cross of Manzhouguo. The Spreading Welfare Society's own records portray this merger primarily as an internal fiscal decision—income from interest on the million *yuan* seed funding was far too low to fulfill their mission of providing medical services to the entire country.[60] But there were clearly other issues at work. Globally, the Red Cross had expanded rapidly in the period between the wars. Between 1919 and 1940, Geneva accepted no fewer than 37 new national organizations, many of which came from newly independent states in Europe and Latin America.[61] Like membership in the League of Nations, establishing a branch of the Red Cross was a mark of a country's standing in the emerging state system. The idea to form a Manzhouguo Red Cross received broad support from within the government, the Mantetsu and the Kantō Army. One of the key figures in the actual merger was Department of Welfare minister Sun Qichang, who was also active not only in the Spreading Welfare Society, but also in the World Red Swastika Society. Sun served as a go-between both sides of the merger: in 1937, he traveled to Tokyo to discuss the idea with the RCJ, and later headed the merger committee of the Spreading Welfare Society. The merger was formally carried out in January of 1939, by directive of the Kantō administration.[62]

The Red Cross of Manzhouguo technically remained a volunteer organization, albeit one that operated within the context of full national mobilization. In a moving memoir of her youth in Japanese Manchuria, Kazuko Kuramoto recalled her experience as a volunteer with the Red Cross in 1944. She describes a training regimen that was highly militarized and intensely nationalistic, both of which were largely in keeping with Manzhouguo as a whole at this late stage of the war. Not surprisingly, the Manzhouguo Red Cross was fully integrated with the state's health service and medical priorities. It spent its short but active existence entirely on a wartime footing, running military care centers, organizing civilian blood drives, and caring for refugees.[63] It disbanded with the demise of

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[59] *Onshi Zaidan Fushikaishi*, 1–4, 40–43, 61–70.

[60] Relying on interest and investments, the society calculated that a fund of ten million would be necessary. *Onshi Zaidan Fushikaishi*, 64.

[61] Nihon Sekijūjisha, *Nihon sekijūjisha shashikō*, *5. Shōwa 11 nen –20 nen*, 74–81, 91–93.

[62] *Onshi Zaidan Fushikaishi*, 22–24; *Minsei Nenkan 1934*, 450–51.

[63] Kazuko Kuramoto, *Manchurian Legacy: Memoirs of a Japanese Colonist*.

the state in 1945.

Although short-lived, the Manzhouguo Red Cross was the logical endpoint of a long evolutionary process of grooming a charitable sphere, and bringing the informal medical sector under ever greater and more overt state control. With the combination of unprecedented ambition in state planning and the exigencies of war, Manzhouguo had needed to vastly expand its provision of medical services, to bring modern medicine to the populace and to fully tap the manpower potential of its population. Like earlier charities, the Spreading Welfare Society and Manzhouguo Red Cross were intended to work with the government to fill a very particular role in a highly centralized medical strategy. But more than merely being compliant clients, the new generation of medical charities were now effectively branches of the state structure.

## Conclusions

Constant political, military, and economic competition throughout the first half of the twentieth century made the Northeast a proving ground for new and ambitious ideas and policies. When healthcare somewhat abruptly emerged as an issue of high political, economic, and humanitarian concern, a variety of state and non-state actors stepped in to fill what each one perceived to be the greatest need. Although the Qing was belatedly energized by its near brush with epidemic disaster, one that actually threatened China's increasingly shaky sovereignty over the region, the division of political institutions and loyalties after 1911 thwarted a coordinated response.[64] The private health sector that emerged to fill the vacuum could only play a small and piecemeal role. Missionary and charitable efforts responded quickly and effectively to moments of humanitarian disaster, but they did not have the financial, human, or political resources to build lasting institutions on the scale that would have been needed. However, the strategic importance of state control over health seems to have been taken to heart. Soon after taking power in the late 1920s, the new government in Nanjing began to enact legislation that brought private and charitable and health provision under political control, aiming not to destroy the sector, but to co-opt it into a coordinated, government-led health policy. Absent Japanese military action, these winds would no doubt have reached the Northeast, as well.

Japanese medicine and medical charities followed a rather different dynamic. Japanese holdings in Kantō and the SMR were smaller and more manageable: the image of empty street grids in what would become the planned cities of Dairen or Shinkyō visually reflects Japan's vision of building from the ground up. Every

[64] The political significance of epidemic disease is discussed in Cheng Hu, "Quarantine Sovereignty, 1910–1911."

aspect of this venture was planned and managed: the administration, economy, and society were all carefully engineered and curated. Medicine was a practical necessity, both as a matter of public order, and to ensure a constant supply of healthy workers, and Japanese migrants. It also served social purposes. Medicine was a reflection of what Japan wanted to imagine its colonial venture to be: modern and scientific, but also humanitarian and communitarian. Early ventures like the Dairen Hospital aimed to impress foreign observers, but especially after 1931, the audience for this social vision was increasingly directed inward to the Japanese public, and the newly engineered society of Manzhouguo. It was war that finally pushed these existing trends to their logical conclusion, completing the transformation of medical charities into state medicine on the one hand, and scripted mass organizations on the other.

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