

China Health Bibliography Update

October 2004

EASHD---China Rural Health AAA

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- [Xinhua: Key Chinese drug firms see profits down in 2004](#)

All around the net: [news from Chinese websites](#)

Note: Below are selected results from PubMed using EndNotes (search terms: 2004/10/01:2004/10/29, China)

Chai, F. and R. Zhang (2000). "[Progress in the prevention and control of neonatal tetanus in China]." *Zhonghua Liu Xing Bing Xue Za Zhi* **21**(1): 58-60.

** Doak, C. M., L. S. Adair, et al. (2004). "The dual burden household and the nutrition transition paradox." *Int J Obes Relat Metab Disord*.

OBJECTIVE:: The purpose of this study is to document the prevalence of households with underweight and overweight persons (henceforth referred to as dual burden households) and their association with income and urban residence. The explorations by urban residence and income will test whether dual burden households differ from 'underweight only' and 'overweight

only' households, respectively. These comparisons are relevant to differentiating or adapting nutrition-related interventions wherever obesity and undernutrition cluster at the household level. POPULATION: Data analysis is based on national surveys conducted in Brazil, China, Indonesia, the Kyrgyz Republic, Russia, Vietnam and the United States. METHODS: All persons were first classified into categories for underweight and overweight, using body mass index (BMI) cutoffs, and then all households were categorized into four types: dual burden, overweight, underweight and normal. Income and urban residence were explored as key risk factors for being a dual burden household, with the effects modeled separately for each country. Multiple logistic regression was used to explore income and urban risk factors, controlling for household size, region of residence and either urban residence or income, as appropriate. RESULTS: In six of the countries studied, 22-66% of households with an underweight person also had an overweight person. Countries with the highest prevalence of dual burden households were those in the middle range of gross national product (GNP). The dual burden household is easily distinguished from the 'underweight only' households in Brazil, China, Indonesia, the United States and Vietnam. In these five countries dual burden households were more likely to be urban and more likely to be among the highest income tertile. There were no significant differences between dual burden and 'underweight only' households in Russia and the Kyrgyz Republic. In contrast, dual burden households were not easily distinguished from the 'overweight only' households in China, Indonesia, the Kyrgyz Republic, the United States and Vietnam. In Brazil and Russia dual burden households were more likely to be lower income and urban than 'overweight only' households. CONCLUSION: The prevalence of dual burden households presents a significant public health concern, particularly for those countries in the middle range of GNP. In some countries (China, Indonesia, the Kyrgyz Republic, the United States and Vietnam), dual burden households share sociodemographic profiles with overweight households, raising concerns for underweight individuals who may inadvertently become the focus of obesity prevention initiatives. For this reason, obesity prevention efforts should focus on messages that are beneficial to the good health of all, such as increasing fruit and vegetable intake, improving overall diet quality and increasing physical activity. *International Journal of Obesity* advance online publication, 26 October 2004; doi:10.1038/sj.ijo.0802824.

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** Eggleston, K. and W. Yip (2004). "Hospital Competition under Regulated Prices: Application to Urban Health Sector Reforms in China." *Int J Health Care Finance Econ* 4(4): 343-68.

We develop a model of public-private hospital competition under regulated prices, recognizing that hospitals are multi-service firms and that equilibria depend on the interactions of patients, hospital administrators, and physicians. We then use data from China to calibrate a simulation model of the impact of China's recent payment and organizational reforms on cost, quality and access. Both the analytic and simulation results show how providing implicit insurance through distorted prices leads to over/under use of services by profitability, which in turn fuels cost escalation and reduces access for those who cannot afford to self-pay for care. Simulations reveal the benefits of mixed payment and expanded insurance cover for mitigating these distortions.


** Liu, Y. (2004). "China's public health-care system: facing the challenges." *Bull World Health Organ* 82(7): 532-8.

The severe acute respiratory syndrome (SARS) crisis in China revealed not only the failures of the Chinese health-care system but also some fundamental structural deficiencies. A decentralized and fragmented health system, such as the one found in China, is not well-suited to making a rapid and coordinated response to public health emergencies. The commercial orientation of the health sector on the supply-side and lack of health insurance coverage on the demand-side further exacerbate the problems of the under-provision of public services, such as health surveillance and preventive care. For the past 25 years, the Chinese Government has kept economic development at the top of the policy agenda at the expense of public health, especially in terms of access to health care for the 800 million people living in rural areas. A significant increase in government investment in the public health infrastructure, though long overdue, is not

sufficient to solve the problems of the health-care system. China needs to reorganize its public health system by strengthening both the vertical and horizontal connections between its various public health organizations. China's recent policy of establishing a matching-fund financed rural health insurance system presents an exciting opportunity to improve people's access to health care.

Qian, H. and L. Tand (2000). "[Prevention and control of malaria in China, in last 50 years]." Zhonghua Liu Xing Bing Xue Za Zhi **21**(3): 225-7.

Watts, J. (2004). "Wheeling and healing." Lancet **364**(9441): 1205-6.

Full text : 

Wu, J., Y. Liu, et al. (2004). "Education-related gender differences in health in rural China." Am J Public Health **94**(10): 1713-6.

We investigated gender differences in education-related health inequalities in rural China. Household interview data were obtained from 6 provinces in 1993 and 2001. Remarkable health inequalities existed and favored the higher educational groups; among women, the inequalities were greater and health inequalities increased from 1993 to 2001. Education serves as a more powerful mediating factor for health inequalities among women than among men in rural China.

Yip, K. S. (2004). "Political dominance of mental health services in the People's Republic of China." Adm Policy Ment Health **31**(6): 495-502.

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

** Prime, P. B. (2004). "Funding Economic Transition in China: The Privatization Option." Eurasian Geography and Economics **45**(5): 382-94.

An American specialist on the economy of China examines whether gradual and partial privatization remains a viable option for the future, or whether rapid privatization of remaining state-owned enterprises is now necessary. The paper presents estimates indicating that rising expenditures stemming from changes in the country's economy, demographics, and technology will increase fiscal pressure on government revenues, resulting in fiscal shortfalls and exposing other vulnerabilities. Privatization is then assessed in terms of its potential to generate additional resources to support the next round of economic growth in China.

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

** Cook, I. G. and T. J. B. Dummer (2004). "Changing health in China: re-evaluating the epidemiological transition model." Health Policy **67**(3): 329-343.

This paper reviews the changing health Situation in China, which has shown remarkable improvement in the 50 years since the founding of the People's Republic of China (PRC) in 1949. At first sight this improving health Situation follows the classical epidemiological transition model. Just three decades ago health in China was characterised by high rates of infections disease and early mortality (diseases of poverty) in a mainly peasant society. More recently infectious disease rates have decreased, with corresponding and extended morbidity and mortality associated with an aging population in a rapidly Urbanising society. This process has given rise to new health

problems, including chronic and degenerative diseases (diseases of affluence). Nonetheless, while there is some validity in the application of the epidemiological transition concept, further analysis demonstrates that China faces a new epidemiological phase, characterised by increasing life expectancy and diseases of affluence Coupled with the emergence and re-emergence of infectious diseases. We demonstrate that China's state policy plays a major role in defining the parameters of health in a Chinese context. We conclude that, today, China is faced with a new set of health issues, including the impact of smoking hypertension, the health effects of environmental Pollution and the rise of HIV/AIDS; however, state policy remains vital to the health of China's vast population. The challenge for policy is to maintain health reform whilst tackling the problems associated with rapid Urbanisation, widening social and spatial inequalities and the emergence of HIV/AIDS and other infectious diseases. (C) 2003 Elsevier Ireland Ltd. All rights reserved.

** Ekman, B. (2004). "Community-based health insurance in low-income countries: a systematic review of the evidence." Health Policy and Planning **19**(5): 249-270.

Health policy makers are faced with competing alternatives, and for systems of health care financing. The choice of financing method should mobilize resources for health care and provide financial protection. This review systematically assesses the evidence of the extent to which community-based health insurance is a viable option for low-income countries in mobilizing resources and providing financial protection. The review contributes to the literature on health financing by extending and qualifying existing knowledge. Overall, the evidence base is limited in scope and questionable in quality. There is strong evidence that community-based health insurance provides some financial protection by reducing out-of-pocket spending. There is evidence of moderate strength that such schemes improve cost-recovery. There is weak or no evidence that schemes have an effect on the quality of care or the efficiency with which care is produced. In absolute terms, the effects are small and schemes serve only a limited section of the population. The main policy implication of the review is that these types of community financing arrangements are, at best, complementary to other more effective systems of health financing. To improve reliability and validity of the evidence base, analysts should agree on a more coherent set of outcome indicators and a more consistent assessment of these indicators. Policy makers need to be better informed as to both the costs and the benefits of implementing various financing options. The current evidence base on community-based health insurance is mute on this point.

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** Gustafsson, B. and L. Shi (2004). "Expenditures on education and health care and poverty in rural China." China Economic Review **15**(3): 292-301.

Household health and education expenditures have increased rapidly in rural China. Based on data from households in 18 provinces in 1988 and in 1995, we investigate how such expenditures affect poverty assessments. After accounting for these expenditures, we cannot state that poverty decreased during this period of rapid economic growth. Further, poverty in China in 1995 appears to be even more concentrated in the west and in officially designated poor areas when education and health expenditures are considered. (C) 2003 Elsevier Inc. All rights reserved.

Lee, L. M. (2004). "The current state of public health in China." Annual Review of Public Health **25**: 327-339.

In the past 50 years, China has made great achievements in controlling infectious diseases and improving the public's health and hygiene. However, in the twenty-first century, owing to the negative effects brought on by aging of the population and the burdens of diseases, urbanization, industrialization, and globalization, Chinese public health officials are encountering greater difficulties than ever. Old operating models of public health cannot meet present requirements. The main problems are poor capacity to respond to public health emergencies, severe inequality of health care services, and lagging development of public health information systems. Public health in China can gradually meet the requirements of social development and

the increasing public demand for health care services only when the public health is directed by informatization, globalization, technification, and humanization.

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** Li, S. Z., C. Z. Zhu, et al. (2004). "Gender differences in child survival in contemporary rural China: A county study." Journal of Biosocial Science **36**(1): 83-109.

Using data from a survey of deaths of children less than 5 years old conducted in 1997 in a county in Shaanxi Province, China, this paper examines gender differences in child survival in contemporary rural China. First, excess female child mortality in the county in 1994-96 is described, followed by an analysis of the mechanisms whereby the excess mortality takes place, and the underlying social, economic and cultural factors behind it. Excess female child mortality in this county is probably caused primarily by discrimination against girls in curative health care rather than in preventive health care or food and nutrition. Although discrimination occurs in all kinds of families and communities, discrimination itself is highly selective, and is primarily against girls with some specific characteristics. It is argued that the excess mortality of girls is caused fundamentally by the strong son preference in traditional Chinese culture, but exacerbated by the government-guided family planning programme and regulations. This suggests that it is crucial to raise the status of girls within the family and community so as to mitigate the pressures to discriminate against girls in China's low fertility regime. Finally, the possible policy options to improve female child survival in contemporary rural China are discussed.

Zimmer, Z. and J. Kwong (2004). "Socioeconomic status and health among older adults in rural and urban China." Journal of Aging and Health **16**(1): 44-70.

Objectives: The association between socioeconomic status (SES) and health, which has proven to be quite robust, is rarely tested in societies where levels of economic development and systems of stratification differ from those in Western developed countries. This article examines associations in rural and urban China. Method: Techniques include logit equation estimates of separate and pooled samples. The latter employ interaction terms to test rural and urban effects. Socioeconomic indicators include those more customarily used in these types of studies (e.g., education) and several that are less traditional (e.g., pension eligibility). Results: Results indicate associations exist in China. Bank savings is the strongest predictor. Some unexpected results are also found, including a positive association between socioeconomic status and chronic conditions (e.g., cardiovascular disease) among older adults in urban China. Discussion: Use and access to a health care professional might explain part of this anomaly.

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Note: Below are selected search results from Factiva using search builder for news dated Oct. 1-30. 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

Poor Regulation and Fake Medical Products in China Cause Widespread Death and Hospitalisations

Amit Chanda
280 words
29 October 2004
WMRC Daily Analysis
English

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The Beijing Morning Post newspaper reported today that ineffective regulation and largely absent supervision of domestic pharmaceutical product quality in **China** resulted in 190,000 deaths and around 2.5m hospitalisations within a 12-month period. A major part of the problem is thought to stem from the complexity of new drugs on the market, and the traditional tendency of Chinese consumers to self-administer medicines. As Zhang Heyong, head of the **China** Non-Prescription Drug Association, told state media, 'Pharmacies must protect consumers when they buy drugs... and pass on medical knowledge in order to make medicines more safe'. According to surveys, only around 30% of Chinese consumers have a clear knowledge of the non-prescription medication they take, while 70% rely on past experiences when self-administering non-prescription drugs.

Pirated medicines are also partly to blame for the high number of casualties; drugs that have been illegally manufactured or packaged as brand-name products continue to mislead consumers and threaten their **health**. Zheng Xiaoyu, head of the State Medical Products Supervision Commission, said that 'there are all kinds of fake, dangerous and low quality medical products; not only are there fake herbal medicines, but also medicinal precursors and medical instruments, as well as well-known domestic brand medicines'.

Significance: In addition to being a major trade issue with large pharmaceutical goods producers such as the US and European Union (EU), **China's** apparent inability to eradicate the manufacture and distribution of dangerous pirated drugs is also exacting a substantial human toll, while increasing the strain on an already creaky national healthcare system.

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Urban Chinese' disposable income up 7% in 1st 3 quarters

164 words

28 October 2004

Business Daily Update

English

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China's per capita disposable income of urban residents stood at 7,072 yuan (US\$850) in the first three quarters of 2004, up 7 percent in real terms from last year, said a report from the National Bureau of Statistics Wednesday.

Statistics showed that the urban dwellers' average wage income rose by 11.8 percent year-on-year to 5,364 yuan (US\$646). During this period, Chinese people earned 54.5 percent more from house lease over a year earlier, or an average of 65 yuan (US\$7.8).

Meanwhile, Chinese urban residents spent more. The per-capita spending went up 10.9 percent year-on-year to 5,373 yuan (US\$647), up 6.5 percent in real terms.

Urban dwellers spent 40 percent more in transportation compared to a year earlier. During this period, their per-capita expenses for **health** care products went up 41 percent over a year earlier.

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Chinese rural dwellers get better medicare service

490 words

25 October 2004

Business Daily Update

English

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The outbreak of severe acute respiratory syndrome (SARS) early last year propelled the government to accelerate the pace in rebuilding a rural medical network. The government set a deadline of eight years for completion.

Under the government scheme, a villager only needs to pay an average of 10 yuan for medicare insurance. The central government and local government each pays additional 10 yuan for it respectively. The sum of 30 yuan will be deposited in the pool of a so-called rural cooperative medicare fund. In case of illness, a villager who has joined the fund can be hospitalized and has part of his/her medical expenses covered by the fund.

Farmers are asked to join the cooperative medicare program on a voluntary basis.

Niu Huimin, deputy director of the **Health** Bureau of Qinghai Province, cited a survey as saying that among Qinghai's farmers and herdsman who had fallen ill, 40 percent did not have money to see a doctor. Thirty-eight percent borrowed money for medical fees and as high as 56 percent were pulled back into poverty due to illness.

"By covering part of their medical expenses, the new medicare cooperative system could largely ease rural people's worry of illness," he said.

Qinghai Province began its pilot of the cooperative medicare scheme in August 2003. By the end of that year, 866,500 people joined the fund. To September this year, the province reimbursed a total of 12.34 million yuan to 91,387 villagers and herdsman.

"Beside the direct benefits to local people, the cooperative medicare scheme also effectively boosted the development of local medical services," Niu said.

Citing Gangca County as an example, Niu said the proportion of births attended by trained **health** workers in the county increased to 81.96 percent during the first six months of 2004, up from 65 percent in 2002. The number of patients who visited clinics and were hospitalized increased 39.9 percent and 97.6 percent respectively.

As a matter of fact, while being quite positive to the new pilot system, the Chinese government also appeared to be very cautious. President Hu Jintao and Premier Wen Jiabao urged local **health** authorities to be fully aware that the pilot was an "arduous and complicated" reform.

Nie Chunlei, deputy director of the rural **health** department under the **Health** Ministry, said **China's** rural areas covered large territory and the people's demands for medical services varied greatly.

"The central government has laid out the major principles and framework of the new

cooperative medicare system, under which various localities experiment the patterns that are most applicable to their conditions," he said.

The latest statistics showed that by the end of last June, the new cooperative medicare system had covered areas with 95.04 million residents, among whom 68.99 million joined the system. The cooperative medicare fund had reached 3.02 billion yuan.

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Wu: Rural healthcare gets much better

442 words

25 October 2004

Business Daily Update

English

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Vice-Premier Wu Yi said at the weekend that the nation's efforts to build a co-operative healthcare system in rural areas had started to pay off, with improved healthcare, better facilities and lower costs.

Wu made the remarks at a two-day national meeting in Beijing on rural co-operative healthcare.

Wu urged officials at all levels to fully recognize and solve the problems concerning the pilot work for co-operative healthcare.

Under the pilot system, each villager contributes 10 yuan (US\$1.25) each year, while the central and local government both contribute 10 yuan (US\$1.25) per person to a fund, which reimburses members' medical costs.

In case of illness, a farmer recruited into the network will have part of their medical expenses paid by the fund.

China started to set up a co-operative healthcare system last July to enable its 900 million rural residents to receive basic medical care services.

The government has set a deadline of eight years for its completion.

Each province and autonomous region has selected two or three counties for the trial project and farmers are asked to join the co-operative healthcare programme on a voluntary basis.

Despite the achievements, some problems still exist, Wu added. She said some local authorities did not carry out the central government's policies effectively.

Wu added that the majority of the pilot counties had yet to established a reasonable mechanism for collecting funds from farmers and some of the funds had been used improperly.

She urged local governments and officials to solve the existing problems and improve the pilot programme to create a good base for its national operation.

The pilot counties have all welcomed the new system.

Northwest **China's** Qinghai Province began its co-operative healthcare pilot in August 2003.

By the end of that year, 866,500 people had joined the fund. The province had paid a total of 12.34 million yuan (US\$1.5 million) to 91,387 people by September this year.

Niu Huimin, deputy director of the **Health** Bureau of Qinghai Province said that by covering part of their medical expenses, the new healthcare system could largely ease rural people's fear of illness.

In Midu County in Southwest **China's** Yunnan Province, the healthcare network helped residents save more than 5 million yuan (US\$604,595).

According to the White Paper on **China's** Social Security and Its Policy, by the end of June this year, the new co-operative healthcare network had covered areas with 95.04 million rural residents, among whom 68.99 million joined the system.

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China to Invest CNY1bn in Developing Rural Health Service System

131 words

21 October 2004

SinoCast China Business Daily News (Abstracts)

Page 1

English

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CHINA, October 21, SinoCast -- The Chinese Government will invest CNY 1 billion, raised from government bonds, for starting up the rural **health** service system.

The investment will be mainly applied to the construction of **health** centers in the state new rural cooperative medical pilot counties, HIV synthesis prevention demonstration counties, and major schistosomiasis epidemic-stricken counties, which has been approved by the State Council.

The government will select and reconstruct some rural **health** centers with a high proportion of service dilapidated houses or lack of service houses.

The construction mainly adopts national bonds and requires all concerned provincial governments to arrange the budget.

In principle, the investment in western provinces accounts for 20% while that in central provinces accounts for 30%.

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China: Cancer county

961 words
19 October 2004
Straits Times
English
(c) 2004 Singapore Press Holdings Limited

Polluted water from the Huai River has poisoned thousands, many dying of cancer
Tschang Chi-Chu China Correspondent In Shenqiu County (Henan)

FARMER Wang Ziqin lost his two brothers to oesophageal cancer in the space of a month earlier this year. His younger brother, Ziling, died 27 days after their older brother, Zizhong.

Mr Wang, his wife, their six children and four grandchildren have managed to avoid cancer because he has dug four wells since 1975, each one deeper than the last, to draw the water they need for cooking, drinking, bathing and washing their clothes.

His hometown of Dongsunlou is one of **China's** notorious 'cancer villages', where people have been poisoned by contaminated water from the Huai River, even though there are no factories nearby.

When the government began digging a network of canals from the Huai River's largest tributary, the Shaying River, decades ago, the benefits of irrigating the county's 500-plus villages seemed obvious.

That is no longer the case.

'Before, the water was clear. You could see to the bottom,' the 63-year-old farmer said, pointing to the water basin in front of his house. 'In the past couple of years, the water has turned black.'

Paper-making, tanning and chemical fertiliser factories have for decades been dumping untreated waste into the Huai River.

This has turned the water-diversion projects from a blessing into a cancer curse.

Said Dr Wang Yongzeng, director of Shenqiu County Hospital's internal medicine division: 'In the past several years, as pollution of the river became worse, the frequency of tumours arising in villagers living along the river has increased, and it is affecting them at a younger age.'

No figures for cancer-related deaths in Shenqiu county, where some of the unlucky villages are located, are available. However, some villages in the county have begun tabulating the number of cancer deaths since 1990.

In Dongsunlou village alone, 57 residents out of 1,500 have died from oesophageal cancer.

In the neighbouring village of Huangmengying, 114 residents out of 2,466 have died from cancer, while another 100 villagers have been diagnosed with cancer since 1990.

The 'cancer village' phenomenon is not limited to the central province of Henan. Other 'cancer villages' have been identified in the southern provinces of Guangdong and Jiangsu, where the water is also polluted.

The term 'cancer village' is a bit of a misnomer, as the villagers exposed to the contaminated water also suffer from other symptoms like fainting, nausea, skin irritation and infertility, even if they are not cancer-stricken.

'Public **health** is so inextricably linked to the overall prosperity of the nation - and cuts across so many different sectors - that any government ignores it at its peril,' said Mr Henk Bekedam, the World **Health** Organisation's representative in **China**.

Water is one precious resource that **China** can ill afford to waste or contaminate. Already, two-thirds of the country's 699 cities are short of water.

In northern **China**, hundreds if not thousands of lakes and rivers have dried up.

Drought and overuse have shrunk the Yellow River, causing the 'mother of Chinese civilisation' to dry up before reaching the sea every year since 1985.

What little water there is left may not be safe for consumption.

Around half of **China**'s 1.3 billion people drink water contaminated with levels of animal and human waste that do not meet consumption standards, according to the State Environmental Protection Administration.

The agency said that only a quarter of the country's 21 billion tonnes of annual output of household sewage is being treated.

The remainder of the untreated waste water often seeps into rivers or ground water.

'The Chinese government wants to attract foreign investment into this industry to build enough waste-treatment facilities in **China**,' said Mr Xu Jie, industry manager of Frost and Sullivan consulting firm's industry and chemical practice in Shanghai.

'They don't have enough facilities to treat the sewage and that causes a lot of problems.'

China would need to build 10,000 waste-treatment plants just to treat half of the 3.7 billion tonnes of daily sewage being pumped into the water, Frost and Sullivan estimates.

Mr Eric Oh, the chief financial officer of Singapore-listed waste and wastewater treatment company Asia Environment Holdings, told The Straits Times: 'The market potential is very great.'

The Huai River, which provides water to 150 million people in Henan, Anhui, Jiangsu and Shandong provinces, is the most polluted among the country's seven major river systems today.

According to chemical oxygen demand (COD) laboratory tests of water samples taken from an 8m-deep well in Huangmengying village, the nitrate nitrogen level in the water was three times higher than **China**'s sanitary drinking-water quality

standards.

When raw sewage undergoes a chemical change, one of the end products is nitrate nitrogen.

An abnormal amount of nitrate nitrogen in drinking water is an indication of pollution.

While there is no conclusive evidence that nitrate in drinking water causes cancer, nitrates can react with amines or amides in the body to form nitrosamine, which is known to cause cancer.

In a country where 900 million peasant farmers are without **health** care, cancer not only kills the victim, but also destroys his family's hopes of climbing out of poverty.

Mr Wang's older brother, Zizhong, borrowed and spent 10,000 yuan (\$2,070) on medical fees before dying.

His son inherited the debt.

Shenqiu County Hospital's Dr Wang estimates that only 10 to 20 per cent of the cancer patients around the area seek any kind of treatment for cancer.

The rest just wait at home - for death.

TOMORROW CHINA TRIES TO FIGHT POLLUTION

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Urban Health; Chinese study finds most city dwellers in poor health, educated most at risk

637 words

17 October 2004

Medical Letter on the CDC & FDA

English

(c) Copyright 2004 Medical Letter on the CDC & FDA via NewsRx.com

2004 OCT 17 - (NewsRx.com & NewsRx.net) -- Up to 75% of all urban Chinese suffer from ill **health**, and life expectancies are declining for skilled and educated workers as modern lifestyles exact a deadly toll, according to a study by the Chinese Red Cross.

The survey of 16 Chinese cities with more than 1 million people found that 75% of Beijing residents were in poor **health**, along with 73% of those in Shanghai and the southern city of Guangzhou, the state-run newspaper Shanghai Daily reported September 20, 2004.

The findings illustrate a darker side of **China's** economic success story: deteriorating public **health** and a decline in well-being for many Chinese, even in the country's richest cities.

The Red Cross study defined poor **health** or "sub **health**" as illness causing reduced

levels of energy and fitness but with no specific diagnosis of a disease.

The problem was worst among senior and mid-level managers and well-educated white-collar workers, it said.

"Bad working habits, poor disease prevention, inadequate government funding and lack of **health** education are the main reasons," it quoted Yang Xiaoduo, a healthcare expert, as saying.

Death rates among the elite are rising, largely due to poor **health** habits, lack of exercise and stress.

The Chinese Academy of Sciences reports that the average life span of an educated person is 58, more than 10 years lower than the national average of 72 years.

A separate study found that among the 380,000 information technology professionals working in Zhongguancun, Beijing's equivalent of Silicon Valley, the average life expectancy was only 53 years, five years lower than a decade ago, the official Xinhua News Agency reported September 20, 2004.

It cited rising rates of lung cancer, cardiovascular illness, respiratory illness and strokes.

Economic losses from disease are as high as 400 billion yuan (US\$48 billion) a year, the Shanghai Daily said, citing government figures.

Various trends are contributing to the problem.

Urban Chinese are getting gaining weight as they switch from diets heavy in vegetables and staple grains to much higher consumption of fats, meats and sugar. Physical labor has given way to more sedentary work, and stress levels are rising as workers lose cradle-to-grave employment and struggle to make ends meet in a competitive job market.

Meanwhile, **China's** industrial boom and soaring number of vehicles have spoiled water and air to the point where its cities are among the worst polluted in the world, and respiratory diseases are the No. 1 cause of early death.

Although Shanghai has claimed progress in cleaning up its notoriously noxious Suzhou Creek, upstream canals remain heavily polluted. Most waterways are unsafe for drinking, and some are not fit even for agricultural use.

The population of cities is also aging quickly, raising the percentage of people more likely to be suffering from chronic diseases such as diabetes and heart problems.

In Shanghai, 19% of the population is over 60 years old. However, by 2030, half the population will be at least 65, the government recently reported.

The government once touted the country's broad provision of basic services, such as medical care and education, as obvious benefits of Communist Party rule. But for many, those services have been dismantled.

Farm families in the countryside can no longer count on "barefoot doctors" for basic

health services. And although city dwellers have access to the country's best medical facilities, the lack of a comprehensive **health** insurance system means that many cannot afford medical care.

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Sales of medical instruments in China grows 14 percent annually

270 words

15 October 2004

Xinhua's China Economic Information Service

English

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BEIJING, October 15 (CEIS) – Sales of medical apparatus on Chinese market top 54.8 billion yuan a year at present, according to official statistics.

Annual sales of high-tech medical instruments are about 10 billion yuan at present and are still growing at an annual rate of 14 percent. To be specific, annual sales of CT products are about 1.6 billion yuan; that of magnetic resonance products, 1.2 billion yuan; that of ultrasonic products, 2 billion yuan; that of X-ray product, 2 billion yuan; and that of patient monitoring and bio-chemical analytic testing equipment, about 1.5 billion yuan.

Following is market demand prediction for some high-tech medical instruments in **China**:

Digital CT scanner: there are over 3,000 sets in **China** at present, of which over 60 percent are second-hand. **China's** market demand for the product stands around 20,000.

Color ultrasonic diagnosing instrument: there are 5,000 sets in **China** at present, and the market demand stand at 40,000sets.

Magnetic resonance installation: **China** has imported 300, and its market capacity should be at least 3,000 sets.

Digital X-ray equipment: there are 100,000 sets in **China** at present.

According to experts, there will be four growth points in medical instrument sector in the future, namely computer related technology; household and self **health**-care apparatus; minor injury medical apparatus; and human organ transplanting and auxiliary medical apparatus. It is learned that **China** will increase its support to medical instrument industry, and several R&D bases have been completed.

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Beijing signs framework to guarantee migrant workers' legal rights - report

190 words

15 October 2004

AFX Asia

English

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Beijing signs framework to guarantee migrant workers' legal rights - report BEIJING (XFN-ASIA) - The governments of Beijing and the northeast province of Heilongjiang have signed an unprecedented framework agreement guaranteeing the legal rights of migrant workers from the province in an attempt to alleviate the serious labor shortage in the capital, the **China** Daily reported. The agreement deals with the protection of migrant workers' employment rights, timely payment of wages, working hours and environment, **health** conditions and social security, the paper said. Other provinces are expected to sign similar agreements, the paper added.

There are currently more than 3 mln migrant workers in Beijing, of which nearly 120,000 are from Heilongjiang, the paper said.

However, the capital needs over 50,000 workers to fill vacancies in the construction, security, housekeeping and hotel industries.

Low wages, harsh conditions and rising rural incomes have been blamed for a chronic labor shortage in the booming eastern and southern provinces as farmers choose to stay home rather than move to the cities to find work.

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NTU to train China hospital managers

223 words

15 October 2004

Business Times Singapore

English

(c) 2004 Singapore Press Holdings Limited

THE Nanyang Technological University (NTU) and **China's** Ministry of **Health** have sealed an agreement to provide education programmes for **China's** senior hospital management staff.

Under the agreement, NTU will provide a customised Executive Master of Business Administration Program (EMBA) in hospital management for senior staff in **China's** hospitals.

The EMBA, taught mostly in Mandarin by a team of bilingual faculty members from the Nanyang Business School (NBS), will cover hospital administration, finance, logistics, service quality, information technology and other areas in modern hospital management.

Participants will also observe first-hand and study the running of Singapore hospitals. NBS plans to conduct shorter executive programmes in specialised areas for senior managers from major general hospitals at the provincial level.

In all, some 500,000 Chinese hospital managers will undergo the NBS programmes.

The agreement between **China's** MOH and NTU was signed in Beijing recently by Li Feng, director of human resource training at MOH, and Hong Hai, NBS' dean.

An NTU press statement yesterday said NTU was selected as one of a small group of universities, and the only one from Asia, to collaborate in this project.

Singapore's success in dealing with the Sars crisis was one of the factors that led China to pick NBS from among Asia's leading business schools.

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China acts to resolve nutrition imbalance

470 words

14 October 2004

Business Daily Update

English

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China is drafting a new national non-communicable diseases prevention and control programme, a senior official has revealed.

Drafting of the programme is being hastened by a report of a national survey on the status of nutrition and **health** of Chinese people, which was released yesterday.

The report shows **China** continues to face the twin challenges of nutrition deficiency and nutrition imbalance, as well as a rapid increase in non-communicable diseases.

China will promulgate relevant regulations, guidance about public nutritional intervention, agriculture, food manufacturing, distribution and marketing, said Vice-Minister of **Health** Wang Longde.

Wang made the remarks at a press conference yesterday held by the Information Office of the State Council.

It is estimated that more than 160 million people are currently suffering from hypertension in **China**, which also has more than 20 million diabetic patients, 200 million overweight people and over 60 million obese residents.

Moreover, all these chronic diseases are increasing at a rapid rate due to unhealthy lifestyles, such as the intake of too much fat and too little exercise.

The energy contribution from fat reached 35 per cent in 2002, exceeding the World **Health** Organization's recommended upper limit of 30 per cent.

In contrast, the energy contribution from cereals among urban residents is only 47 per cent, which is significantly lower than the recommended range of 55 to 65 per cent.

Moreover, the deficiency in micro-nutrients such as iron and Vitamin A is a common problem among urban and rural populations.

China seriously lacks nutritionists, Wang said, and his ministry is drafting relevant

regulation on the management of this sector.

"Another very important area of work for us is to increase public awareness on the scientific intake of food and nutrition both in urban and rural areas," Wang said.

In rural areas, the problem is not only related to the lack of nutrition caused by poverty, but is also the result of the serious lack of necessary knowledge, Wang noted.

For example, many farmers should be able to get enough nutrition but do not know how to do so properly.

Wang said he once witnessed in a village that many mothers sold eggs at the market in order to buy sugar or chocolate for their children.

Moreover, there is a great shortage of Vitamin A in rural areas. However, it is very easy for farmers to get carrots, which are a very good source of vitamins.

"**China** has entered into a very vital period of nutrition intervention as its economy develops rapidly, otherwise, we will follow in the footsteps of some developed countries," Wang warned.

The ratio between obesity and the overweight population is three to one, which means that a lot of people are expected to suffer obesity, the most dangerous factor in chronic diseases.

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China to conduct first nationwide survey on AIDS epidemic

379 words

14 October 2004

Agence France Presse

English

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BEIJING, Oct 14 (AFP) - **China** will conduct the first-ever nationwide survey to learn the extent of an AIDS epidemic from blood selling, demanding local governments find and test every person who sold blood, officials said Thursday.

The Ministry of **Health** issued an order Wednesday requesting provinces and cities throughout **China** carry out a comprehensive search to "fully grasp" who sold blood and test them for the HIV virus.

"Not one person should be missed," said a notice posted on the ministry website. It added that the survey comes at a time when the country's AIDS situation is "critical".

"Those who became infected with the virus by selling blood around 1995 have entered the peak of symptoms and death," it said.

"A growing number of AIDS cases involving blood sellers have been exposed in some regions which were not previously regarded as being seriously affected. At the same time, there are still some areas where HIV-positive blood sellers remain

undiscovered."

Detecting and treating the infected, many of whom were poor farmers desperate for income, was an "urgent task... without immediate anti-retroviral therapy, they will die in a short period of time," it said.

The ministry said in its notice that every local government must present a report by April 15, 2005 with a database on which residents in their jurisdiction have sold blood.

The blood sellers would then be tested for the HIV virus, the ministry said, adding that their privacy would be protected.

China says it has an estimated 840,000 HIV/AIDS patients, of which some 20 percent are believed to have been infected through unsanitary and often illegal blood buying schemes.

International activists say the real figure is probably much higher, with the United Nations and even government officials saying there could be 10 million cases by 2010 if the epidemic goes unchecked.

Independent **health** workers in the hardest hit province, Henan, said there could be one million people who sold blood and contracted HIV in that province alone.

The blood-selling schemes, carried out in many provinces, were endorsed by the government. Chinese leaders in the past year have finally begun seriously addressing the problem after initially ignoring it.

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Business Update; Healthcare products company opens offices in China

360 words

11 October 2004

Health & Medicine Week

English

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2004 OCT 11 - (NewsRx.com & NewsRx.net) -- Hans Wijers, CEO of Dutch multinational Akzo Nobel, announced the setting up of a new regional head office in Shanghai.

The decision to establish a new base in the city marks another milestone in the company's ongoing efforts to consolidate its activities in one of the world's most important emerging markets. "We more than doubled our sales in **China** in less than 5 years and our ambition is to repeat that," said Wijers. "We are strongly committed to further expansion in **China**, which has a key role in the company's growth strategy.

In the space of just 10 years, Akzo Nobel has strengthened its presence in **China** considerably. This expansion has seen the company surge from a position where it imported products through five representative offices to the stage where it is now a dedicated organization with around \$500 million in sales and runs more than 20

Chinese operations employing 3000 people.

Nearly all of Akzo Nobel's businesses have some active involvement in **China**, where nearly 70% of all locally manufactured goods are sold in the country itself. Bearing this in mind, **China** has become an important strategic region for the company.

"Our approach with regards to **China** and its enormous market potential is based on the firm strategy Akzo Nobel follows across the globe," added Wijers. "We are actively obtaining leadership positions in selective markets in healthcare products, coatings and chemicals.

"We look for market segments with attractive structural profitability and we are developing the necessary critical mass to play a significant role in our industries. Our entrepreneurial way of doing business is the best way to encourage further growth, and our continued expansion in **China** will be accelerated by directly serving the fast-growing Chinese market," Wijers said.

"The new Shanghai office will play a vital role in supporting our businesses in this important part of the world," Wijers said.

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China: Healthcare and pharmaceuticals background

2,921 words

10 October 2004

Economist Intelligence Unit - Executive Briefing

Executive Briefing

English

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FROM THE ECONOMIST INTELLIGENCE UNIT

Background articles provide a concise overview of an industry in a particular country. They are designed to brief senior executives on key local players, on demand and consumption, and on supply and production. They are complementary to our industry forecasts, which provide the Economist Intelligence Unit's five-year forecasts for the industry in question.

	1998(a)	1999(a)	2000(a)	2001(a)	2002(a)	2003(a)
Life expectancy, average (years)	70.3	70.5	70.7	71.0	71.3	71.6
Life expectancy, male (years)	69.0	69.2	69.4	69.6	69.9	70.1
Life expectancy, female (years)	71.8	72.0	72.1	72.5	72.9	73.3
IMR (per 1,000 live births)	32.4	31.3	30.3	28.9	27.6	26.4
Healthcare spending (% of GDP)	–	–	5.1	5.2	5.4	5.5
Healthcare spending (US\$ bn)	–	–	55.4	60.7	68.7	80.3
Healthcare spending (US\$ per head)	–	–	44	48	53	62
Physicians (per 1,000 population)	1.6	1.7	1.7	1.7	1.5	1.4
Pharmaceutical sales (US\$ m)	4,630	5,185	6,191	6,872	7,484(b)	8,442(b)

(a) Actual. (b) Economist Intelligence Unit estimates.

Sources: US Census Bureau; Economist Intelligence Unit.

Overview

Like most other economic and industrial indicators, spending on healthcare in **China** has risen rapidly in recent years, reaching Rmb568.4bn (US\$68.5bn) in 2002 (latest available data), up from Rmb458.7bn in 2000 and just Rmb74.7bn in 1990. The rate of increase in healthcare spending has been even greater than that of the overall economy, with the result that by 2002 medical expenditure was equivalent to 5.5% of GDP, up from 5.1% of GDP in 2000 and 4% of GDP in 1990. The sharp increase in spending has been accompanied by an improvement in **health** indicators. Between 1981 and 2000 average life expectancy rose from 67.9 years to 71.4 years, and the infant mortality rate fell from 34.7 per 1,000 births to 28.4.

Still, despite the sharp rise recorded in recent years, healthcare spending in **China** remains low in international terms: most OECD countries spend around 8% of GDP on healthcare. The improvements in healthcare have also been uneven, with the results being much more dramatic in towns and cities than in rural areas. This has not just been because personal incomes in **China** have been rising much more rapidly in towns and cities than in the countryside. Government policy has also played a part, with officials in recent years allowing the already skeletal healthcare system in rural areas to begin to fall apart.

The outbreak in 2003 of Severe Acute Respiratory Syndrome (SARS) is expected to give new impetus to the government's attempts to improve the quality of rural healthcare. SARS was quickly brought under control, but in 2004 **China** reported an outbreak of bird flu (although no human cases were reported). Other particular **health** challenges facing **China** include HIV/AIDS and also smoking-related diseases—more than 300m people, including a rising number of women, smoke in **China**.

Healthcare system

According to the Ministry of **Health**, **China** had almost 300,000 **health** centres in 2003. Almost two-thirds of these were outpatient facilities, but there were also nearly 18,000 hospitals and 45,000 **health** centres. Foreign investment in healthcare facilities has been permitted since 1991 but is only possible through joint ventures with local partners, and most ventures to date have been small outpatient clinics that tend to target the expatriate community. That around 50% of **China**'s medical centres are run on a profit-making basis is therefore the result of domestic changes rather than an influx of foreign investment. The growth of the commercial sector might explain why out-of-pocket expenditure on healthcare by individuals has been rising so rapidly in recent years. Personal expenditure on healthcare totalled Rmb331.7bn in 2002, accounting for almost 60% of total medical spending in **China**, up from Rmb26.7bn in 1990, or just 35% of the total.

The rise in the number of profit-making hospitals and the increase in individual spending on healthcare reflect reform of the official urban healthcare system, in which responsibility for financing has been shifted from the government and state-owned enterprises on to individuals. Historically, **China**'s urban healthcare system centred on government units and state-owned enterprises (SOEs). Government units were required to set aside 11-14% of wages for a Government Insurance Scheme (GIS) to cover medical costs, while large SOEs had to make contributions to a Labour

Insurance Scheme (LIS, to which smaller SOEs could make contributions to on a voluntary basis). According to the Chinese Medical Association, a government-sponsored professional organisation, these schemes ensured that almost 50% of the urban population had access to free or heavily subsidised medical care.

This system suffered from cost inflation, and in any case began to break down as economic reforms led to more and more people working outside the state sector (by 1998 GIS and LIS covered just 39% of the urban population). In its place, local governments have begun to institute a basic medical insurance system, of which the costs are shared by employers, employees and the government. In Shanghai this new system has two elements, a Unified Plan and a Medical Savings Account (MSA). The first part of this scheme reportedly covers in-patient costs, emergency room stay, and the cost of treatment of catastrophic illness up to Rmb56,000 (US\$6,700). Coverage provided by the MSA depends on patient age, income and employment status. The entire system is funded through contributions by employers (12% of salary) and employees (2%). The exact details of the official urban insurance system vary across **China**, as does coverage: at the end of 2003 only 100m people out of a total urban population of over 520m were covered by the scheme.

Private medical insurance schemes are also becoming available in **China**: the value of **health** insurance premiums rose from Rmb4.1bn in 1999 to Rmb24.2bn in 2003. This increase has been driven in part by the expansion in **China** of foreign insurance companies. The growth of this sector has, however, been restricted by urban incomes that remain low on average. There is also a lack of uniformity in hospital billing procedures and medical costs, which has made insurance firms cautious when extending coverage.

At its peak in the 1970s, a Co-operative Medical System, operated by the communes, provided basic healthcare services to 90% of rural dwellers. However, with the disappearance of the communes, the system has largely broken down, leaving most of the rural population with the prospect of financing all healthcare costs out of their own pockets. Few can afford to do so, and as a result healthcare expenditure per head in rural areas was little more than Rmb200 in 1999, compared with nearer Rmb650 in urban areas (in 1990, by contrast, healthcare expenditure per head in both urban and rural areas had been under Rmb200). In recent years the paucity of medical care in rural areas has begun to attract more government attention. This is because of official concern about the general underdevelopment of the countryside, and also because of the outbreak of SARS in 2003—an epidemic which would have been much more difficult to control if it had spread much beyond the confines of **China**'s cities.

	1998(a)	1999(a)	2000(a)	2001(a)	2002(b)	2003(b)
Nominal GDP (US\$ bn)	946	991	1,081	1,176	1,266(a)	1,447(a)
Population (m)	1,248	1,258	1,267	1,276	1,285	1,292
GDP per head (US\$ at PPP)	3,341	3,630	3,960(b)	4,329(b)	4,722	5,224
Private consumption/head (US\$)	357.5	377.8	408.8	434.5	456.5	488.8
Number of households (m)	323.8	331.1	338.2	345.3	351.4(a)	358.1

(a) Actual. (b) Economist Intelligence Unit estimates.

Source: Economist Intelligence Unit.

Pricing

Item	Price (US\$)	% of monthly personal disposable income	Affordability rank
Aspirins, 100 tablets (supermarket)	18.00	32.50	52 out of 52
Routine check-up at family doctor (av)	78.50	141.8	50 out of 52

One X-ray at doctor's office or hospital (av)	64.01	115.6	50 out of 53
Visit to dentist, one X-ray and one filling (av)	96.62	174.5	51 out of 53

Note. Affordability rank: for each country the price of an item as a percentage of monthly personal disposable income is calculated. Countries are ranked according to these percentages. The most affordable country will have the lowest percentage and be ranked first.

Pharmaceutical market

Foreign participation in the local pharmaceutical market is limited. Multinationals selling into **China**, either via imports or from a domestic production base, are constrained by stringent caps on prices and promotional expenditure. In most cases they cannot distribute their drugs to hospitals and pharmacies themselves, and must employ middlemen. **China** is adapting its pharmaceutical market to World Trade Organisation regulations. It has committed itself to tariff cuts, liberalisation of distribution practices and strengthening of intellectual property rights (IPR). A State Drug Administration was established in 1998 to regulate the industry. Its remit includes cracking down on drug counterfeiting—a serious problem in **China**. In recent years, growth has been solid but not explosive. The total market for ethical and over-the-counter (OTC) drugs in **China** in 2002 was US\$7.4bn (ex-factory price) according to IMS, a US-based pharmaceutical research firm, up from US\$5.5bn in 1997 and US\$6.2bn in 2000. By some measures, **China** is a substantial world market: in 2002 **China** was the seventh-largest drug market in the world, behind the US, Japan, Germany, France, the UK and Italy, and was close in size to Brazil, Canada and Spain. The size of **China's** market for drugs is related to the huge population, but also to the fact that the healthcare budget is skewed towards the buying of drugs. Of average expenditure in hospitals per in-patient of Rmb3,910 in 2003, almost one-half was spent on drugs. One reason for this is that profits from drug sales represent an important source of revenue for many hospitals, giving them little incentive to curb consumption.

Despite its comparable size, **China's** pharmaceutical market does in fact differ substantially from its Western counterparts. This is partly because of low incomes: the majority of the country's 1.3bn people simply cannot afford to buy expensive medicines; they do not even have access to what many foreigners would consider a basic level of healthcare. But preferences play a part, too. Among those who have the ability to pay for drugs, many prefer traditional Chinese medicine to Western medicine, especially for chronic conditions that require long-term treatment. Drugs such as Celebrex (for arthritis), Lipitor (to lower cholesterol), Premarin (hormone replacement therapy) and Prozac (for depression) have not been hugely successful in **China**, as they have been in the West, primarily because Chinese consumers prefer traditional Chinese medicines for long-term treatments and Western medicines (such as antibiotics) for short-term treatments.

The structure of the national healthcare system also affects **China's** pharmaceutical market. In **China's** government-run, hospital-based **health** system, drug registration, pricing and reimbursement are all strictly controlled. Most medical care is provided in government-controlled hospitals, where 70-80% of drugs are sold. (Retail pharmacies account for only about 14% of drug sales, although their share is growing and is as high as 30% in more advanced cities, such as Guangzhou). Reimbursement in the state-controlled hospitals is limited to drugs on provincial and national drug lists that, in turn, largely determine which products a pharmaceutical manufacturer can sell to which hospitals and at what price.

In an effort to control costs, the Chinese government is cutting prices at the central and provincial levels for reimbursed medicines, and aims to reduce the price of off-patent drugs from multinationals to no more than 30-35% above the price of locally made generics. Moreover, the Chinese government is favouring generic drugs whenever possible, and is restricting the list of drugs sold through hospitals. As with anti-retroviral medicines to treat HIV/AIDS, there is certainly a case for lowering the price of drugs directed at diseases such as diabetes and hepatitis, which are major medical and social problems, in order to expand access to treatment. More broadly, it must also be acknowledged that the pharmaceutical industry does battle against restrictive pricing and reimbursement policies in virtually every Western country, with the notable exception of the US. Still, the result of all these policies is a market that is highly fragmented, which significantly limits the sales in **China** of brand-name drugs. Thus, one "blockbuster" pill generates more sales in the US alone than the sales of all foreign drug companies' products in **China** combined. The world's bestselling drug in 2003, the cholesterol-lowering pill, Lipitor (made by Pfizer of the US), had global sales of US\$10.3bn, more than the value of all the medicines sold in **China** in that year. A blockbuster drug in **China**, by comparison, is any that reaches just US\$75m in sales.

It is difficult to analyse **China's** pharmaceutical market without addressing the issue of protection of IPR and patent recognition. In its 2003 white paper the American Chamber of Commerce (Amcham) in **China** described 2002 as a "milestone year in **China** for the promulgation of laws to improve intellectual property protection of pharmaceuticals". The main change was legislation extending the period of patent protection to 20 years, but improvements were also made in the areas of data protection and patent linkage.

Still, inadequate protection of intellectual property remains one of the biggest bugbears of foreign drug firms in **China**. Despite the changes that have been made in recent years, in its white paper Amcham still called for further progress to be made in the areas of data exclusivity, patent linkage and patent-term restoration. Amcham also highlighted the problem of counterfeit drugs, which according to some estimates account for 10-15% of OTC pharmaceuticals sold outside hospitals in **China**. Drug enforcement authorities at the central government level have devoted significant resources to anti-counterfeiting efforts. But more needs to be done at the local level to enforce the law and prosecute offenders. One problem is limited criminal sanctions. Currently, only counterfeiters who produce substandard drugs that result in serious injury can face criminal sanctions.

Key players

China has more than 200 Sino-foreign joint-venture medical facilities. The best known is the Beijing United Family Hospital and Clinics (BJU), a joint venture (JV) between Chindex International of the US and the Chinese Academy of Medical Sciences. BJU started in 1997 with a capacity of just 20 beds and services that focused primarily on obstetrical and paediatric care. The hospital is now licensed for 50 beds, although its capacity is still below 35. The venture has launched a satellite clinic in the capital, Beijing. Chindex will open another hospital in Shanghai in December 2004, and has recently signed a letter of intent to open one more in Xiamen in 2005. In a reflection of the difficulty of opening private hospitals in **China**, the Shanghai unit will be only one-quarter of BJU's current size, but according to the general manager of BJU, Andrew Nevin, it "still required 150 chops [name stamps

signalling approval from a particular department] to get the project off the ground”.

China's pharmaceutical market is highly fragmented. Annual sales in **China** by foreign-invested enterprises total no more than US\$2.2bn, equal to about 20-30% of the Chinese market (although the share is bigger in Guangzhou, Shanghai and Beijing). But the market is highly fragmented. There are about 1,700 Chinese-foreign JVs operating in the country, according to IMS, with the top ten global companies controlling less than one-fifth of the market. By comparison, the top ten pharmaceutical manufacturers have 50% of the global market, with the biggest, Pfizer, capturing 9.25%, followed by UK-based GlaxoSmithKline (GSK) with 7% and French-based Sanofi-Aventis with 6.6%. In Europe, the top ten companies hold 45% of the market, with the leader, GSK, at 7.2%. The weight of the Chinese market on these companies' overall portfolios is still quite light, representing less than 1% of their global business.

Disappointment about market share, however, masks the satisfying performance of individual companies. The past couple of years have been good for many foreign drug manufacturers, and many have already increased, or are considering increasing, their investment in **China**. For some companies **China** has become their fastest-growing market, and many are predicting continued growth. Sales by Novartis of Switzerland, for example, were up by 30% in 2003 to about US\$120m, from US\$92.3m in 2002, and it expects 20-30% growth each year for the next five years. Roche of Switzerland expects its prescription-medicine business to double in the next five years to US\$240m. AstraZeneca of the UK and GSK are also optimistic.

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China: Healthcare and pharmaceuticals forecast

731 words

10 October 2004

Economist Intelligence Unit - Executive Briefing

Executive Briefing

English

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FROM THE ECONOMIST INTELLIGENCE UNIT

	2004	2005	2006	2007	2008	2009
Life expectancy, average (years)	72.0	72.3	72.6	72.9	73.2	73.5
Life expectancy, male (years)	70.4	70.7	70.9	71.1	71.4	71.6
Life expectancy, female (years)	73.7	74.1	74.5	74.8	75.2	75.5
Infant mortality rate (per 1,000 live births)	25.3	24.2	23.1	22.1	21.2	20.3
Healthcare spending (Rmb bn)	737.2	813.2	894.0	994.5	1,108.0	1,239.5
Healthcare spending (% of GDP)	5.6	5.7	5.7	5.8	5.8	5.9
Healthcare spending (US\$ bn)	89.0	100.4	111.7	124.3	138.5	154.9
Healthcare spending (US\$ per head)	69	77	85	94	104	116
Physicians (per 1,000 population)	1.5	1.5	1.5	1.5	1.5	0.0
Pharmaceutical sales (US\$ m)	9,484	10,793	12,250	13,906	15,770	17,849

Sources: US Census Bureau; Economist Intelligence Unit.

Healthcare spending will rise relative to GDP

The continuous increase in expenditure on healthcare recorded in recent years is likely to continue during the forecast period. This will partly be because of a further rise in incomes (economies tend to spend a larger proportion of income on healthcare as standards of living rise). But the rise in spending will also be a reaction to the very real **health** issues facing **China**. It seems unlikely, for example, that SARS will be the last flu-type disease to emerge from southern **China**. Partly because of the fact that humans live in such close proximity to livestock and poultry in the area, southern **China** is believed to have been the breeding ground for some of the major epidemics of the 20th century, such as Asian flu (1957) and Hong Kong flu (1968), outbreaks that together killed an estimated 1.5m people worldwide. In what was interpreted by some as confirmation that **China's** role as an incubator for major diseases was far from over, in 2004 cases of bird flu were reported across the country. On this occasion other Asian countries suffered worse outbreaks, and **China** itself reported no human cases. History suggests, however, that **China** may not be so fortunate next time.

Even without the emergence of a new bout of flu, **China** still faces some serious **health** challenges, notably from HIV/AIDS and smoking. Although reported cases of HIV/AIDS stood at only 23,905 at end-March 2001, the Ministry of **Health** said in September 2002 that the real figure could be as high as 1m, owing to the use of contaminated transfusion blood in the mid-1990s. The UN believes that **China** could have more than 10m HIV/AIDS sufferers by 2010. Drug abuse and prostitution have also contributed to the problem. Awareness of the dangers posed by smoking is also much lower in **China** than in developed countries. More than 300m people smoke in **China**—there is particular concern about the rise in the number of women smokers. Last but not least, **China's** population is ageing: the UN expects the proportion of the population aged over 65 to rise from 6.1% in 1995 to 9.3% in 2015, but then to more than double in the next 20 years to more than 19% in 2035. This process will inevitably increase demand for healthcare.

All these developments represent a great challenge to the government, and are likely during the next few years to prompt officials to implement far-reaching changes to the medical care system: hospitals will be reformed; the use of **health** insurance will be further encouraged; and community-based primary care and the full range of private healthcare services will be developed. The government will also hope to restructure and modernise the domestic pharmaceutical industry (comprising makers of both Western and traditional Chinese medicines), to bring manufacturing up to international quality standards and to maintain the dominance of local companies. This broad programme of reform will not be completed by the end of the forecast period, but changes implemented by then will be significant enough to affect the structure of the market for pharmaceuticals (see box: **China's** healthcare reforms).

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Chinese policy to concentrate on helping rural workers, urban poor

2,461 words

6 October 2004

BBC Monitoring Asia Pacific

English

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The government is giving priority to improving the lot of rural workers and the urban poor, the Chinese news agency Xinhua has said. This uncharacteristic policy of concentrating on one aspect of society was vital given the fact that 900 million of the 1.3 billion Chinese lived in the countryside, the agency added. The 2004 policy document set out the principle of "Giving more while charging them less". Measures to help workers who lost their jobs as a result of market reform, as well as AIDS sufferers, were also high on the government's agenda, the agency said. Following is the text of a report entitled: "Feature: Exercising government power in the interest of the people", carried in English by official Chinese news agency Xinhua (New **China** News Agency); subheadings as published

Beijing, 6 October: The story goes back to October 24, 2003 when Xiong Deming, a woman living in a poverty-stricken village in southwest **China**, was on her way back home with a sack of pig feed on her shoulder.

She happened to meet Chinese Premier Wen Jiabao, who was visiting her village in Yunyang County, Chongqing Municipality. Gathering enough courage, the woman elbowed into the crowd and told the premier that her husband had worked for a whole year on a road project launched by the local government but had been unable to get his pay, 2,240 yuan (8.27 yuan against the US dollar) in total.

"That accounted for one-third of our income for the year," she said in a recent interview. "Most families here make no more than 6,000 yuan a year."

The premier intervened without delay. Xiong's family got the money before midnight and, five days afterwards, the county government paid the wages it had owed to all others who had worked on the project.

After Xinhua News Agency, released a story about what the premier had done for the woman and her fellow villagers, governments all over **China** began pressing employers to pay wages in full and on time to peasant labourers working for them.

In Beijing, the national capital, construction companies were ordered to pay wages in arrears before the Spring Festival, which fell on 22 January, or to be deprived of access to the local construction market.

From November 2003 to February 2004, more than 24bn yuan in wages held back or pocketed by employers was paid to "immigrant workers" - those from the countryside who, like Xiong's husband, live on permanent or temporary jobs in cities and towns.

Xiong Deming's story became known across the country overnight, as an example of how earnestly Chinese leaders are implementing the principle of "exercising government power in the interest of the people." The principle calls for special attention to the well-being of "vulnerable groups" - people facing difficulties in work and life despite the remarkable achievements the country has made in striving for modernization.

"No 1 Document" of 2004

When the late Chairman Mao Zedong proclaimed the founding of the People's Republic of **China** on 1 October 1949, **China** was scarred all over after incessant wars and natural calamities, and more than 90 per cent of the Chinese population, estimated at about 400 million, were living in dire poverty.

In contrast, the same **China** has come to be recognized as one of the fastest growing economies in the world. Most of the Chinese people have benefited from the market-oriented economic reforms going on over the past 25 years.

In 2003, the country generated 11.67 trillion yuan, or 1.41 trillion US dollars, in gross domestic product (GDP). Calculated on a per capita basis, that exceeded 1,000 US dollars even though the Chinese population had grown to nearly 1.3 billion.

More than 250 million Chinese were living below the poverty line when **China** kicked off the reforms in 1978. The number has been brought down to about 29 million. To put it graphically, the Chinese people, taken as a whole, have freed themselves from hunger and want, and the best-developed parts of **China** - regions along the coast - are rapidly modernizing, whose per capita annual GDP ranges from 4,000 US dollars (Tianjin), 4,500 US dollars (Beijing), to 7,000 US dollars (Shanghai).

Nevertheless, distribution of the national wealth is not even, given the size of the country (9.6m square kilometres) and the complexity of differences in conditions between different social groups and between different regions.

From 1990 to 2002, net incomes for the rural population increased by 69.7 per cent, averaging 4.45 per cent annually. In comparison, net incomes for city people grew 138.3 per cent, or 7.5 per cent yearly during the same period. The income gap between **China**'s urban and rural residents has kept widening. In 1985, disposal incomes for the urban population were 1.89 times those for the rural population. By 2003, the disparity had increased to 3.1 times.

Since the early 1990s, the Chinese government has spared no effort in resolving what it calls "problems facing agriculture, rural areas and rural population". According to the National Bureau of Statistics, from 1998 to 2002 the government raised a total of 660bn yuan from sales of treasury bonds, and invested nearly one-third of the sum in infrastructure facilities designed to improve living and production conditions in the countryside.

The current Chinese leadership, in particular, has made it clear that to strive for an increase in rural incomes is a "task of paramount importance for the entire party and government". Chinese President Hu Jintao has made 15 inspection tours outside Beijing since he was elected general secretary of the Chinese Communist Party Central Committee in mid-November 2002. According to a Xinhua news report, 11 of these were in the countryside. Wen Jiabao, on his part, has toured the Chinese countryside 17 times since he was elected premier in mid-March 2003.

As a routine, the CCP [Chinese Communist Party] Central Committee and State Council jointly issue a so-called "No 1 Document" at the beginning of every year - in fact a policy paper on anything and everything to be done in the year. The "No1 Document" for 2004, however, is devoted exclusively to policies designed to help the rural population increase their incomes.

It broke the convention by concentrating on just one aspect of the Chinese society,

the aspect that undoubtedly is vital to the country, given the fact that 900 million of the 1.3 billion Chinese live in the countryside.

"Giving more while charging them less" - this is the general policy set in the 2004 "No 1 Document". It calls for direct subsidies to grain producers in 13 major grain-producing regions, averaging 300 yuan per hectare. In accordance with the same 2004 "No 1 Document", the state is investing 150bn yuan in agriculture and rural development for this year, 30bn yuan more than 2003.

Moreover, beginning 2004, the agricultural tax will be reduced by one percentage point every year and, in five years, it will be revoked once and for all. With tobacco as the only exception, "special agricultural products" - things like fruit and mushrooms - are now all tax-free.

The agricultural tax was already revoked in some best-developed regions in 2003, including for example Beijing Municipality and Zhejiang Province. In Heilongjiang and Jilin provinces, **China's** "bread baskets", work is in full swing to make sure that such tax breaks are truly implemented.

The central government has earmarked a special fund to make up possible shortfalls in local government revenues, through what is known in **China's** official terminology as "transfer payments".

The result has been immediate. On 16 July, when summer harvest has just ended in most parts of **China**, a spokesman for the State Bureau of Statistics announced that net incomes increased 7.8 per cent year-on-year for **China's** rural population in the first six months of 2004, the fastest growth in the most recent two decades.

Laid-off workers and the unemployed

China's state-owned companies began laying off workers in the early 1990s, in a bid to help the national economy become truly market-oriented. For millions of them this means loss of care from cradle to grave by their employers under a Soviet-style planned economy that held sway in **China** before the reform era began in the late 1970s.

The Chinese government has responded to the problem with a will. Work has been under way over the past decade to build up a social security system - in fact a mega-dollar project which, in 2003 alone, cost the central government 70bn yuan, nearly 20 per cent more than in the previous year.

Under such a system, a laid-off worker receives a living wage if he or she cannot find a new job in the first three years. If the worker remains unemployed at the end of the three-year period, he or she may apply to the local government for a subsistence allowance.

The "subsistence allowance" provides a minimum living standard for all those living below the poverty line in Chinese cities and towns. The sum varies from region to region, depending on the economic strength of each.

In Guangzhou, one of the best-developed cities in **China**, a recipient was given 300 yuan per month at the end of 2003, in comparison to 155 yuan for a recipient in Xining, capital of Qinghai, one of the poorest provinces in the country. Official

statistics show that over the past decade, some 26 million people have benefited from the programme, which has cost the government more than 100bn yuan, including 46bn yuan spent in 2003.

To help laid-off workers and other unemployed people find jobs, a range of assistance has been developed, apart from customary help such as free job-hunting advice, free job training and recommended job opportunities. Helpers come from not only government departments but also communities and the private sector consisting mainly of small-and medium-sized companies.

In Shanghai, a preferential tax policy has been granted to companies hiring laid-off workers aged between 40 and 50, the hardest hit as they are considered too old to learn new jobs while having families to support. In Dalian, northeast **China**, 3,600 private companies have offered 13,000 job openings so far this year. In Shanghai and Beijing, job subsidies have been given to those willing to take low-paid jobs such as cleaning streets and public toilets.

Women's federations across the country are mobilized to help train unemployed women as household helpers and babysitters. Among laid-off workers, many mothers work in families to take care of women in confinement.

"They are earning up to 2,000 yuan a month, much more than before they were laid off," Wang Shulan of the Beijing Women's Federation said. "Since they themselves are mothers, they know what should be done and what should not."

In a latest development, the People's Bank of **China**, the country's central bank, and the Ministry of Labour and Social Security have decided to make bank loans easily available to laid-off workers and other unemployed people seeking to become self-employed. According to a government decision made in early July, the Ministry of Finance will set up a special fund to subsidize such loans, typically smaller than 20,000 yuan with a period of repayment not longer than two years.

Altogether, some 28 million workers had been laid off from state-owned companies by the end of 2003, and more than 90 per cent of them had got new jobs.

HIV/AIDS

In 2003, **China** fought a hard battle against the onslaught of SARS, or severe acute respiratory syndrome, and won. It is now taking up the growing challenge posed by AIDS, or acquired immune deficiency syndrome, a global scourge.

On 26 February 2004, a committee was set up under the State Council to coordinate efforts of all sides for AIDS prevention and treatment. Chinese Vice-Premier Wu Yi, who doubles as **health** minister, chairs the committee consisting of senior officials from 23 ministries and state commissions and seven provinces and municipalities where AIDS is epidemic.

AIDS-infected peasants and urban poor are the most vulnerable of all the vulnerable groups. At the meeting inaugurating the committee, Wu Yi summarized the policy towards them as "four-free plus care". "Four-free" means free treatment for poor AIDS patients; free blood tests, on an anonymous basis, in areas where the disease is epidemic; and free education for AIDS orphans and free HIV-AIDS counselling for pregnant women there. By "plus care," she meant relief in cash and kind to patients'

families in financial difficulties, as well as campaigns to publicize AIDS knowledge and urge fair treatment of AIDS patients by the general public.

Wu, as a matter of fact, has set a personal example of sympathy and attention to AIDS-infected people. Shortly after the battle against SARS was won, she visited villages in Shangcai County, Henan Province, where thousands have been infected through sale of blood.

The vice-premier was found right in their homes, talking with patients and their families to make sure that the "four-free plus care" policy was truly implemented, and drinking from their bowls. In a latest development, 72 officials of the Henan provincial government have been sent into these villages.

They are charged with helping local families improve their conditions while seeing to it that patients take the medicines, all free of charge, in doses and on time as prescribed.

From "serve the people" to "exercising government power in the interest of the people"

Far back in the 1930s, the founding fathers of New **China** set "serve the people" as the guideline for the Chinese Communist Party in all its work. "Serve the people", in fact, represents the finest tradition the party has passed on and has now evolved into "exercising government power in the interest of the people".

"Exercising government power in the interest of the people," as a formulation in **China's** official terminology, may be beyond the comprehension of those outside the country who have little or no idea about **China**. For the 1.3 billion Chinese people, however, it means they can count on the government for an increasingly prosperous life, and those vulnerable groups among them can expect improvement in their life when the country is rapidly modernizing.

That, in part, explains why the Chinese people are so confident in building **China** into a modernized, highly democratic country in the decades ahead.

Source: Xinhua news agency, Beijing, in English 0115 gmt 6 Oct 04

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China's key state-owned drug firms Jan-Aug profit down 13.9 pct yr-on-yr

282 words

30 September 2004

Xinhua Financial Network (XFN) News

English

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BEIJING (XFN-ASIA) - **China's** 23 key state-owned pharmaceutical firms recorded a combined profit of 2.91 bln yuan in the first eight months of this year, down 13.9 pct year-on-year, the State-owned Assets Supervision and Administration Commission (SASAC) said on its website.

The commission said the drop in profit was largely due to falling drug prices and

rising raw material prices, including coal, grain and petrochemical products.

It did not specify whether profit was net or gross.

Companies which have gained the Good Manufacturing Practice (GMP) certification -- which sets minimum standards for the industry -- saw profits squeezed by higher production costs.

China's GMP requirements, based on recommendations by the World **Health** Organization, cover labeling, production processes and some 200 other areas related to product quality.

The 23 firms' total costs increased 17.8 pct year-on-year to 65.53 bln yuan in the January-August period, with the growth accelerating 3.4 percentage points from the first half.

Core business costs rose 23 pct to 53.28 bln yuan.

The commission said the companies posted total industrial output of 35.29 bln yuan in the first eight months, down 2 pct from a year earlier, and booked a combined revenue of 70.59 bln yuan, up 14.9 pct.

Loss-making companies among the 23 firms moved further into the red with combined losses of 330 mln yuan, up 110 pct year-on-year, the commission said, without specifying the number of companies.

(1 usd = 8.3 yuan)

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News Digest

http://www.cnhos.com/more_info.asp?id=003006

China Medical Services Information Network website

(Note: this website requires membership to review all the content. Since I don't have a membership I can only review the headlines of the following news but not the actual content of the news)

News all around China:

1. BOH of Haidian District, Beijing no longer directly manages hospitals (05/13/2004)
2. No discriminations against private investment in hospital sector: all the secondary hospitals in Nanjin, Jiangsu province fully transition towards market (05/12/2004)
3. Henan province fully launches reforms on public hospitals: non-public capital is allowed to enter into public hospital sector (05/12/2004)
4. Guidance on Pilot Reforms of Urban Healthcare Sector officially announced: Non-public capital is encouraged into public hospitals (05/11/2004)
5. Jiangxi province launches policies to encourage the development of private hospitals: Three-year-waiver of business taxes for private hospitals (05/10/2004)

6. Shenyang, Liaoning Province announces open-up of medical care markets starting in July: health institutions with capacity below 100-bed will be reviewed and approved by districts and counties from onward (05/10/2004)
7. No quota: Fujian province encourages to open private hospitals (05/07/2004)
8. In deepening medical reforms, Shantou, Guangdong province encourages small- and medium-hospitals to change ownership (05/06/2004)
9. Foreign capital is allowed to enter into hospitals and there is not quota on licenses (04/29/2004)

<http://www.qhwst.gov.cn/leader/ldjh2.htm>

Health reform in Qinghai Province

1) implementing regional health planning in a full scale. In some counties where population were thin, general county hospitals, Traditional Tibetan hospitals, CDCs, MCHs and Family planning guidance stations were combined into one entities. 2) categorized hospitals into non-profit and for-profit institutions. 3) public bidding process in county drug purchases 4) reviewed and reduced drug prices by provincial pricing control bureaus 5) Practices to promote greater transparency such as public notice of doctors available in the hospitals, fee schedules and drug prices were required at every county- and above hospital. 6) personnel and compensation reforms so there were no iron-bowls for anyone

<http://garden.2118.com.cn/jzfb/jcfy/2002102801.htm>

Rural Health Reform Deepening all around China (Oct. 28, 2002)

Various practices in reforming rural health: 1. In Zhejiang, the focus was on township hospitals. Reform areas included ownership reform, personnel and compensation reform, the separation of party affairs and business management, and more management autonomy etc. Specifically, they integrated rural health organizations, community health services and CMS into "one body". Some hospitals offered partial equity to attract investment while others with redundant assets sold all or part of hospital assets to their employees through public bidding process. 2. In Inner Mongolia, township hospitals were divided into three categories based on the community they served, i.e., farming community, nomadic community, and frontier community. Hospitals of different category have different standards in terms of size and facilities equipped. 3. In Hubei, CMS had been piloted in Wuxue, Gucheng and Changyang counties. Focuses varied from "catastrophic illness plus preventive care" to "pure catastrophic illness". Some CMS were run by village committees and administered at village level, some were run by and administered at township level, while other were run by villages but administered at township level.

http://www.he.xinhua.org/news/2004-06/23/content_2362623.htm

Xinhua, June 23, 2004---- Hebei provincial government: no more gov't investment in for-profit hospitals. Other reform specifics include every district/city should keep 1-2 public general hospital and TCM hospital, every township keep 1 public health center. All the other existing public hospitals should be phased into state-owned private-run or private-owned for-profit/non-profit hospitals.