

China Health Bibliography Update

August 2004

EASHD---China Rural Health AAA

***Contents in this update are from the following database: [PubMed](#), [EconLit](#), [Social Science Citation](#), and [Factiva](#)

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- [Economist: Where are patients? China's health care](#)

Note: Below are selected search results from PubMed using EndNotes (search terms: 2004/07/24:2004/08/31, China).

** Brajer, V. and R. W. Mead (2004). "Valuing Air Pollution Mortality in China's Cities." [Urban Studies](#) **41**(8): 1567-85.

Although China has made tremendous economic progress in recent years, air pollution continues to exact significant health and economic costs. Using pollution data from 38 Chinese cities and China-based epidemiological functions, this paper estimates some of the economic benefits of reducing urban air pollution. It calculates the averted mortality which would result from the clean-up of particulates, sulphur dioxide and nitrogen dioxide--a pollutant not included in most previous China studies. The paper expands on earlier studies by examining the impact of seasonal variations in pollution levels. Finally, the monetary valuation of pollution-related averted mortality is developed using a China-based valuation study and, for a number of cities, the valuation is compared with city-level GDP.

** Chi, G. B. and S. Y. Wang (2004). "[Pattern of road traffic injuries in China]." [Zhonghua Liu Xing Bing Xue Za Zhi](#) **25**(7): 598-601.

OBJECTIVE: To explore the pattern of road traffic injuries (RTI) in China and to furnish evidence to formulate strategy and measures to improve RTI. METHODS: Using the data from the National Statistical Office, Ministry of Communications and the Traffic Administration bureau,

factors as the time trends, features and risk factors of RTI were analysed for all provinces in China. RESULTS: Over the past 51 years, RTI have increased more than 100-fold. The fatality rate of RTI was up to 8.51 per 100 000 population in 2001, almost doubled for the past ten years. In the past decade, the deaths of RTI always held in the front fifth rank in Guangdong, Shandong and Zhejiang. Calculating mortal coefficient (MC) to evaluate the severity of RTI, Tibet, Xinjiang, Qinghai, Ningxia and Gansu stood the worst. The 26 - 45 years age-group represented the majority of all fatalities and overall casualties, and the age-group over 65-year olds having an increased trend in China. The main risk factors of RTI were road quality, motorization, volume of traffic transportation, maldriving and the behaviors of pedestrians. CONCLUSIONS: The main means to reduce RTI would include: improving road traffic environment, setting road safety rules and securing compliance, changing perception, understanding and practice traffic safety.

**** Li, W. D., Y. Zhang, et al. (2004). "Pharmacology teaching and its reform in China." *Acta Pharmacol Sin* 25(9): 1232-7.**

The general situation of pharmacology teaching in China was introduced and the educational reform in China in recent decade is summarized. The aim of the article is to provide those who are interested in teaching of pharmacology to be acquainted with the teaching of pharmacology, including the teaching of both principles and practice, in China.



Full-text:

Liang, H. and Y. Xue (2004). "Investigating public health emergency response information system initiatives in China." *Int J Med Inf* 73(9-10): 675-85.

Infectious diseases pose a great danger to public health internationally. The outbreak of SARS has exposed China's fragile public health system and its limited ability to detect and respond to emergencies in a timely and effective manner. In order to strengthen its capability of responding to future public health emergencies, China is developing a public health emergency response information system (PHERIS) to facilitate disease surveillance, detection, reporting, and response. The purpose of this study is to investigate the ongoing development of China's PHERIS. This paper analyzes the problems of China's existing public health system and describes the design and functionalities of PHERIS from both technical and managerial aspects.

**** Shi, G., M. O'Rourke, et al. (2003). "Organisational reform in healthcare in China: impacts on the social functions of public hospitals." *Aust Health Rev* 26(3): 61-72.**

Public hospital reform in China since the mid 1980s has had detrimental effects on hospitals' social functions, especially the provision of care for poor people. This study of hospitals in Northern China, using a range of economic measurements, indicated that there has been an overall decline in social functions since 1985, especially in secondary and tertiary level hospitals. Reason for this include the increasingly competitive medical market in China and, under the decentralisation reforms, the imperative for hospitals to generate revenue. We put forward policies to strengthen hospital social functions, including funding for essential packages of services to specifically benefit the poor and vulnerable, and increased government subsidies to support social functions in primary level hospitals where care can be more easily accessed.

**** Zhang, X., X. Li, et al. (2004). "Attitudes of Chinese medical students toward the global minimum essential requirements established by the Institute for International Medical Education." *Teach Learn Med* 16(2): 139-44.**

BACKGROUND: The Institute for International Medical Education has published "Global Minimum Essential Requirements (GMERs) in Medical Education." PURPOSE: This study examined attitudes of a sample of Chinese medical students toward the GMERs. METHODS: Matriculating and graduating West China School of Medicine Sichuan University medical students were administered parallel surveys during the 2001 to 2002 academic years. RESULTS: Both cohorts produced similar response profiles. The majority in both groups rated the 7 GMER domains as either important or very important for their medical education. Matriculating students rated professional values, attitudes, behavior, and ethics as most important, whereas graduating students valued clinical skills highest. Population health and health systems received the lowest

importance ratings from both groups. Please note that this study was conducted before the SARS outbreak. As a result of the SARS experience, attitudes toward population health and health systems might have changed. CONCLUSION: Although medical students ascribe importance to the GMERs, efforts are needed to increase the perceived importance of the population health and health systems domain.

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** Zhang, T., Y. Q. Wu, et al. (2004). "[An evaluation of effects of intervention on maternal and child health in the rural areas of China]." *Sichuan Da Xue Xue Bao Yi Xue Ban* **35**(4): 539-42.
OBJECTIVE: To evaluate the impact of training maternal and child health care providers in the rural areas of China on improvement of health care to pregnant and puerperal women. METHODS: The data originated from the Reproductive Health/Family Planning Project implemented by the State Family Planning Commission and the Ministry of Health from 1998 to 2002, which covered 32 counties in 22 provinces of China. A quasi-experimental design was used. 6 counties were selected from 32 project counties as the intervention group, while 6 non-project counties were taken as the control group with the condition similar to that of the selected project counties in respect to their number of population and economic level. The subjects of the study were mothers with child under 3 years. A total of 348 mothers were interviewed using a structured questionnaire by strictly trained surveyors. It was focused on prenatal care and postpartum follow-up in the survey. INTERVENTION: According to the plan of the project, all maternal and child health care providers at the grass-root level were given a 2-week theoretical training, and some of them were assigned to hospitals where they were given a 1-month clinical skills training. RESULTS: With regard to prenatal care, the mothers in intervention group received more prenatal care than those in control group (mean number of obstetric visits: 6.64 vs 5.64, $P < 0.05$). The number of items of examination taken in intervention group was more than that in control group (6.71 versus 5.67, $P < 0.05$). The proportion of the mothers in intervention group who were told that they must visit doctors if they felt uncomfortable in pregnant period, was higher than that in control group ($P < 0.05$). 8 symptoms or signs that possibly occur in pregnant period were listed; in this connection, the mothers in intervention group knew more than those in control group (3.43 vs 2.09, $P < 0.05$). In the postpartum follow-up, more mothers in the intervention group were examined by the doctors. The proportion of mothers who were informed of contraceptive methods was higher in intervention group than in control group (94% vs 78.5%, $P < 0.05$). The descending rate of maternal mortality rate in the intervention areas was much higher than that in the control areas. CONCLUSION: The training of maternal and child health care providers had a significant impact on improving their service skills and quality; consequently, the women covered by their service could receive better maternal and child health care. This indicates that the Reproductive Health/Family Planning Project implemented in the rural areas of China is successful.

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Below are selected search results from EconLit using EconLit Advanced Search (search terms: China, 2004, rank by date)

** Lin, J. Y., G. Wang, et al. (2004). "Regional Inequality and Labor Transfers in China." *Economic Development and Cultural Change* **52**(3): 587-603.

** Wan, G. (2004). "Accounting for Income Inequality in Rural China: A Regression-Based Approach." *Journal of Comparative Economics* **32**(2): 348-63.

This paper proposes a framework for inequality decomposition in which inequality of the target variable, e.g., income, can be decomposed into components associated with any number of determinants or proxy variables in a regression equation. The proposed framework is general enough to be applied to any inequality measure and it imposes few restrictions on the specification of the regression model. This generality is illustrated by quantifying root sources of

regional income inequality in rural China using a combined Box-Cox and Box-Tidwell income-generating function.

** Wang, F.-L. (2004). "Reformed Migration Control and New Targeted People: China's Hukou System in the 2000s." China Quarterly n177: 115-32.

This article outlines the latest reforms of China's hukou system in 1997-2002 and reports the system's functional changes and continuities. Today's hukou system still performs two leading functions: the widely discussed internal migration control with reformed mechanisms and the previously scarcely examined socio-political management of the targeted people (zhongdian renkou). An adapted and adjusted hukou system is expected to continue as a key component of China's institutional framework, playing a crucial role to determine socio-political stability, facilitate a rapid but uneven economic growth, and shape socio-economic stratification and spatial inequality in the PRC.

** Wu, W. (2004). "Sources of Migrant Housing Disadvantage in Urban China." Environment and Planning A 36(7): 1285-1304.

The increasing level of labor mobility in China challenges the current population-management structure. In particular, recent reforms in urban housing provision seem largely to overlook the needs of the migrant population. In this paper I examine the sources of migrant housing disadvantage in cities. Specifically, I analyze the institutional and socioeconomic factors underlying migrant housing choice and conditions, and how these factors influence migrants differently from the locals. Data are drawn primarily from citywide housing surveys and interviews conducted in Shanghai and Beijing. The findings show that migrants make housing decisions based on whether they intend to settle in the cities, and market-related factors such as income and education have a significant, positive impact on migrant housing conditions. But more importantly, the general disadvantage experienced by migrants has much of its root in the institutional restrictions associated with the hukou system that outweigh the combined effects of socioeconomic factors.

** Zhang, X. and S. Fan (2004). "Public Investment and Regional Inequality in Rural China." Agricultural Economics 30(2): 89-100.

This paper develops a method for decomposing the contributions of various types of public investment to regional inequality and applies the method to rural China. Public investments are found to have contributed to production growth in both the agricultural and rural non-agricultural sectors, but their contributions to regional inequality have differed by type of investment and the region in which they are made. All types of investment in the least-developed western region reduce regional inequality, whereas additional investments in the coastal and central regions worsen regional inequality. Investments in rural education and agricultural R&D in the western region have the largest and most favorable impacts on reducing regional inequality.

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Below are selected search results from Social Science Citation using EndNotes (search terms: 2004, China, health)

** Doherty, J., I. Kamae, et al. (2004). "What is next for pharmacoconomics and outcomes research in Asia?" Value in Health 7(2): 118-132.

Objectives: Pharmacoconomics and outcomes research have the potential for rapid adoption in the Asia Pacific region. Nevertheless, the region is characterized by great diversity in social and economic development, ethnicity, population size, health-care system, culture, language, and religion. Thus, the rate of adoption is also quite diverse across the region. Methods: Among the countries reviewed in this article, governments take varying levels of interest in applying this research in health policy decisions. For example, some countries have already implemented systems that require pharmaco-economic studies as one component of a new pharmaceutical product's approval for reimbursement, whereas others recommend such data but

do not require it in policy and medical decision making. The literature in the countries reviewed is actually quite robust given the early stages of development of this field in most countries. The academic community has members trained in this field of research in all the countries reviewed and some universities have established departments whereas others have just introduced a few classes in the area. Results: At the moment, pharmacoeconomics and outcomes research are being conducted mainly by academics. In addition, some pharmaceutical researchers are active and pharmaceutical companies are currently preparing to conduct more of this research as part of their strategy for Asian drug development. Conclusions: Prospects for future growth and development in this field are quite good in Asia as rapid health-care inflation, increasing rates of chronic conditions and aging population, and increasing technology diffusion will underpin the need for greater awareness of the need to incorporate economic efficiency into the health-care systems.

** Wu, X. G. and D. J. Treiman (2004). "The household registration system and social stratification in China: 1955-1996." Demography 41(2): 363-384.

The Chinese household registration system (hukou), which divides the population into "agricultural" and "nonagricultural" sectors, may be the most important determinant of differential privileges in state socialist China, determining access to good jobs, education for one's children, housing, health care, and even the right to move to a city. Transforming one's hukou status from rural to urban is a central aspect of upward social mobility. Using data from a 1996 national probability sample, we show that education and membership in the Chinese Communist Party are the main determinants of such mobility.

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Note: Below are selected search results from Factiva using search builder for news dated in last 3 months. Search terms: China and health, All sources, All companies, Subject: Analysis or Audio-visual links or Commentary/opinion or Country profile or Dow Jones/Reuters Top Wire News or Economic News or Editorial or Intl Pol-Econ Organizations or Interview or Letter or News Digest or Political/General News or Review or Routine General News or Transcript, Region: China, All industries, Language: Chinese simplified or traditional or English, Sort results by: publication date, most recent first

China regulatory watch: Healthcare

88 words

30 August 2004

Economist Intelligence Unit - Business China

Business China

Number 306

English

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Doctors receive pre-surgery exam. Physicians at Shanghai Ren'ai Hospital are required to pass brief physical and mental health examinations prior to performing non-emergency surgery. The requirement took affect in mid August and includes temperature and blood pressure checks, as well as a questionnaire on alcohol consumption, sleep and recent alterations in mood. Doctors who are deemed unwell or unfit to execute their duties will not be permitted to perform surgery. Business China 30 Aug 2004 Main Report, Part 14 of 18 Document EIUBC00020040829e08u0000f

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Chinese law addresses AIDS for first time ever in legal amendments

277 words

28 August 2004

23:02

Agence France Presse

English

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BEIJING, Aug 29 (AFP) - China's lawmakers have addressed the AIDS threat directly for the first time ever in a sign the government hopes to curb the disease before it becomes an epidemic, state media said Sunday.

Amendments to the law on infectious diseases urge officials at all levels to step up the control of AIDS and take measures to prevent the spread of the disease, the Xinhua news agency reported.

They were signed by President Hu Jintao after being passed by the national legislature over the weekend, according to the agency.

The amendments also emphasize the need to help areas that are too poor to fund a healthcare system that effectively prevents diseases and treats people already infected, the agency reported.

"Lack of adequate funds has undermined contagious disease prevention and control capabilities of organizations entrusted with the tasks," Vice Minister of Health Gao Qiang was quoted as saying.

"Due to the lack of money, some patients could not receive timely, effective and formal treatment and became new sources of infection," he said, according to the agency.

The amended law also strengthens requirements imposed on blood donation centers following a series of scandals in recent years in which people were infected with HIV/AIDS after selling blood under highly unsanitary conditions. The official number of HIV carriers in China is 840,000, a figure that has been left unchanged for nearly a year and has probably grown steeply since then. State-run media have warned that unless China takes urgent action it could end up with 12 million HIV patients by 2010.

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Facing One-Child Rule, Chinese Top World in Caesareans

By Karen Mazurkewich

1,145 words

26 August 2004

The Wall Street Journal

B1

English

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Shanghai -- WANG JIAPIN spent the months leading up to the birth of her son agonizing whether she should have a Caesarean section. Ms. Wang's view of natural childbirth had been formed by seeing women give birth in soap operas and in "Hibiscus Town," a Chinese film in which the leading character nearly dies during a difficult labor.

"They are all very dramatic, with lots of sweating and screaming," says the 27-year-old Ms. Wang of the depictions. "The only picture you get is a woman's suffering face."

Fear of pain wasn't the only thing on the mind of the Shanghai advertising company manager. Shanghai women are taking a modern approach to motherhood, says Ms. Wang, as her two-year-old son, Qi Qi, who was born by Caesarean section, tosses toys around the family's high-rise apartment. "Women don't want to feel wasted after delivery," she says. "They want the same sex life as before."

Ms. Wang is one of a soaring number of Chinese women, up to 6.5 million a year, who are choosing Caesarean surgery. Researchers at the World Health Organization estimate that 47% of births in **China** are C-sections -- the highest rate in the world. Just a decade ago the figure was less than 20%.

China isn't alone. Around the world, healthy pregnant women, worried about sexual dysfunction, pelvic-floor damage and labor pain, are spurning natural deliveries. In the U.S., the Caesarean rate hit an all-time high of 26.2% in 2002. In Britain, the rate has jumped to 22% now from 10% in 1985.

In **China**, a confluence of factors -- other than viewing C-sections as a modern approach to childbirth and a fear of pregnancy complications -- is causing the Caesarean boom. C-sections are seen as safe. In addition, Chinese women tend to follow tradition, especially if other family members have had C-sections. Better medical care, meanwhile, now allows doctors, at least in urban areas, to perform more complicated procedures such as C-sections, and it has become a lucrative business for them.

Perhaps most of all, Chinese parents-to-be believe that C-sections are the most reliable birthing option to protect the one, precious offspring they are allowed under **China's** one-child policy. "Women think, `I will only have one baby, so I want it to be healthy and of high quality,'" says Dr. Wang Shanmi, director of obstetrics at People's Hospital of Peking University.

Families have a great influence on pregnancy matters, says Wang Qi, medical director of obstetrics at Beijing Obstetric and Gynecological Hospital. "Women usually listen to the people around them before making a decision, and women from a family with more C-sections will likely choose a C-section."

Ms. Wang's sister, who had given birth by Caesarean two years earlier, repeatedly pointed out her C-section scar. "It was low and small and horizontal," Ms. Wang says. "I thought maybe a C-section was not so bad."

Then her mother started to pressure her. "In my mother's day there was not the level of care and there was a high rate of death with childbirth," Ms. Wang says. "My mother begged me: `Please, please, look at your sister, she's kept fit and her baby is nice.'"

Caesareans also make it possible for Chinese families to factor in traditional beliefs. Hong Kong bank employee Faustina Chan had a C-section earlier this year so she could plan her maternity leave and vacation. But she also liked that she could choose the day for the birth of her child. Her feng shui master, who helped rearrange her home for better energy flow through the rooms, chose April 9. If she was born on that day, her daughter would be smart, attentive to her parents, and able to snag a rich husband, Ms. Chan says.

After years of basic medical facilities, the increasing availability of advanced medical technology is seducing newly affluent families who want the best that money can buy.

Back in the 1980s, hospitals had few facilities; many didn't even have basic fetal heart monitors, doctors say. And when women did opt for a Caesarean, vertical belly incisions were the norm until the late 1980s, whereas in the West, doctors started to make horizontal cuts lower on the abdomen in the early 1970s. (Lower incisions are smaller and less visible once scarring has healed, and damage no muscle, unlike vertical incisions.) In addition, the number of specialty obstetric hospitals in **China** has jumped to 81 from 49 in just eight years.

Caesarean surgeries are also more lucrative for doctors and hospitals. "Hospitals don't earn any money from a natural delivery," says Dr. Wang of Peking University.

In Beijing's big hospitals, the cost of a regular birth is 3,000 to 5,000 yuan (\$360 and \$600), while Caesarean deliveries cost 5,000 to 6,000 yuan (\$600 to \$720). "Because each family only has one child, parents don't care about paying a few more thousand yuan for a one-time operation," Dr. Wang says.

Yet not all physicians believe the trend is a good one, especially when it involves giving Caesarean sections on demand to healthy women. Many doctors believe women undergoing the operation have an increased chance of serious complications, while babies are at risk if doctors miscalculate the due date and the baby is delivered prematurely.

"It's major surgery and the rate of serious complications such as pulmonary embolism and infection is high," says Robert Lorenz, vice chief of obstetrics at William Beaumont Hospital in Royal Oak, Mich.

The most dangerous potential problem, he says, is a uterine rupture during pregnancy, which can occur in women who have had prior **Caesareans**. "It can be catastrophic, with the loss or permanent injury to the baby; hemorrhage and possible hysterectomy for the mother," he says.

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Analysis of causes of death in China

66 words

13 August 2004

SinoFile Information Services

a08

English

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Peking Union Medical College Chronic Disease and Danger Factors Research Center has ranked the causes of death for Chinese people between 1991 and 2000. Lung cancer, liver cancer, brain aneurysm, injuries and tuberculosis are the biggest enemies threatening the lives and health of Chinese people.

TRANSLATED & ABSTRACTED FROM: Southern Weekend

BY: null - Southern Weekend

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HOSPITALS ON LIFE-SUPPORT

By Xing Bao
1,098 words
12 August 2004
Shanghai Star
English

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By Shanghai Star. 2004-08-12

Zhu Yong, a reporter from the Shanghai Youth Daily, had a bitter experience when seeking treatment for his chronic gastritis in the Shanghai Oriental Hospital in Pudong. He later sued the hospital for giving him unnecessary medical examinations and medicines.

While he was waiting for a gastroscopic examination, he was told to take a Type-B Ultrasound examination first.

"When I asked why I should have that examination, the doctor explained that the gastroscopic exam was not available. So they gave me a Type-B Ultrasound examination," Zhu said.

Later the hospital also gave him other examinations, such as those for blood lipids and an electrocardiogram.

"I wonder why they gave me such examinations. My gastritis was not that serious," Zhu said.

With these doubts, Zhu later consulted the hospital and was told that most of the examinations should not have been done.

"I am so angry about what the hospital did to me. The doctors later prescribed medicines to treat my problem, which turned out to be expensive pills," said Zhu.

"But I was told later these expensive medicines could have been replaced by alternatives which were much cheaper."

The nine days of treatment in hospital cost him 3,930 yuan (US\$475), most of which was spent on medicines.

"I later found that most of the medicines had been imported at a high price. I even found some of the medicines were not appropriate for my disease," he said.

Zhu accused the hospital of deceitfully undertaking unnecessary examinations and prescribing expensive medicines just to make a bigger profit.

Better care

The Shanghai Oriental Hospital is not the only hospital to face such accusations.

"In China, many hospitals have to survive by selling medicines. This is no longer a secret. Even the AAA comprehensive hospitals do the same thing to make ends meet," said one director (who refused to give his name) from an AAA hospital in Shanghai.

However, as State-owned hospitals are struggling to survive by selling medicines, foreign ventures have rushed to enter the market.

Two hospitals will soon be established in Shanghai with foreign ventures taking a majority of the share holdings. The whole investment is announced at over 400 million yuan (US\$48 million), according to the Shanghai government.

The two hospitals are the first comprehensive ones in China in which foreign ventures have a majority stake.

A US company will invest 120 million yuan (US\$14.7 million) to set up a comprehensive hospital in Shanghai's Anting Town together with Anting Hospital, a local comprehensive hospital, according to an official from Anting Hospital.

They have chosen to locate the hospital in an industrial zone in Anting based on automobile and parts manufacturing.

"The process of applying to establish such a hospital is complex and the requirements are quite strict," said Chen Xueping, an official from the Shanghai Foreign Economy and Trade Committee.

But the huge market in Shanghai, with its growing middle class, has attracted foreign ventures despite these strict requirements.

Previously, United Family Hospitals and Clinics, with a US venture background, has provided services in Shanghai after achieving success in Beijing.

Foreign ventures have taken part in the co-operative running of professional hospitals and clinics for a long time.

"They prosper on the basis of the better service they provide, rather than the medicines they sell," said Professor Zhu Renyuan, chairman of the Shanghai Ophthalmology Association.

"Our aim is to set up a hospital where mothers do not fear and fathers can find a seat while waiting," said Li Beijing, founder of United Family Hospitals and Clinics.

"The wall was decorated with plants and beautiful pictures. You could see the pictures of babies smiling in the arms of their parents. I was later told those were the babies born in the room. It felt like a home," said Wang Suyi, who gave the birth to her baby in the hospital.

"I felt shy when I was about to give birth. But the doctors and nurses told me nobody could see into the operating room because it had two doors. The equipments were all in good order and clean. They convinced my husband to stay with me during the operation and encouraged me with warm words. My nervousness faded away."

In such hospitals, the service fee is about 10 times the ordinary level. It costs 500 yuan (US\$60) to see the doctor each time.

"Although the public hospitals charge a smaller service fee, they charge you more for medicines. I prefer hospitals like United Family," said Zhang Jing, a Shanghai white collar.

Each doctor only sees 10 patients a day in hospitals like United Family, so as to guarantee they can give enough time to each patient.

"But in the public hospitals, especially the comprehensive ones, each doctor might have to see more than 100 patients every day," said Zhu.

Zhu himself sometimes has to see more than 130 patients in a single day.

Better service has lured many middle class people away from the public hospitals to the new hospitals.

More competition

This competition has upset the local hospitals. "We lose our personnel when these hospitals arrive in Shanghai," said Zhu. "They grab the best doctors and nurses by offering higher salaries, better opportunities for promotion and a better mode of operation."

Some hospitals have responded to the challenge by co-operating with the foreign hospitals and absorbing foreign ventures. Some 200 out of the 600 hospitals in Shanghai have now entered into co-operation arrangements with foreign hospitals and investment capital. The UK and Shanghai, for instance, have signed an agreement to establish a chest hospital.

An academic affiliation agreement was signed between Shanghai Second Medical University (SSMU) and the University of Nebraska Medical Centre (UNMC) early this year to undertake joint efforts in the fields of academic exchange and biomedical research.

To further co-operation through joint programmes, the UNMC said they would send their scientists to China and help Shanghai train high quality health care workers.

A special zone has been set up in Nanhui District of Shanghai to attract foreign investment into health care.

But who will look after the health care needs of people with low incomes and those without health care insurance?

"The joint-venture hospitals target the middle class and rich people while the government gradually reduces its investment in health care. So the reform of public hospitals is vital for everybody, especially for the under-privileged," said Zhu.

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Heavy spending earmarked for public health network in Guangzhou

241 words

12 August 2004

Xinhua's China Economic Information Service

English

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GUANGZHOU, August 12 (CEIS) -- Guangzhou, capital of south China's Guangdong Province, will spend some two billion yuan (about 2.41 billion US dollars) over three years in construction of a public health emergency response mechanism.

According to Huang Jionglie, head of Guangzhou City Health Bureau, a network for disease prevention and control, rescue and treatment of contagious diseases and supervision of health law enforcement will take shape in the near future.

Construction of the network for disease prevention and control in urban communities and rural areas of the city has begun and will be finished by 2008, said Huang.

According to Huang, the projects the city government has decided to construct will include a new CDC with a combined floor space of 40,000 square meters, a modern hospital with 1,000 beds for contagious diseases and a specialized city-wide health information network.

He pledged the city would continue to spend more in improving health facilities in the city's rural areas.

Guangdong was one of the first areas hit by the severe acute respiratory syndrome (SARS) in late 2002. The air-borne epidemic quickly spread to Beijing, Shanghai and elsewhere in China from late spring and ensuing summer in 2003. Guangzhou, the provincial capital and the busiest hub of transportation in south China, has appointed a command team and has prepared countermeasures for potential public health

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China opens 2004 government procurement for medical equipment

298 words

9 August 2004

Business Daily Update

English

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More than 400 Chinese and overseas businesses gathered in a vast Beijing exhibition hall Monday to compete for a share of more than two billion yuan (US\$240 million), the amount the Chinese government has allocated to buy medical equipment in 2004.

Nine expert teams organized by the Ministry of Health will evaluate the equipment, said Huang Jiefu, China's vice minister of health, at the opening ceremony of the 13th China International Medical Equipment and Facilities Exposition and Symposia (China-HOSPEC).

The Health Ministry announced earlier that the central government would spend 1.5 billion yuan (US\$181 million) this year on ambulances, in-car equipment, and devices for testing and treating infectious diseases. Another 573 million yuan (US\$70 million) will be used to buy overalls for medical personnel, emergency rescue equipment, laboratory devices for provincial and municipal disease control centers, vehicles with special purposes and testing machines for AIDS and schistosomiasis (commonly known as snail fever).

"With the continuous growth of China's economy and the public's increased attention on healthcare, the potential healthcare market in China is huge and fast growing," said Aris Bruin, chief operation officer of Philips Medical Systems in China. China has become the third largest healthcare market in the world, behind the United States and Japan. "In the next three years, the annual growth rate of China's healthcare market is expected to exceed 10 percent," Bruin said. In 2003, the Health Ministry spent more than 800 million yuan (US\$96.4 million).

Sources with the Health Ministry noted that items to be purchased this year would include computerized tomography (CT) machines, magnetic resonance imaging (MRI) machines, X-ray machines, clinical devices, ambulances, PET-CT machines and high-value consumable materials.

Document BDU0000020040809e0890001a

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Global medicine ties enriched

298 words

9 August 2004

Business Daily Update

English

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China has strengthened co-operation with overseas agencies on traditional Chinese medicine (TCM) in recent years.

By last month, China has signed memoranda with 17 countries, including Italy, the Republic of Croatia and the Republic of Moldova, about co-operation in the field of traditional Chinese medicine, data from the State Traditional Chinese Medicine show.

TCM has also been included as part of co-operation agreements with 54 countries.

In line with the memoranda, China and its overseas partners will carry out exchange and training of professionals, and research and develop herbal medicines.

For example, China and Moldova plan to set up a national centre of traditional Chinese medicine in Moldova. They will give policy support to the licensing of TCM doctors and approval and application of TCM products.

The signing of memoranda indicates the recognition of TCM and its administrative agencies in overseas countries. However, more needs to be done to promote

legislation, according to officials with the State Administration of Traditional Chinese Medicine.

The State Administration of Traditional Chinese Medicine lately has launched a strategy to promote TCM's entry into the world market.

Research has been carried out to standardize manufacturing of TCM products.

Also, action has also been taken to emphasize IPR protection and the conservation of resources, said Shen Zhixiang, an official with the TCM administration.

Chinese TCM researchers and developers are also working hard to introduce more high-tech products to the outside world.

A recent success story is the Kanglaite injection, an anti-cancer TCM invented by Zhejiang Kanglaite Pharmaceutical Co in Hangzhou, in east China's Zhejiang Province.

The medicine has been approved for clinical application as a prescribed medicine by the health authority in Russia, say sources with the State Administration of Traditional Chinese Medicine.

Document BDU0000020040809e08900017

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Mentally ill attacker gains public sympathy

Jason Leow

583 words

7 August 2004

Straits Times

English

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Incident highlights the plight of people with personality disorders, who are shunned instead of given psychiatric help

BEIJING - The mad man who slashed 15 children at a Beijing playschool this week has helped to revive a debate about the status of China's mentally ill, who are regarded even more as pariahs than the disabled.

Rather than anger, parents and psychiatrists have expressed sympathy for Xu Heping, whose Chinese name means peace.

The security guard with a history of schizophrenia had been working for two years without incident.

But on Wednesday, he suddenly lunged at teachers and children at the Peking University Number One Hospital kindergarten with a kitchen knife, killing a four-year-old boy.

The public has not blamed him. Instead, the people blame a culture that prefers to hide away people with mental or personality disorders, rather than acknowledge them and provide help for them.

A psychiatrist's response to The Straits Times was telling. Dr Li Bing, from Peking University's Number Six Hospital Mental Health Institute, said: 'I don't want to talk about this sensitive issue.'

But Xu may be helping the society to break the silence.

The official media yesterday called for legislators to get moving on a mental health law, drafted in 1985, aimed at providing the mentally ill with legal protection and minimal health care.

Only Shanghai has passed the law in 2001. The lack of progress elsewhere may be due to the small population of mental patients.

About 1.2 per cent of China's population, or 1.6 million people last year, suffered from any form of mental illness.

The society, however, appears to have realised that the problem is not one of numbers, but of patient protection. Today, just one in five patients gets treatment. The rest blend inconspicuously into normal society.

'We can't evade the problem of mental illness,' the official People's Daily said yesterday.

'It's not an ideological problem but a real abnormality that needs medical treatment.'

If passed, the mental health law guarantees people like Xu the right to schooling, employment and job interviews.

Patients whose families dispute their custody would also have a safety net.

They would be able to seek shelter and treatment at public hospitals if their families orsook them. Currently, patients depend on social connections to get help, as Xu did.

For five months in 1999, he was warded at Beijing Anding Hospital, a top facility for mental illnesses. His wife worked there. She got him the job at the Number One Hospital kindergarten.

Lawyers also want laws to be less discriminatory. The maternal and child health-care law, for instance, bars people with acute mental illnesses from marrying.

The state media has been kind to Xu. Newspapers quoted lawyers pushing for the kindergarten that hired him to be held accountable and for the man to receive psychiatric help.

Beijing's public security bureau told The Straits Times yesterday that Xu's case was being investigated. It could not confirm if he was being treated.

Yuetan Number Four kindergarten and other play- schools in Xicheng district, where the attack took place, yesterday held staff meetings to raise safety awareness.

One school, Fusuijing Kindergarten, even required all teachers to provide extensive details about their families' health history.

China's Education Ministry, however, told The Straits Times there was no nationwide campaign to raise school safety standards as a result of Xu's attack.

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Special report

Present Status and Development Trend of the Vitamin Industry in China

1,741 words

6 August 2004

China Chemical Reporter

English

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The vitamin industry in China started towards the end of the 1950s. Vitamin production at that time was mainly intended to provide raw materials for pharmaceutical production. In the 1970s several varieties of vitamin B could be produced in China and the development of the two-step process in the vitamin C production shocked the world. In the 1980s a production system of various vitamins excluding biotin (vitamin H) was formed in China, but intermediates could not meet the market demand in both capacity and output and still had to depend on import. Since the 1990s breakthrough advances have been made in production technologies of vitamins and intermediates and the development of the

vitamin industry has been greatly promoted. The drastic price decrease of vitamins has led to the elimination of producers with no cost advantage. Producers able to self-supply intermediates and having the resulting cost advantages have, however, expanded rapidly. They have not only occupied the domestic market but also gained a firm foothold in the international market in spite of fierce competition.

1 Application sector

In vitamin products, varieties with the most extensive application include vitamin E, vitamin C, vitamin A, vitamin B and vitamin D.

1.1 Vitamin E

Vitamin E has biological activity not available in other substances and necessary for animal organisms. It has become a focus of attention in the vitamin sector in recent years. With recent in-depth research into nutrition and pathology, the biological and chemical functions of vitamin E have been further discovered and verified, and the demand for vitamin E in the global market has shown rapid growth.

1.2 Vitamin A

Vitamin A can assist growth and is therefore especially important to infants and babies. It can maintain night vision function, maintain integration of epithelial cells and prevent the incidence of epithelial tumors. It is used extensively in OTC drugs and nutrition supplements.

1.3 Vitamin C

Vitamin C is also called ascorbic acid and is the vitamin variety with the greatest output. It is used as an antioxidant in the food processing industry to keep food fresh. In addition, it has extensive applications in the pharmaceutical sector.

1.4 Vitamin B

Vitamin B includes more than 20 compounds. It can enhance appetite, protect the nervous system, promote digestion and absorption and assist milk production. It is used extensively in the pharmaceutical, health-care product, animal drug and feed additive sectors.

1.5 Vitamin D

Vitamin D is a derivative of steroids. Varieties important to human bodies include vitamin D2 and vitamin D3. Vitamin D affects the absorption of calcium and phosphorus and their precipitation in bones and teeth.

2 Present production status

According to statistics from China Chemical Drug Industry Association and China Feed Industry Association, the total capacity of various vitamins in China is around 200 000 t/a at present. The output was around 180 000 tons in 2001. Of this figure, the output of choline chloride was around 100 000 tons, accounting for 40% of the world total; the output of vitamin C was 48 700 tons, accounting for 40%; the output of vitamin E was 12 000 tons, accounting for 30%; and the output of vitamin A was 3 000 tons, accounting for 10%. The output of other vitamins was around 20 000 tons. The market demand for feed-grade vitamins in China was around 120 000 tons a year, nearly one fifth of the world total. China has become an important international vitamin consumption market.

The dependence on import in vitamins - feed-grade vitamins in particular - has totally changed. Almost all vitamins needed in the domestic market are produced in domestic-funded enterprises or joint venture enterprises. A large amount of the products are also for export. China has become an important vitamin supplier in the international market.

Research units and production enterprises in China have made research achievements and technical breakthroughs in the vitamin sector in recent years. This is the main reason for the existence and development of domestic vitamin

producers in spite of fierce competition. There is domestic production of 14 vitamins and the history of dependence on the import of feed-grade vitamins has been brought to an end. Major breakthrough and commercialization of production technologies for vitamin D3, biotin, vitamin B2, nicotinic acid and calcium pantothenate have been achieved. Production technologies for some varieties such as vitamin B2 and vitamin C have also reached high international standards. A group of strong vitamin producers have emerged in China. The capacity of vitamin C in Northeast China Pharmaceutical General Factory, North China Pharmaceutical Group, Jiangsu Jiangshan Pharmaceutical Co., Ltd. and Shijiazhuang Weisheng Pharmaceutical Group is more than 10 000 t/a and their output of vitamin C accounts for 40% of the world total. The capacity of vitamin E in Zhejiang Xinhecheng Co., Ltd. and Xinchang Pharmaceutical Factory of Zhejiang Pharmaceutical Co., Ltd. is more than 10 000 t/a, ranking among the top four in the world. The capacity of vitamin A powder in Zhejiang Xinhecheng Co., Ltd. and Xiamen Jindawei Vitamin Co., Ltd. has reached 2 000 t/a and 1 000 t/a respectively, and the products are mainly for export. Shaanxi Weinan Feed Additive Plant is the biggest feed-grade choline chloride producer in Asia. Hubei Guangji Pharmaceutical Co., Ltd. is the biggest vitamin B1 producer in Asia. Owing to improvements made in fermentation technology, production costs in the company have fallen dramatically, and the competitive status in the international market has been greatly enhanced. Furthermore, Zhejiang Huayuan Biological High-Tech Co., Ltd. (engaged in vitamin D3 production), Zhejiang Brother Industrial Development Co., Ltd. (engaged in Vitamin K3 Production) and Zhejiang Xinfu Biochemical Co., Ltd. and Huzhou Lion King Fine Chemical Industrial Co., Ltd. (engaged in D-calcium pantothenate production), have become backbone producers in the vitamin sector both at home and abroad. Their products have participated in competition in the international market.

3 Prospect analysis

Demand in the vitamin market in China is mainly concentrated on varieties for feed and varieties for pharmaceuticals and health-care products.

3.1 Feed

The output growth of feed was less than 1% in the world in 2001, but it was 5.1% in China. Owing to the improvement in living standards and the demand increase for animal meat and milk products, the demand for industrial feed in China will reach 121 million tons in 2005 with an average annual growth of 12%. The demand for vitamins for feed will have a synchronous increase. Judging by the domestic demand for feed-grade vitamin A, the demand for 500 000 unit vitamin A powder was 3 200 tons in 1998, increasing to 3 790 tons in 2001 and is expected to reach 5 880 tons in 2005. The demand for feed-grade vitamin E powder was 5 000 tons in 2001 and is expected to reach 7 750 tons in 2005.

3.2 Pharmaceuticals

(1) Vitamin E: In spite of the rapid development of vitamin E manufactured in China in recent years, the per-capita consumption is still much lower than the world average and there is a huge market potential. As a food additive, China has already formulated sanitary standards for vitamin E. The demand for natural vitamin E in the health-care, pharmaceutical, food, cosmetic and feed sectors will increase steadily and is expected to reach 5 600 tons in 2005.

(2) Vitamin A: Vitamin A is used extensively in OTC drugs, nutrition supplements, feed additives and food processing. With the improvement in living standards, the demand for vitamin A will increase further.

(3) Vitamin C: The production and consumption of vitamin C in Asian countries, China in particular, are seriously unbalanced. Most of vitamin C products in China are for export. The domestic consumption is very small, at only approximately 4

000 tons a year. The per-capita consumption is less than 4g, much less than the average per-capita consumption of 60-90g in advanced countries, for example in Western Europe and the United States. There is therefore a huge market potential in China.

4 Development trend

4.1 Great market potential for vitamin health-care products

With the improvement of production levels, the awareness of health care has increased constantly. Vitamins are the most important nutrition and health-care products in China. Their function of improving health has an adequate scientific basis. The SARS epidemic in China and Southeast Asia at the beginning of 2003 greatly enhanced the awareness of health care. As health-care products with a solid scientific basis, vitamins have been quickly accepted. Vitamin health-care products such as vitamin C powder drinks, vitamin C/vitamin E composite powder drinks and composite vitamin tablets are suffering from a supply shortage. A huge market for vitamin health-care products is rapidly developing.

4.2 Rapid increase of feed-grade vitamin products

The international market growth of vitamins has been only 3-4% in recent years, but the market growth of multi-component and pre-blended products is more than 9%. 40% of vitamins in vitamin giants such as Roche and BASF are sold to end users in the form of multi-component and pre-blended products. Feed producers in China are also highly concentrated. The top 20 feed producers hold a 30% share of the domestic market. The capacity of single-component vitamin producers is also highly concentrated. For example, the top three producers have 90% of the total vitamin E output, 80% of the total vitamin A output and 60% of the total vitamin C output. The market of multi-component and pre-blended products is however widely scattered. Producers are mostly medium and small enterprises and there are few famous brands. Most feed producers with a considerable scale have their own pre-blending units and can be basically self-sufficient. 70% of the domestic market is left to specialized pre-blending plants. It will be an inevitable trend for domestic vitamin producers to gradually extend from single-component products to multi-component and pre-blended products.

Table 1 Export of Vitamins in China in 2003 (kt)

Product	Export amount
Vitamin C	54.10
Vitamin E	20.81
Vitamin A	2.03
Vitamin B1	2.55
Vitamin B2	1.29
Vitamin B6	2.09

Vitamin B12 0.57

Source: CNCIC Chemdata
China Chemical Reporter No. 22 (450). Vol. 15
Document CHCR000020040812e0860000o

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Chinese agency reports unsafe injections behind 390,000 deaths

367 words

5 August 2004

08:08

BBC Monitoring Asia Pacific

English

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Text of report in English by official Chinese news agency Xinhua (New China News Agency)

Beijing, 5 August: About 390,000 Chinese have died prematurely from unsafe injections, said a think tank of China's Ministry of Health [MOH] here Thursday [5 August].

The Think Tank Health Research Centre released the statistics at a seminar on unsafe injections that opened here Thursday.

The results show that AIDS and HBV (Hepatitis B Infection) caused by unsafe injections have caused 390,000 premature deaths and 6.89 million Disability Adjustment Life Year losses. The direct medical spending on unsafe injections has reached 142m US dollars.

There are 3 billion injections in China annually, one fifth of the global total. In poor western regions and rural areas, it's a common practice of grassroots clinics to reuse disposable syringes without effective disinfection measures.

Statistics show that 30 per cent of immune injections and 50 per cent of therapeutic ones are unsafe. In western rural areas, more 70 per cent of disposable syringes for single use are reused.

Unsafe injections have also caused damage to doctors and nurses. Guo Yanhong, in charge of the MOH injection department, said one million medical workers had been hurt by needles annually, some of whom got HBV or HIV/AIDS.

China has 840,000 HIV carriers and 120 million HBV carriers, 10 per cent of the total population. Two thirds of the latter caught the virus before the age of five.

Ye Lei, national director of the United States Centres for Disease Control and Prevention Global AIDS Programme-China, believes that the best way to avoid unsafe injections is to use auto-disabled (AD) syringes which can be self-destructed after the injection. Ye said AD syringes, with a price only 0.01 US dollars higher than the current single-use ones, are cheap enough for rural consumers.

However, the product is far from popular in the country. Despite 30 manufacturers with an annual capacity of 1.7 billion, the annual sales of AD syringes linger at 100 million due to low domestic demand.

Source: Xinhua news agency, Beijing, in English 1212 gmt 5 Aug 04
Document BBCAPP0020040805e08500335

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China can expect zero growth rate in population by 2034

236 words

4 August 2004

The Press Trust of India Limited

English

(c) 2004 Asia Pulse Pte Limited

Beijing, Aug 4 (PTI) The coming two decades will see China's aggregate population rising at a net growth rate of about 10 million per year and the most populous nation can expect zero growth only after the population touches 1.6 billion some time around 2034, a senior official has said.

With a total fertility rate (TFR) of 1.8, China will have 1.486 billion people in 2034 and a zero growth is likely only by then, director of China National Commission of Population and Family Planning, Zhang Weiqing said.

If some complicated and changeable factors are taken into consideration, at a TFR of 2.0, the population may reach 1.575 billion in 2034.

This means there will be 300 million more people and zero growth can be realized only after China's population reaches 1.6 billion, Zhang said.

In 2020, China's floating population will exceed 900 million, 300 million more than that in developed countries, he said.

The system of public health and hygiene is very fragile. Eighty per cent of the health resources are concentrated in cities; there are 120 million hepatitis B virus carriers and 80 per cent of the AIDS-infected are in rural areas, he added.

Lastly, the life of those parents with only one child is inadequately guaranteed as they are ageing, the official said.

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CHINA REPORTS 30% DROP IN ANNUAL TB INFECTION RATE DUE TO INTRODUCTION OF DOTS - WHO.

260 words

2 August 2004

10:25

Interfax China Business News

English

(c) 2004 Interfax Information Services, B.V.

Shanghai. August 2. INTERFAX-CHINA - The infection rate of tuberculosis (TB) has fallen 30% in China after the government's introduction of DOTS (Directly Observed Treatment Short Course), a TB control strategy, to half of the country's population, according to a World Health Organization (WHO) statement. Chinese authorities plan to spread DOTS nationwide by 2005.

A survey conducted by the Chinese TB Control Collaboration, which includes the Ministry of Health and the WHO, indicated a substantial drop of an estimated 382,000 TB cases in China. China now has the world's second highest infection rate for TB per year with 1.4 mln new cases reported annually. Consequently, China is now faced with a major challenge as it tries to reach the United Nations Millennium Development Goal (MDG) of cutting the number of TB cases by 50% by the year 2015, according to the WHO. In China, 20% or more of the population in certain provinces do not have access to DOTS. China's national TB survey

began in 2000, and covered 376,000 people at 257 investigation points from all 31 provinces, autonomous regions, and municipalities in Mainland China. A similar survey was conducted in 1990. The Chinese government began introducing DOTS in 1991. DOTS is the internationally recommended strategy for controlling TB, and combines five elements of political commitment, microscopy services, drug supplies, surveillance and monitoring systems, and the use of highly efficacious treatment regimes with direct observation of treatment. - JC.

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China to send modern-day "barefoot doctors" to boost rural healthcare

349 words

2 August 2004

00:23

Agence France Presse

English

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BEIJING, Aug 2 (AFP) - Residents in China's poverty-stricken countryside will soon benefit from basic healthcare provided by mobile hospitals, state media reported Monday.

The National Development and Reform Commission and the Ministry of Health have invested 230 million yuan (27.7 million dollars) in a new programme to provide "door-to-door" health service to rural residents, the China Daily said. Some 1,000 coaches, or mobile hospitals, will be sent to rural areas in central and western China to diagnose common disease, to perform minor operations and health check-ups as well as to promote health education to farmers who have limited access to hospitals in towns and cities.

The vehicles will also be used for testing for HIV and other contagious diseases. The new arrangement is reminiscent of a similar system in the 1970s, when the country sent large groups of the so-called "barefoot doctors" -- many of whom were paramedics -- to rural areas to provide primary health care and promote public health campaigns.

Another 800 coaches bought with treasury bonds will be put into service at the end of the year, the paper said.

"We aim to equip every county in western and central China with a mobile hospital," Li Shenglin, vice-minister of the National Development and Reform Commission was quoted as saying.

Li said the programme was part of China's resolve to develop a sound healthcare system in rural areas.

Rural residents currently enjoy only around 30 percent of China's health resources. China's social security system is still provided to mainly urban residents.

Many farmers cannot afford increasingly expensive medical bills and deterioration of their health conditions propagates the poverty problem in the countryside, the report said.

Since last year, the central government has earmarked 10 yuan (1.2 dollars) per year for each rural resident, as well as collecting the same amount from local authorities and the residents themselves in central and western China to enroll farmers onto a new medical insurance scheme.

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Where are the patients? - China's health care

EC00000020040820e08I0001q

SA

2849 Words

21 August 2004

The Economist

ECN

372

English

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China's collapsing health care

Health care and the environment have been overlooked in China's rush to capitalism. We look at health care below; at pollution on page 63

RONGRONG was only a few weeks old when her parents noticed swellings. They took her to a village clinic and to a rural hospital. Both failed to spot that the baby was severely malnourished, though they charged the equivalent of two and a half months of her father's income as a brick-factory worker. The delay probably cost Rongrong her life. When her parents eventually took her to a city hospital, where a correct diagnosis was made, she was in a critical condition. After seven days, and another three months' salary-worth of hospital bills, she was dead.

The baby, from a village in the central province of Anhui, was one of at least 200 infants around China who were seriously malnourished, and in some cases killed, by consuming substandard milk powder in the past few months. Parents had no way of knowing that the cheap but well packaged product they were buying was illegal and hardly more nourishing than water. And because of the prohibitive cost of health care, parents often failed to get their children treated in time to save them.

After the scandal came to light in April, the government announced that affected children would be treated free (the Chinese press has since reported that some hospitals resumed charging after the departure of the central government officials sent to investigate). Rongrong's parents, like other bereaved families in the area, received compensation from the local government. The payout of 12,000 yuan (\$1,450) was the equivalent of nearly two years' income for Rongrong's father.

But the tragedy had taken its toll on Rongrong's mother, who now needs medical treatment herself. To have more time to look after her, her husband has given up his job at the brick factory and returned to subsistence farming. His wife's hospital bills have already amounted to more than three months' worth of his former salary.

Criticism of the affair has focused on the ubiquitous sale of fake and substandard products. But just as big a failing was that of the health system itself. The families who bought the milk powder were mostly poor country people. Undoubtedly fewer lives would have been lost if they had had better access to basic health care.

Mao Zedong, for all his egregious faults, would have done better at providing it. In his day, nine out of ten country people had access to subsidised health clinics run by

the much celebrated “barefoot doctors”. But in the course of China's relentless march towards capitalism in the past two decades, this arrangement has collapsed. In the countryside, 90% of the population now has no health insurance. In the cities, nearly 60% are uncovered. Out-of-pocket spending on health care is soaring.

When the World Health Organisation (WHO) ranked the public-health systems of 191 countries four years ago, China was placed at 144, behind some of Africa's poorest. India, which has half China's GDP per head, came in at 112. The criteria included fairness of access to health care and fairness of contributions to the cost.

Better to live on the coast

Judged by life expectancy, infant mortality and child-birth deaths, China's record looks impressive. Twice as many children in India die in the first few months of life, and twice as many mothers die in childbirth. At birth, Chinese girls can be expected to live to 73 and boys to 70—a level comparable to medium-level developed countries. But there are huge disparities between regions. In richer areas, such as around Shanghai on the coast, health indicators are as good as they are in many western countries. In western China, they are those of a basket-case country.

After making strong gains in the first three decades of Communist rule, health indicators have changed little in the past quarter-century, despite the extraordinary economic achievements of China, with annual average GDP growth of 9.7% in the past 20 years. Some health experts believe that in parts of the country—particularly in the west where incomes are half the level of the booming eastern seaboard—life expectancy might even be falling.

According to the World Bank, China has lifted 400m people out of severe poverty in the past two decades. But millions have slipped back into it as a result of health-care costs. Millions of others are dying because they cannot afford health care. A government survey three years ago found that some 60% of rural residents avoid hospitals altogether because of the expense. Diseases once declared tamed, such as tuberculosis, measles and snail fever, have been making a comeback. And amid the disarray of the system, a new infection, HIV, is rapidly taking hold.

Things could get much worse. In the coming years, the customary Chinese way of dealing with expensive medical crises—borrowing from family and friends—will become more difficult as the proportion of elderly citizens in the population rises steeply. The UN predicts that by 2040 China will have only two working-age people for every person over 60, compared with 6.4 in 2000. While ageing populations are common in the developed world, the Centre for Strategic and International Studies said in a recent report that China may be the first major country to grow old before it becomes rich.

Too nervous to spend

Public anxiety over the collapse of affordable health care is reflected in China's high savings rate. Despite the parlous state of China's state-owned banks, bank savings by individuals have grown rapidly in recent years. Worries about the fast-rising costs of health care and education—and the lack of private-insurance schemes and other low-risk investment opportunities that might help offset them—are restraining

consumer demand and thereby imperiling China's long-term economic growth.

This makes health-care reform a crucial part of China's development strategy. To ease growing pressures on its fragile financial system, China wants to become less dependent on government investment as an engine of growth. But unless consumers feel confident that they can cope with the risk of a serious health problem (as well as with all the other increasingly costly contingencies), it will be difficult to encourage them to spend.

Last year's outbreak of severe acute respiratory syndrome, or SARS, not only concentrated the government's attention on the problem but aroused the world's attention to the potential health threats from a country with a patchy record on epidemic control. Fortunately, SARS never took hold in the rural areas where facilities are the shabbiest. Had it done so, it would have been hard to stop its spread.

Well into the crisis, the government realised this and tried to reassure people that they would not have to pay for any SARS treatment costs. But given the high possibility that SARS-like symptoms might turn out to be caused by another ailment not covered by free treatment, there was the likelihood that many people would have avoided the hospitals anyway.

The outbreak demonstrated how fragile and threatening the health system had become. Suddenly, officials began to turn their attention to neglected health problems such as HIV. China estimates that it could have around 1m HIV carriers at present. The WHO says this could rise to 10m by the end of the decade. Last year, for the first time, top leaders, including the prime minister Wen Jiabao, were shown on television shaking hands with AIDS patients. Officials, at least in some areas, have begun to overcome their prudishness and to promote condom use and the distribution of clean needles to drug addicts.

For President Hu Jintao and Mr Wen improving health care has also become part of a political strategy aimed at salvaging the Communist Party's badly tarnished image. Mr Wen and Mr Hu now stress the need to address the concerns of the marginalised. In 2002, the party set a goal of turning China into a middle-income country with a "well off" population by 2020. But in recent months the emphasis has shifted from simply increasing GDP per head to achieving broader measures of wealth, such as enjoying good health.

But getting there will be far more difficult than fulfilling GDP growth targets. For the past 20 years, the government's financial commitment to health care has been declining. Urban hospitals, though mostly still state-owned, now receive only about 10% of their operational funds from the state. For the rest they have to generate their own revenues, mostly from selling medicine and medical tests (the cost and wilful over-prescription of which is the biggest grievance of patients).

Even immunisation isn't free

Rural hospitals are in even worse financial shape. The most basic ones are run by governments at the township level, the lowest tier of government hierarchy. For most of these administrations, the only source of funding is the trickle of income

they receive from higher-level government, plus taxes and fees that they raise from farmers and businessmen. Even preventive medicine now has to rely on fees. The WHO says that China is the only country in the western Pacific region which relies on patients to finance childhood immunisations. Not surprisingly, many peasants now avoid such treatment.

State-owned enterprises once shouldered much of the responsibility for basic health care, including the running of their own hospitals. But with the collapse of many such businesses, workers have been left to fend for themselves. Private businesses are supposed to pay for medical insurance, but most do not bother.

The chronic underfunding of public health has created a culture of cynicism and corruption in China's hospitals. As well as having to pay up front before they are treated, patients frequently complain that in order to get good treatment they need to pay "red packets" (bribes) to doctors and nurses.

In the past year—goaded by the SARS outbreak—the authorities have stepped up their efforts to ensure that country people and the poor get access to basic health care. In the countryside, they have designated more than 300 counties (about 10% of the total) where a new "co-operative medical system" is being tried, with a plan to make it countrywide by 2010. Funding is shared between voluntary participants, the local authorities and the central government. In addition, a new insurance scheme, paid for by central and local governments, has been introduced for the poorest of urban and rural families to cover the cost of serious illnesses. The scheme is due to be implemented nationwide next year.

But both projects have serious drawbacks. Local governments are often unwilling to make the necessary contributions, especially in poorer areas. And individuals are often unwilling to pay for a service they feel they may not immediately need. For the past two decades, local governments have gouged farmers for contributions to an almost non-existent health-care system, with the money being used mostly to pay staff (many surplus to requirements or simply non-existent, with the money being used to line officials' pockets) rather than to pay for services. Consequently, there is reluctance to join any new scheme.

Can market forces provide the answer?

What other options does China have? Some officials, seeing the market as the panacea, suggest that the government should withdraw entirely and let prices be controlled by competition. In recent years, many township governments have sold off or leased their hospitals to private investors. But while in some cases the investment may have helped improve conditions, there is little evidence that the price of health care has fallen.

In the cities, a few hospitals have been built with private money, and businesses have taken over some of the hospitals that used to be run by state-owned enterprises. By 2005, state enterprises are supposed to cease their support for all hospital facilities. Some hospitals will be closed, others merged with bigger ones or sold off.

Privatisation remains controversial. Two years ago the central government tried to

limit the trend by decreeing that every township must retain at least one state-owned hospital. But many cities have pressed ahead with their own reforms without explicit approval from Beijing.

Xinxiang, a city in the central province of Henan, has engaged in the biggest sell-off, and one of the most controversial. Earlier this year it sold majority control of all of its five main hospitals to a single state-owned pharmaceutical company, China Worldbest Group. The government was happy to have reduced its health-care burden, and the Shanghai-based company was happy to have guaranteed outlets for its drugs. But what about competition? Many health-care specialists saw the move as the replacement of one overpriced monopoly by another, and the Shanghai government banned further such deals between drug companies and hospitals.

But there are signs that the central government is at last trying to adopt a more coherent policy for health-care reform. In early April, at its annual national conference on health-care issues, the Health Ministry circulated a secret draft of a policy paper outlining the respective roles of the government and the private sector in urban health care. Experts familiar with the document say it suggests that the government retain control of the main hospitals, but let second-tier hospitals be owned and operated privately. One expert estimated that this could involve the privatisation of 60% of urban hospitals. This would allow the government to increase its spending on the hospitals it keeps, thus reducing their financial dependence on charges for medicine and tests.

On the face of it this sounds a good idea. China's problem is not a shortage of medical facilities. It has a relative abundance of them: 1.6 doctors per 1,000 people compared with 0.4 in India, and 2.4 hospital beds per 1,000 people compared with India's 0.8. But this means that official resources are stretched too thin. Concentrating on key hospitals would enable the government to pay doctors a decent wage (though Chinese sources say that the document does not promise this will happen). At present a hospital director earns about the same as a company sales representative with a couple of years of experience. No wonder doctors are demoralised.

But if large numbers of people are still unable to afford treatment, such reforms will create a better system only for the affluent. In the long run, what China needs most is a health-insurance system that works. This should include insurance for private treatment (now non-existent), giving patients a bigger choice of facilities and stimulating private investment in hospitals. It would also need to ensure that those who contribute little or nothing to the system still get some coverage. In other words, the government needs to spend a lot more, particularly in the countryside and among rural migrants to the cities.

One reason why China's health-care system is in such a mess is that the central government's share of tax revenue has dropped in the past 20 years. But relying on local governments to do more will not work. At the township level, the majority are bankrupt. The central government needs to allocate more of its own money—and to force provincial governments (which like to go their own way fiscally) to make sure the allocations reach their intended targets.

Strong incentives, such as tax breaks, will be needed to encourage private business

to run hospitals on a not-for-profit basis. Although there has been considerable interest among foreign and domestic private investors, very few large-scale investments have been made because of regulatory uncertainty and questions over profit and pricing. The establishment of a handful of foreign-run hospitals in the big cities for the rich and well-insured are rare exceptions. In poor areas, including much of the countryside, the government will need to remain the primary provider.

Achieving this will involve changing priorities. Prestige projects may have to be abandoned. And there will have to be a fairer allocation of resources to address the current imbalance by which cities currently enjoy 80% of health resources despite having only 35% of the population. And to make sure it all works, there will need to be an effective system of oversight which China now sorely lacks. The idea of good corporate governance is novel enough in China, but in health care it is non-existent. A sea change is needed in everything from hospital management to the way central and local governments spend their money. Even so, slowly and reluctantly as it may be, China is beginning to discover that market forces alone cannot produce good health care.

Growing old before China's rich

But who is going to keep them well?