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   - MOH send med-vans to serve farmers in remote areas
English Summary: **Five gov’t departments jointly manage all municipal PSUs in Harbin, Heilongjiang province**

Beijing, Dec. 22 2004 (China Economic Information Network) -- Five municipal government departments, i.e. Office of Institutional Management, Department of Organization, Bureau of Personnel, Bureau of Finance and Bureau of Labor and Social Security are to jointly manage all the PSUs in Harbin city in expectation of getting rid of old problems such as departmental fragmentation and mismatch between mandates and responsibilities.

The PSUs that are under this joint management arrangement include all municipal administrative support units, pure public welfare units, semi-public welfare units, and business-type public service units.

Original Chinese text: [Annex 1 (1)]

English summary: **All PSU employees in Henan province will be put on contract type appointment in 2005**

Beijing, November 22 2004 (China Economic Information Network) – Henan provincial government announced its PSU personnel reform framework and timetable. This year, all the PSU employees will be put on contract except those who are in public servants status and those whose units will be converted into enterprise status.

Middle-level management positions in PSUs will be filled on a competitive basis instead of being assigned by upper-level management. Incumbents who are selected into those management positions are to sign contracts with PSUs and in general the contracts can’t be longer than 5 years. Except for security or policy-related reasons, all vacancies in PSUs are to be announced to the public and to be filled on a competitive basis. Hiring units may not discriminate against applicants based on their residential places and employment status.

Full text Chinese original: [Annex 1 (2)]

English Summary: **Liaoning freezes hiring at all PSUs for two years**

Nov. 15 2004 (China InfoBank) – Liaoning announced that it’s going to freeze hiring in all provincial PSUs for two years starting in November 2004.

Full text Chinese original: [Annex 1 (3)]

English Summary: **Changchun city of Jilin province cut down over 4600 jobs in its 3-year PSU reform**

Beijing, November 10 2004 (China Economic Information Network) – Changchun city of Jilin province has basically finished its municipal and county/district-level as well as township-level PSU reform by the end of 2003.
According to sources close to Changchun government, this reform was fully launched in 2001. Over the three-year course, 131 municipal PSUs were cut or streamlined, accounting for 28.9% of total municipal PSUs; 5879 positions were made redundant, 17.9% of the total; and 4673 people were let go, accounting for 15.4% of total employees.

Changchun started PSU reform in 2001 with pushing employees at all PSUs on contract. The rationale behind pushing the contract-mode of employment is that PSUs would have more say on hiring and firing of employees and employees would have more flexibility in choosing jobs. There is no more iron-bowls at PSUs any more.

Full text Chinese original: Annex 1 (4)

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English Summary: Employees at Zhejiang PSUs will be paid on different schemes based on their PSU category

Beijing, Nov. 8th 2004 (China Economic Information Network) – All the PSUs in Zhejiang province of Southeast China have been divided into four categories in the PSU reform, which are supervision and management type, social and public welfare type, intermediary and service type, and production and business type. Supervision and management type includes law/regulation enforcement troops, which are to be gradually incorporated or merged into public servants units as they carry out government functions. Social and public welfare type can be further divided into three subdivisions, including pure public welfare type, semi-public welfare type and easily-marketized public welfare type. Intermediary and service type such as accounting agents, notary agents and law firms should be completely detached from government departments in principle.

The income distribution reform at PSUs will follow the same lines as the above divisions. Supervision PSUs that are not incorporated into public servant units are expected to make 30% of their income on their own while the rest are to be provided by the governments. Pure public welfare PSUs will be paid on a basic salary provided by the government and they are encouraged to make more money through market mechanism. Semi public welfare PSUs will also be paid a basic salary and on top of the basic salary, an adjustable salary component which hinges on personal contributions to the units’ income generation. Intermediary and service type will completely follow enterprises model in terms of income distribution.

Full text Chinese original: Annex 1 (5)

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English Summary: Employees at Shenzhen PSUs will not be on “Cadre Administrative Rank” any more

Hongkong, Nov. 5th 2004 (China News Agency) – Employees at all Shenzhen PSUs of Guangdong province will not be on administrative rank, i.e. cadre, any more in the future. Instead, they will be staff that can be hired and fired. This reform is expected to start with education and health departments.

It is told that at the core of PSU personnel reform is position management and staff-hiring system. Specifically there will be no more division between cadre and worker status at PSUs. From now on, employees at Shenzhen PSU will all be categorized into three types: administrative management personnel, professional/technical personnel and employee. All the hiring at PSUs is to be announced to the public and be filled on a competitive basis.
The “Cadre Administrative Rank” unique to PSUs will be phased out in the reform. New employees at PSUs will not be paid based on their administrative ranks but on individual responsibilities and contributions to their units. Old employees at PSUs will gradually transition to the new pay scheme. It is also expected that Shenzhen city is going to downsize its PSUs to reduce financial burden on the municipal government.

Full text Chinese original: Annex 1 (6)

English Summary: **Jiangsu set framework on reforming production-business type PSUs**

Beijing, July 21st 2004 (China Economic Information Network) – Jiangsu has decided to start its PSU reform with production-business PSU being the first to bear the brunt.

An initial screening has divided the 1006 provincial PSUs into four categories with 101 being classified as business type PSUs. All the PSUs affiliated to provincial SOEs must first be changed to business type, so do all the enterprises affiliated to provincial PSUs.

The main reform components include ownership reform to make PSUs truly market entities and employees of PSUs becoming contract-type staff rather than tenure “cadres”. While the ownership of post-reform PSUs need to be clarified, state equities are encouraged to completely or partially exit to make PSUs corporatize, jointly owned or individually owned. Financially troubled PSUs are to be merged or reorganized.

All the current employees of reforming PSUs are to adjust their relationship with their employers by signing a contract. Those who choose to leave PSUs after the reform or those who choose to stay at post-reform PSUs where state-ownership ceases to dominate are to be given severance or compensation packages. The compensation packages can be issued at once or be set aside in a separate account within post-reform PSUs for the employees. Reforming PSUs are encouraged to hire more their original employees. Post-reform PSUs that hire more than 85% of their original employees and sign more than 3-year contract with them are to receive an award from the provincial government. The social insurance matters of reformed PSU are to be handled by local governments.

The protection of retirees’ rights is to be safeguarded in the reform. Retirees/early retirees who retired from PSUs before and at the reform are to keep their pension packages. Those who have joined PSU-sponsored old-age insurance are to transfer their insurance to other entities. Retirees who retire after the reform are to receive subsidized pension. PSUs that are to be closed or reorganized and have participated in old-age insurance have to deduct from their assets before closing or reorganization the equivalent of 10-year worth pensions for all their retirees and hand over the money provincial PSU social insurance agents, the later will in turn distribute the pensions for the deceased PSUs. The same apply to the medical insurance expenses of the retirees of to-be-deceased PSUs.

Full-text Chinese original: Annex 1 (7) a and b

English Summary: **Harbin: PSUs will be funded based on their functions**

Harbin, September 8 2004 – Carrying out the guidelines outlined in Opinions on Harbin PSU Funding Mechanism Reform issued by Harbin municipal government, the Bureau of Finance of Harbin will start providing funding to municipal PSUs based on the functions they have been performing. Specifically, PSUs that function entirely to provide public goods or services are to be funded entirely by the municipal government. These include PSUs that provide administrative
support to the government and PSUs that provide purely public goods. PSUs that provide some public goods but at the same time have the ability to make their own profits will be partially funded by the government. PSUs that are making good money or have already demonstrated ability to be financially self-sustain will be cut off from the government funding list and not receive any subsidies from the government any more.

The budgets assigned to PSUs will be based on the volume of job performed rather than on the headcount of PSUs. For the PSUs of which the volume of job is difficult to quantify, the budget will be assigned based on the current payroll size.

Retirees of PSUs will keep their original pension packages.


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**English Summary:** Old-age pension reform for self-sustaining PSUs has officially launched yesterday, meaning that more than 70,000 workers in Beijing will have more security.

According to recently issued Temporary Method on Reforming Financially Self-sustaining PSUs, self-sustaining PSUs may participate in basic pension insurance social pooling fund based on the principle set up by Rules on Pension Insurance for Beijing Urban Enterprises Workers. Employers and employees are expected to pay jointly the premiums.


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**English Summary:** Public Servants say goodbye to GIS and are to participate in BMI starting May 2002

According to Beijing Youth Daily on Jan. 24th 2002, starting from May 2002, all the public servants working at all central governmental departments and public servants of Beijing Municipal Government are going to say goodbye to GIS and to participate in BMI like all employees in Chinese enterprises.

The reporter was told by Beijing Bureau of Labor and Social Security on Jan. 23rd that the framework for public servants working at central governmental departments has been formulated and the detailed implementation plan is pending for approval of MOF and MOLSS. *Temporary Method for Providing Medical Subsidies for Public Servants of Beijing Municipal Government* has been approved by Beijing Municipal Government and is expected to be officially launched soon.

MOLSS requires that all self-sustaining enterprises affiliated to Central Governmental Departments and PSUs that receive supplementary government funding have to make sure that their employees are covered by supplementary health insurance before they join BMI. Otherwise they would be denied entry. By the end of this year, a total of about 1 million employees from enterprises affiliated to central government departments have joined BMI. Furthermore, around 0.99 million public servants from central government departments, Beijing municipal government and employees at PSUs who enjoy a status of public servants also joined, along with 0.3 million employees of PSUs that receive supplementary government funding and PSUs that are financially self-sustaining.


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Progress of “3-items construction” in 8th Five-year period: the State Planning Committee (SPC), MOF and MOH jointly invested in total 458 million yuan. To evaluate the impact of “3-items construction”, SPC, MOF and MOH conducted a mid-term review and it was found that during 1991-1994, a total of 6790 million yuan had been put into finished Three-items Construction projects, a total of 20202 rural health institutions had been renovated, a total of 5.2 million square meters dangerous building space had been demolished, and a total of 343,000 persons had been trained. Around 36.5% township hositals, 35.6% county CDCs and 33.6% county MCHs had basically finished the task of renovation.

Anhui province started Three-items Construction in 1991. According to statistics, by 1993, a total of 111.21 million yuan had been collected for this cause. Of which, the appropriations from central and provincial governments were 21.54 million yuan, prefectual and municipal governments put together 1.009 million yuan, county and city governments contributed 12.48 million yuan, and township governments made out 22.47 million yuan, self-financed funds from township hospitals, CDCs and MCHs were 36.99 million yuan, and others contributed 16.70 million yuan. A total of 668 rural health institutions were renovated or constructed, 604 of them were township hospitals, accounting for 43.9% of all township hospitals that should be renovated or built; 39 of them were county CDCs, accounting for 57.4% of all CDCs that should be renovated or built, and 25 of them were county MCHs, accounting for 43.9% of all MCHs that should be renovated or built. Total finished Three-items Construction building space was 468,000 square meters, and total dangerous building space was reduced from 32.2% in 1991 to 10.55 in 1993.

Qinghai Completed Three-items Construction

In 2000 Qinghai completely finished its Three-items Construction. Starting in 1991, the Three-items Construction had been the strategic priority of Qinghai’s health work in the 10-year course. During this ten year, a total of 78.418 million yuan was put into this cause. Of which, the central government allocated 46.70 million yuan, and provincial and prefectual governments put in 31.718 million yuan. A total of 424 township hospitals were renovated, and finished building space totaled 174,031 square meters. Among those renovated township hospitals, 60 of them were central township hospitals, and finished building space was 129,045 square meters, accounting for 100% of all township hospitals that should be renovated and built. In total 30 county CDCs were renovated, and finished building space 44,903 square meters, accounting for 85% of county CDCs. Renovated county MCHs totaled 23, and finished building space 20,587 square meters, accounting for 90% of the MCHs that should be renovated and built.
English Summary:  **Build up Rural Medical Safety Net**

Beijing, July 15th (Xinhua News Agency) – What are the main reasons for China’s weak rural health system?

The main problem in China’s rural health is low service quality provided by rural health institutions and weak public health network. Many rural health institutions are poorly equipped and financially struggling and therefore are difficult to attract high quality health personnel. For example, currently only 53% of health professionals working in China’s township hospitals had received junior college medical training and 36% of them only had a high-school degree. These figures are even higher in poor rural areas.

Due to the severe underfunding, many rural health programs have to charge fees in order to recover costs, which in turn seriously undermine the expansion of immunity and MCH programs. The trend of IMR and MMR changes can serve as good examples in this regard. China’s health performance stayed flat after mid-1990s. IMR decreased from 41.6 per thousand live births in 1995 to 37 in 2000, a small reduction of 8.65%, while MMR declined from 76 per 100,000 in 1995 to 69.6 in 2000, a very modest improvement of 8.42%. In some rural areas epidemic or communicable diseases that were under control before now started showing up again.

Government health allocations to rural areas, i.e., transfers from various levels of governments to county- and below governments on health, are seriously under provided. Although measuring in 1990 prices the rural health input increased 48.8% from 1990 to 2000, the annual growth rate was only 4.49%, far lower than that of national total health expenditures for the same period, which is 13.1%, and that of national total rural health expenditures for the same period, which was 12.8%. Measuring in 1990 constant yuan, in 1991 per capita government transfers on rural health was only 5.71 yuan, and in 2000 it was 7.95 yuan, a growth of 39.3% in 10 years and an annual growth rate of 1.75%. The growth of rural health input didn’t reach the goal set by the 1997 "Decision of the Central Committee of the Chinese Communist Party and the State Council on Health Reform and Development" that the growth rate of governmental recurrent health expenditures won’t be lower than that of governmental expenditures.

In rural public health institutions, the share of salary expenditures in total government health expenditures has been growing, from 49.35% in 1991 to 88.98% in 2000. The share of earmarked funds has been declining dramatically, from 16.16% plummeting to 1.63%, and the share of business expenditures also decreased from 34.49% to 9.3%.

Other interesting points from the report:
- The share of government health expenditures in total rural health expenditures has been decreasing, from 12.54% to 6.59% in 1991-2000, during the same period total social health expenditure decreased from 6.73% to 3.26%, while the share of OOP increased from 80.73% to 90.1%.
- Unbalanced distribution of government health budgetary expenditures between rural and urban. During 1991-2000, government rural health budgetary expenditures only took up 15.9% of total governmental health budgetary expenditures, while only 12.4% of the increased government health budgetary expenditures were used for rural areas.
- On three-items construction: during 1991-2000, of all the investments devoted to three-items construction, the Central government only put in 2.85%, provincial governments pitched in 9.28%, county and township governments each contributed a little over 15%, and the self-financing from health institutions were 42.23%.
- Comments on three-items construction: in 1990s, governmental investment in rural health was mainly in the form of three-items construction, i.e., capital investment to build or renovate township hospitals, county CDCs, and county MCHs. Now despite the fact that the buildings and equipment are all in place at township hospitals, technically many township hospitals are still no better than village clinics, as the health personnel
at township hospitals are very poorly trained. Due to misplaced focus on hardware (note: meaning buildings and equipment) instead of software (note: meaning people’s training and hospital management, etc.), scare rural health resources are not able to be utilized to their best.

Due to improved rural transportation and the expanded coverage of village clinics and private doctors, farmers increasingly exhibit a medical consumption behavior featured “when having minor illness go to village doctors and when having major illness go to county or above hospitals”. Therefore in many cases the people and equipment at township hospitals are just sitting idly and don’t get used at all. In response to such changes, governments should encourage township hospitals to play a role in planned immunity and MCHs. Many studies had revealed that low income people, women, children and old people were the main clientele of village clinics. However, currently there are almost no governmental supports for village-level health institutions. The government must take rethink its financial support strategies in rural health area.
raising infection-control awareness through training and publicity. Of course, foreign business is eager to participate in these efforts. Foreign interest in investment in China's healthcare services is rising, as are the country's medical equipment imports, which now stand at around $2 billion annually.

Identifying problems-and solutions

With admirable openness and frankness, Chinese policymakers have acknowledged the shortcomings of the current healthcare system and the acute challenges they face in improving it. In the Ministry of Health (MOH) and in other departments of the PRC government, there is widespread agreement on the need for reform and forthright acknowledgement of problems in medical services that include inefficiency, high costs, corruption, lack of a complete and fully implemented quality standard, and poor service. There is also broad consensus among these officials that private investment—both domestic and foreign—can play a key role in solving these problems. But officials have not yet reached consensus on how to implement a privatization process without abandoning China's public healthcare obligations under its socialist system.

"We are striving for a balance between the government's responsibilities and the market mechanism," Wu Mingjiang, the MOH director of Medical Administration, told a forum in Beijing in August. Striking such a balance will be difficult and will require vast improvements in China's regulatory framework. It will also likely require a unique blending of the many varied approaches now under consideration.

Existing state-owned hospitals may, for example, be permitted to enter into public-private partnerships in which they outsource varying levels of management. Some hospitals might even be allowed to contract out all of their management services. For instance, in Suzhou, Jiangsu, the city issued tenders this year for the management of most of its public hospitals while retaining ownership. Existing hospitals are also increasingly allowed to transform their ownership structure by taking on private capital, most of which has been domestic to date. More private investment is also being used for the construction of new hospitals. In the Zhejiang-Jiangsu area, several public hospitals have been sold to private investors, and the local governments have aggressively tried to attract private capital to build new hospitals. In this region, which has been aggressively working to attract foreign investment in hospitals, investments worth ¥500 million ($60.4 million) have already been contracted. Developments in other parts of the country have been much slower, as the attitudes of the central government and local governments are more conservative.

These new approaches would allow the state to divest itself of inefficient and low-quality assets in the healthcare system. The pressure of market competition, meanwhile, should compel remaining public hospitals to improve their own standards of service and efficiency. Such a system would also allow an expansion of the range and levels of services to an ever-more diverse public. For instance, a growing number of well-to-do Chinese want international-standard healthcare—and are prepared to pay handsomely for it.

Will China let private capital flow?
As PRC policymakers are well aware, plenty of private capital is poised to flow into the healthcare sector, and the notion of for-profit hospitals is no longer entirely taboo. At the same time, many officials are wary of a wholesale privatization of healthcare and insist that public hospitals be able to guarantee the basic health needs of China's hundreds of millions of rural and urban poor. Still others argue that privatization is no panacea at all, pointing to the high cost of medical services in countries with private healthcare systems.

While the debate intensifies, regulations have, for the most part, yet to change. Given such an environment, where the ability to make an adequate return is unproven, and where implementing regulations lack clarity, the relatively small number of newly opened hospitals and clinics should come as no surprise.

Of the 12,599 general hospitals in China, only 8 percent are run for profit and, according to MOH statistics, they handled a mere 3 percent of China's patient load in 2003.

Would-be foreign investors in the sector face additional hurdles, and indeed the regulations do more to deter foreign investment than to encourage it. Wholly foreign-owned investments are prohibited, and in joint-venture healthcare facilities foreign investors are limited to a maximum stake of 70 percent. Regulations also call for a minimum ¥20 million ($2.4 million) investment and require all services and activities to be domiciled at the same licensed facilities. Branch hospitals or clinics are thus prohibited. China has also discontinued duty exemptions for foreign-invested healthcare facilities that import medical equipment. In addition, foreign-invested healthcare facilities are excluded from some preferential tax treatment plans aimed at encouraging foreign investment. And foreign medical professionals are officially limited to being the minority employees at any foreign-invested enterprise, with 6-to-12-month limits on how long they may work in China, though in practice contracts are often renewed for longer periods.

Given these hurdles, it is not surprising that of the 29,000 medical facilities of all types registered in China in 2003, only 45 have foreign investment and another 15 have investment from Hong Kong, Taiwan, and Macao. The vast majority of these are classified as primary care and dental clinics, emergency evacuation centers, and research facilities. Only several would qualify as hospitals.

Reason for caution

Despite the clear gains that would result from the increased use of private capital in the healthcare sector, China has ample reason to move cautiously. Severe weaknesses exist in the regulatory environment, and these need to be fixed if privatization on any substantial scale is to stand a chance of succeeding.

As in other sectors in China, a transition toward privatization could obscure ownership and risk misappropriation of government assets. Other challenges unique to the medical sector include the lack of experience in independent hospital governance among hospital administrators and boards of directors, the fact that the system does not require independent governance, and the poorly developed state of China's hospital accreditation process.
Higher standards

China desperately needs to move away from its old system of evaluating and rating hospitals, which was based primarily on an institution's physical plant and hardware, toward a quality-based accreditation system that takes into account all the "software" that makes a fully equipped hospital run well. To China's credit, it has signaled a move in this direction with new, experimental standards.

Numerous international standards already exist, including those of the Joint Commission International, the international arm of the most widely accepted US hospital accreditation and quality rating body. By referencing and adapting such internationally accepted benchmarks in its own development of hospital standards, China could not only eliminate false starts and wasted efforts, but also gain a common language with the global healthcare community.

Chinese hospitals currently may not apply for accreditation under this standard because the government has yet to clarify regulations that define and authorize healthcare accreditation agencies. Quite apart from the definition of the standards themselves, success will also hinge on the fidelity and absolute integrity of the accreditation process and the bodies that implement it. These reforms are especially vital as a prelude to any privatization effort, so that potential investors and patients can evaluate hospitals, regardless of their ownership or structure, according to reliable and uniform standards. In addition, the widespread implementation of such a quality standard would enhance healthcare quality throughout the system.

Challenges for private investors

Even if the necessary regulatory reforms take place, private investors in Chinese healthcare services will face their own fair share of challenges. Again, some of these issues are common to all sectors of the PRC economy, such as the burdens of bloated staffs and huge pension obligations that plague many Chinese state-owned enterprises. Investors will also need to untangle decades worth of reporting and accounting histories in order to produce reliable financial statements.

More specific to the medical sector will be the need to overcome China's deeply ingrained service style, in which patient-centered care is a new and alien concept. Investors will have to cope with the shortage of hospital administration expertise as they look for managers capable of integrating modern management methods with existing institutional cultures. In many of China's hospitals, top administrators are senior physicians who, despite their distinguished and accomplished careers, lack the necessary management training to run modern hospitals.

Who will pay?

Finally, for private investment to succeed, China will need to reform its payment system for medical services. Other reforms and even privatization will do little good unless the basic economics change, and for that to happen, reimbursement levels must be raised to cover actual costs. At present, reimbursement levels from the government are unrealistically low for many services. If the government remains the only source of insurance, it will be hard-pressed to support the healthcare system at a higher level. What the government can do, however, is encourage the development
of private insurance options, especially those that allow patients to combine social health insurance with private supplemental insurance so they can access more expensive services (see p.18). Private hospitals would then be able to operate profitably, which in turn would allow them to hire hospital management experts and ultimately raise their quality and efficiency.

Healthy competition

China could speed such improvements by leveling the playing field for foreign investors. With fewer restrictions on off-site branch development for qualified foreign providers, on ownership stakes for foreign investors, and on the hiring of foreign physicians, China would gain access to valuable new sources of both medical and management expertise. And all of China's healthcare facilities would benefit from a healthy dose of competitive stimulus.

China desperately needs to move away from its old system of rating hospitals, which was based primarily on physical plant and hardware, toward a quality-based accreditation system that takes into account all the "software" that makes a fully equipped hospital run well.

With admirable openness and frankness, Chinese policymakers have acknowledged the shortcomings of the current healthcare system and the acute challenges they face in improving it. In the Ministry of Health (MOH) and in other departments of the PRC government, there is widespread agreement on the need for reform and forthright acknowledgement of problems in medical services that include inefficiency, high costs, corruption, lack of a complete and fully implemented quality standard, and poor service. There is also broad consensus among these officials that private investment - both domestic and foreign - can play a key role in solving these problems. But officials have not yet reached consensus on how to implement a privatization process without abandoning China's public healthcare obligations under its socialist system.


Chindex in China

Despite the uncertainties surrounding the future of healthcare reform in China, some foreign investors have already entered the field. Pioneering foreign players have been investing and operating in the health services sector since the early 1990s. As the handful of tombstone projects scattered around the suburbs of Beijing illustrate, not all have managed to navigate the pitfalls—but some have.

In China's largest cities, several small, foreign-invested clinics are successfully serving a mixed customer base of expatriate and local patients and several foreign-invested hospitals have opened. The United Family Hospitals Group (UFH), a division of Chindex International, Inc., opened its flagship hospital, Beijing United Family Hospital, in Beijing in 1997. With Shanghai United Family Hospital, which opened its doors this October, and hospitals in Xiamen, Fujian; and Guangzhou to follow, UFH has become one of the top foreign healthcare service providers in China. In accordance with
PRC regulations, each of these sites are separately approved and registered, but contract certain of their management functions to the United Family Hospitals Group. UFH offers a full range of inpatient and outpatient services that include medicine, surgery, dentistry, pediatrics, and obstetrics and gynecology. The Beijing hospital pioneered practices in China such as family-centered birthing services, family medicine, and an integrated women's health center. Although the hospital is the prime provider to the international community, almost one-third of its patients are Chinese.

UFH did not attain such success overnight, however. Official approvals alone took 18 months for Beijing United Family Hospital, and the timeline from application to opening ran for more than five years. Shanghai United needed some 150 official chops (official seals), and the hospital needed late-stage redesigns and re-approvals to comply with new infection control considerations in the wake of the severe acute respiratory syndrome outbreak. Transforming China's healthcare services will take time, patience, creativity, and flexibility on the part of investors.

Across China, business, government, and consumer cultures differ in important ways (see the CBR, September-October 2004, p.53). Some are obvious, and others are subtle. But just as Chindex, the foreign partner and driving force behind UFH, has had to cope with these differences to build its nationwide health services network, so too will systemic healthcare reform need to take regional differences into account. For a full decade before initiating its first hospital project, Chindex got to know the Chinese healthcare system by importing and servicing high-end medical equipment for hospitals at all levels across the country. With this vast experience in helping Chinese hospitals absorb and successfully use the best medical hardware that the West had to offer, Chindex was uniquely positioned to take the next step: finding ways to adapt western business models and management techniques and integrate them into China's own healthcare system. Chindex's long experience in China before setting up a venture has obviously contributed to the company's success. Other investors considering entering China's healthcare sector would do well to follow its lead and familiarize themselves with the sector before jumping in.

—Roberta Lipson

Shanghai United Family Hospital opens

511 words
20 November 2004
Obesity, Fitness & Wellness Week
238
English
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2004 NOV 20 - (NewsRx.com & NewsRx.net) -- Chindex International, Inc., (CHDX), an independent American provider of Western healthcare products distribution and healthcare services in the People's Republic of China, announced the opening of Shanghai United Family Hospital and Clinics Chindex's second hospital in China and first in Shanghai. Based on the successfully proven model of the company's flagship Beijing United Family Hospital and Clinics, Shanghai United is a joint venture between Chindex and Changning Central District Hospital.

An official ribbon cutting ceremony was held at the hospital in Shanghai and drew the attendance of many high level officials from China and the U.S., including His Excellency, the Ambassador Clark T. Randt, Shanghai Vice Mayor Yang Xiao Du, Shanghai Commissioner of Health Liu Jun, and Governor Robert L. Ehrlich, Jr. of the State of Maryland, as well as numerous business leaders.
Shanghai United is located in the Hongqiao area of Shanghai and will open to provide medical services during the week following the ribbon cutting ceremony. With its 50-bed facility, Shanghai United is the first wholly international standard hospital in Shanghai that will offer a full range of inpatient and outpatient services under one roof.

The medical staff is comprised of expatriate physicians, complemented by internationally trained local specialists. A joint membership program for the United Family Hospital network will be introduced, enabling members to have easier access to both the Shanghai and Beijing hospitals, and to receive similar benefits at both locations without the need to re-register.

Chindex president and CEO, Roberta Lipson, commented at the opening ceremony, "The opening of Shanghai United marks the next step in our strategy to expand our hospital and unique health services network. We are honored by the guests who have joined us today to celebrate both the occasion and our aim to provide world-class facilities and services to Shanghai."

Governor Robert Ehrlich of Maryland congratulated Chindex on its achievement, "The opening of Shanghai United demonstrates how the pioneering and successful business model of the Beijing United hospital can be brought to other cities in China. I am very proud of how Chindex, Inc., which is based in Maryland, has leveraged its vast experience in China to build a nationwide international standard healthcare network."

Andrew S. Nevin, PhD, president and General Manager of Chindex's United Family Hospital division commented on the development strategy: "The United Family Hospital network is based on a national hospital administration organization and integrated clinical operations in the primary facilities."

"Our strategy is for satellite feeder clinics associated with each facility to expand the geographic reach within each metropolitan area. This system not only offers international healthcare services to the expatriate community, but extends this quality of service into the huge local Chinese market. We believe that the system offers tremendous growth potential," Nevin said.

This article was prepared by Obesity, Fitness & Wellness Week editors from staff and other reports. Copyright 2004, Obesity, Fitness & Wellness Week via NewsRx.com & NewsRx.net.

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**English Summary:** China's first joint-owned hospital management company was set up in Xinxiang, Henan on April 18th 2004.

Beijing, April 9th 2004 (China News Agency) – The new entity, Huayuan Central China Hospital Management Company, is controlled by China Huayuna Life Industry Ltd. through injecting cash into the new entity, and is jointly owned by Xinxiang Municipal State Assets Management Company which contributed its share to the new entity in the form of the assets of 5 municipal hospitals under its control. The former is a new industry company (Lydia note: China Huayuan Life Industry Ltd. is one of China’s biggest SOEs that has set its feet in medicine, medical equipment and other health products, see website: [http://www.chinaolive.com.cn/gsjj-2.htm](http://www.chinaolive.com.cn/gsjj-2.htm)), while the later manages state assets on behalf of Xinxiang municipal government, Henan.

The new hospital management company is responsible for the management of Xiangxiang Municipal Central Hospital, the Second Municipal Hospital, the Third Municipal Hospital, Municipal MCH Hospital, and Municipal TCM Hospital.

The new boss announced that they will change the current situation in which the resources are scattering around in the hospitals and the hospitals compete against each other in an
unorganized way. They will utilize the economy of scale and hire professionals to manage the hospitals. The new entity will also benefit from Huayuan’s connections in pharmaceutical industry, medical equipment and other healthcare products. The new boss will also try to attract international capital and to collaborate with medical insurers.

It is told that this reform plan has been approved by Xinxiang Municipal Communist Party, People’s Committee, Municipal Government, and other responsible party. During the process the five hospitals each conducted consultations with their employees and got approval from their employees.

Full-text Chinese original: Annex 3 (1)

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English Summary: Chosun Ilbo: China Public Hospitals are Carrying out Radical Reform

Chosun Ilbo, March 31 2004 in its Chinese simplified characters version: In China’s efforts to modernize its health sector, the most noticeable movement is hospital reform. The core of this reform is to “sell unprofitable hospitals” and “introduce international and private capital to improve medical services in a quick way”.

Shanghai Civil Aviation Hospital is a public hospital that is responsible for the care of pilots and air attendants in 25 Chinese airlines. The hospital told the reporter that it was going to set up a joint venture with a Korean dental hospital in Shanghai. At the same time, it is also working with US and Germany investors to set up joint ventures in its cancer department, cosmetics surgery department and G & O department.

All around China, many other hospitals are trying to do the same thing. Last month a delegation from Qingdao city, Shandong province visited Korea in an attempt to find investors for the municipal dental hospital in Qingdao. Shanghai Armed Police Hospital is also looking for potential investors. Government-owned Beijing Sin-Japan Friendship Hospital is joining hands with a private investor to build its 600-800-bed sanatorium.

Full-text Chinese original: Annex 3 (2)

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English Summary: The first hospital with separated pharmacy is expected to emerge in Hangzhou next year

Hangzhou, Dec. 1st 2004 (Daily Morning) – One year after the reform launched in Hangzhou, significant effects have started showing up in Hangzhou: according to statistics, the per capita outpatient costs at municipal-level hospitals in Hangzhou went down 16.96-22.73% between May to September, and inpatient costs per capita reduced 11.92 to 14.60%. The reporter was told by Hangzhou System Reform Committee and Hangzhou Office of Medical Reform that next year the city will push hard forward the separation of hospital from pharmacy and it expects to pilot the first such hospital in 2005.

Hangzhou Municipal Government has planed to set up Hangzhou Health State Assets Management Company to manage all the state assets in Hangzhou hospitals and to change the functions of health bureaus. The administrative affiliations and state ownership of Hangzhou health institutions will be weaken and the management of health institutions will be delegated more to local governments.

Full-text Chinese original: http://biz.zjol.com.cn/gb/node2/node138665/node257861/node257900
English Summary: MOH issued notice to pilot DRG payment

Beijing, September 1st 2004 (Xinhua News Agency) – The basic content of DRG management:
1) the selection of diagnosis: in principle the standard for diagnosis should be consistent with the standard hospitals are using, i.e., ICD-9 OR ICD-10, and take into consideration the following factors: a) common diseases, b) high treatment costs, therefore when two diseases are of the same commonness, the disease that incurs a higher cost will be selected. c) the effectiveness of the treatment for the disease are clear.
2) The design of payment standard. When designing payment standards, the current prevailing payment standard can be used as a reference point and experts are invited to evaluate the payment. The unnecessary or unreasonable components of the total payment should be eliminated and necessary or reasonable parts should be retained or added to form a payment standard for a particular diagnosis.
Hospital information management system should be utilized in collecting data for DRG design. Scientific statistics should be used in choosing cases and sample should be sufficiently big (when no enough cases are available for the current year the hospital is allowed to use cases in the past years).
3) Monitoring and Evaluation. Internal monitoring and evaluation mechanism should be established at pilot hospitals.

Full-text Chinese original: Annex 4 (1)

English Summary: MOH announced measures to solve the problem of “getting medical service is difficult” for its citizens

Beijing, July 26th (Hong Kong China News Agency) – According to official media reports from mainland China, the measures MOH is going to take in the next half year include the following:

⇒ All the provinces have to enforce the Regulations on National Medical Services Pricing issued by MOH in 2001. Next year MOH is going to conduct a special examination on the implementation of this regulation and to notify the results all around the country.
⇒ MOH plans to select 30 diagnoses and to pilot DRG payment method in 7 selected provinces/municipals.
⇒ To establish pricing monitoring and management mechanisms between hospitals and its departments, between departments and doctors, and between doctors and patients. To include the pricing management as one of departmental performance evaluation components. To strengthen trainings and monitoring on doctors’ prescription practices, and to regularly publicize the prescription status of all departments and doctors in a hospital. To establish a system to evaluate doctors’ prescriptions practices and the results of this evaluation should be used as a criterion when the doctor seeks promotion.

Full-text Chinese original: Annex 4 (2)
English Summary: Anhua BOH make it mandatory for city doctors to serve in township hospitals

Anhui BOH recently issued Opinion on Implementing the Practices in Which City Doctors Go to Serve at Township Health Institutions on a Regular Basis. The Opinion is going to become mandatory started in 2005 in Anhui province.

According to this policy, doctors and senior doctors working at provincial B and C level hospitals will not be able to get promoted to next higher grade level if they don’t go to township health institutions to work for at least 3 months during their current grade assignment period. The 3-month service period at township hospitals can be divided into several period but each period can’t be shorter than one month.

Full-text Chinese original: http://www.moh.gov.cn/public/open.aspx?n_id=426&seq=%E6%8C%89%E7%B1%BB%E7%B4%A2%E5%BC%95
Annex 5 (1)

China to Send Modern-Day "Barefoot Doctors" to Boost Rural Healthcare

Beijing, China, August 2, 2004 (AFP) -- Residents in China's poverty-stricken countryside will soon benefit from basic healthcare provided by mobile hospitals, state media reported.

The National Development and Reform Commission and the Ministry of Health have invested 230 million yuan (27.7 million dollars) in a new programme to provide "door-to-door" health service to rural residents, the China Daily said.

Some 1,000 coaches, or mobile hospitals, will be sent to rural areas in central and western China to diagnose common disease, to perform minor operations and health check-ups as well as to promote health education to farmers who have limited access to hospitals in towns and cities.

The vehicles will also be used for testing for HIV and other contagious diseases.

The new arrangement is reminiscent of a similar system in the 1970s, when the country sent large groups of the so-called "barefoot doctors" -- many of whom were paramedics -- to rural areas to provide primary health care and promote public health campaigns.

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

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

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

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

Many farmers cannot afford increasingly expensive medical bills and deterioration of their health conditions propagates the poverty problem in the countryside, the report said.
Since last year, the central government has earmarked 10 yuan (1.2 dollars) per year for each rural resident, as well as collecting the same amount from local authorities and the residents themselves in central and western China to enroll farmers onto a new medical insurance scheme.

**English Summary: UK AstraZeneca International collaborate with Peking Univ. to train health managers and administrators**


According to this Letter of Intent, AstraZeneca will provide 3 million yuan over the next three years to help Peking University to set up research, consulting and training programs for government officials, hospital and pharmaceutical managers.

The content of training programs include inviting national and international experts to conduct a series of seminars and workshops, to provide scholarships for two-year exchange programs, and to carry out short-term training courses nationwide.

Full-text Chinese original: Annex 5 (2)

**URBAN DOCTORS TO PROVIDE RURAL SERVICES**

By Wu Chong
282 Words
11 January 2005
China Daily

Rural residents are to benefit from ever-stronger medical support from urban areas to help narrow their decades-old service gaps.

A 10,000-strong urban medical team will join in medical services and skills training at county level hospitals in three years, said the Ministry of Health yesterday at a national health conference.

As part of China's efforts to improve rural medical care, the national project will start this June and cover 600 hospitals in poverty-stricken counties in central and western areas.

Ten per cent of the targeted hospitals will be specialized in traditional Chinese medicine treatment.

The plan is to dispatch five senior doctors from urban hospitals to each targeted hospital, each with at least half a year's service.

"The central government plans to subsidize each doctor 24,000 yuan (US$2,900) a year," said Vice-Minister of Health Gao Qiang.

The doctors are expected not only to undertake daily treatment but to be responsible for medical
Another pilot project to balance medical service gaps between urban and rural regions will begin this year in Northwest China's Gansu Province.

In Gansu, a number of medical staff from hospitals above county level will go to work for a year in clinics at lower levels.

Wang Yancheng, head of the Gansu Provincial Health Bureau, said: "We plan to first launch it in 360 clinics."

In China, more than 70 per cent medical resources including hospitals, medicines and doctors are enjoyed by urban residents who only make up about 30 per cent of the country's total population.

Guangdong sends medical teams to rural area

South China's Guangdong Province has sent 19 medical teams to its rural area, providing medical services to local residents.

The teams, composed of 114 medical workers, will give free medical treatment to the villagers of the province's remote and poverty-stricken parts and will donate medicine and medical equipment to local medical stations.

The teams will offer training to local medical workers through lectures and demonstrations. They will also distribute pamphlets on health and sanitation knowledge to locals.

Dr Xiao Xin from Huaqiao Hospital, attached to Jinan University, has taken part in such activities several times. "This kind of activities will, in a real sense, incarnate our work ethic of healing the sick and rescuing the dying," he said.

According to the provincial government, Guangdong will send nearly 1,000 more medical workers to the rural areas before the middle of this month.

English Summary: China consider to phase in resident doctor scheme

Jan. 25th 2005. China Medicine Daily – In following the message conveyed at one of the recent MOH meetings, Guangdong province plans to strengthen the resident trainings to recent medical graduates. Furthermore, according source close to MOH, in the future medical graduates who fail to go through resident trainings process after graduation will not be able to be promoted to “doctor” rank.
Currently medical graduates could normally expect to receive “Doctor” licenses and start independently practicing medicine after they finish four-year college medical education and one-year work experiences.

Full-text Chinese original: Annex 5 (2)

Doctors in a Shanghai hospital to receive pre-surgery exam before performing any surgery

88 words
30 August 2004
Economist Intelligence Unit - Business China
Business China
Number 306
English
(C) 2004 The Economist Intelligence Unit Ltd.

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

MEDICAL MALPRACTICE INSURANCE COMPULSORY

By Li Fangchao
385 words
5 November 2004
China Daily
English
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The Beijing Municipal Health Bureau plans to compel all the capital's public medical organizations to take out medical malpractice insurance.

Coverage will extend to doctors and other professionals against liability arising from patient care, reports the Beijing News.

Since 1998, the city has encouraged its medical organizations to take out medical malpractice insurance.

High premium

That has been met by little response on the part of many, citing high premium costs as the main reason for their low take-up, an official from the bureau was quoted as saying.
According to a report by the Beijing Insurance Regulatory Committee released this June, less than 20 city hospitals have taken out medical malpractice insurance. And only two insurance companies, PICC Property and Casualty Co Ltd and the Beijing Branch of Taiping Life Insurance Co Ltd, offer such a policy.

But medical malpractice and doctor-patient disputes which frequently arise are becoming an increasing headache for the normal running of medical organizations.

Six years on, the bureau has decided to take matters in hand.

Under the new directive, all State-owned non-profit-making medical organizations are required to have medical malpractice insurance.

An independent third party, most likely an intermediary, will assess any medical liability claims and mediate disputes.

"It (insurance) is compulsory for those State-owned hospitals," said the official, adding: "All district and county-level health bureaux should organize the medical organizations within their areas to get insured."

Privately run medical organizations are also entitled to take out insurance under the same regulations, he added.

The bureau said the relevant intermediary organization should comprise medical, legal and insurance professionals.

Since the cost of insurance is shouldered by the medical organizations concerned it will not increase the financial burden of patients.

Some doctors are backing the changes.

"Without insurance, a lot of doctors are facing great psychological and economic pressure once a medical accident happens," Chen Wei, director of the doctor-patient relationship office of Jishuitan Hospital, was quoted by the Beijing News as saying.

And that it is impacting medical practice, he asserted.

"At present, a few doctors would rather use some conservative measures in their treatment than to use some new ways which may be more effective," he said.

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DOCTORS UNDER PROTECTION: SCHEME LAUNCHED
CHNDLY0020050110e11b0000k
By Liu Weifeng
471 Words
11 January 2005
China Daily
English
Copyright 2005 China Daily Information Company. All rights reserved.

A growing number of fights between doctors and patients has led to calls for an
insurance scheme to cover doctors in Beijing’s hospitals.

The conflicts usually spring from patients alleging doctor malpractice.

The government is pressing ahead with a scheme which would cover 100,000 doctors in all public-funded and non-profit hospitals in the capital city.

"In the programme, the insurance company will be responsible for not only the malpractice of the doctors, but also the unsatisfactory service and the administration of the hospitals," said Deng Xiaohong, deputy director with the Beijing Municipal Healthcare Administration.

Altogether, some 1,254 hospitals in Beijing are to be involved, and it will be open to any private hospital in the city, pushing the total number to about 2,000.

Hospitals contacted by China Daily said they were unaware or had just "heard about" the programme.

Doctors at the outpatient department of the Sino-Japanese Friendship Hospital said they had not heard of the scheme.

Things were no better in other hospitals.

Doctor Li at Ditan Hospital said she had heard about the insurance from the hospital's director, but it had not yet been implemented.

Xue Hai, an official with the health law and regulation office of the Beijing Municipal Healthcare Administration, still believes all hospitals will eventually get on the insurance track.

But she did not reveal the insurance cost range among different hospitals.

The Beijing branch of PICC (People's Insurance Company of China) Property and Casualty Company Limited will be responsible for some 90 per cent of this business.

Medical practice is considered to be a high-risk occupation, according to a survey conducted last month among 200 doctors in Changsha, capital of Central China's Hunan Province, the local newspaper Xiaoxiang Morning Post reported.

Fearing something could go wrong in treating a patient, more and more doctors prefer a kind of conservative approach, which, in many cases, means ineffective treatment.

Only 6.8 per cent of doctors said the relationship between patient and the doctor is harmonious; and 26.8 per cent could not understand why the patients and their families were so unco-operative.

Zhang Yunlin, secretary-general with the Beijing Municipal Public Health Law Research Institute, said doctors should automatically be insured for medical...
Beijing first introduced the medical insurance in 1998, when insurance was optional to all hospitals in the city.

But only 18 hospitals got involved.

The high premium is a deterrent to most hospitals.

The annual insurance cost is thought to be about 800,000 yuan (US$97,600).

Southwest China's Yunnan Province was the first to introduce this kind of medical insurance in 1999, followed by Shanghai in 2002, Shenzhen in 2003 and Beijing in 2005.

**English Summary: China FDA plans to finish the classifications of drugs by 2006**

Beijing, Jan. 12th 2005 (Beijing Xinhua InfoLink Development Co Ltd) – The State Administration of Food and Drug Supervision (SAFDS) recently announced that it planed to start phasing in prescriptions drugs and over-the-counter (OTC) drugs policy this year and to put all prescription drugs on “prescriptions only” by 2006.

By the end of 2005, all the retail pharmacies that meet the requirements on the classifications of drugs can continue to sell prescription drugs and OTC drugs, while those that fail to meet the requirements can only sell A- and B- type OTC drugs or B-type OTC drugs only.

This year SAFDS will continue to coordinate with MOH to push forward the implementation of the classifications of drug sales. It plans to draft Regulations on the Classifications of Prescription and Non-prescription Drugs and tries to receive approval from the State Council to legalize it into law.

Full-text Chinese original: [Annex 6 (1)]

**English Summary: Good doctors and medicines drive away “fake doctors and medicines” in Hequ county, Shanxi province**

Taiyuan, Shanx, Oct. 22 2003 (Xinhua News Agency) – In its three-year rural health reform, Hequ county reallocated its health resources and used “three goods”, i.e., good doctors, good medicines and good medical equipment to drive away “two fakes”, i.e., fake doctors and fake medicines in its rural areas.

Hequ county is a national-level poverty county with a lot of mountains and very bad transportation conditions. In 1999, the county governments purchased 10 vans and remodeled and equipped them with good medical equipment----brightness ultrasonoscope, electrocardiograph, etc, good medicine-----medicines purchased through collective competitive bidding, and good doctors ----
Wheeling and healing

Jonathan Watts
Oct. 2 2004
Lancet,

As China's government has embraced market economics, health care in rural areas has crumbled and become unaffordable for many. In remote Gansu Province, doctors are being sent out in mobile clinics to reach some of the world's most inaccessible regions. Jonathan Watts reports.

At the county hospital in Kangle, one of the most remote and under-resourced medical establishments in China, doctors and nurses are discussing the shiny new gift that arrived last month from the central government. It is the county's first medi-van: a clinic on wheels designed to take health care to the masses at minimal cost to the public purse. The vans are part of a new scheme to bring the successors of China's famous "barefoot doctors" into the modern age and mollify criticism that the communist party has dangerously neglected rural health care since its conversion to market economics.

This summer, the health ministry funded and dispatched 1004 medi-vans to the poorest regions of central China. At a cost of about RMB300000 (US$36000) each, the vehicles are expensive by local standards. They are also very well equipped, carrying respirators, heart monitors, ultrasound devices, a basic surgery table, facilities for treating minor ailments, and, reflecting the government's desire to rein back the world's biggest population, the implements necessary for abortions.

The need for greater access to care is all too apparent. The dire health-care provision for China's 800 million rural dwellers is a source of shame for the government, which has yet to find an adequate replacement for the health-insurance cooperatives it abolished at the start of market reforms in 1978.

Few places are quite as needy as Kangle and neighbouring Dongxian—two counties in Gansu, the province with the second-lowest per-capita income in China. Poor, remote, and populated by Muslim Hui and Dongxian ethnic minorities, until 5 years ago large parts were off limits to outsiders. But in a sign the government is gradually facing up to its problems and accepting help from overseas, the World Bank and the UK's Department for International Development are jointly funding health projects in the province. The medi-vans are the most visible sign of domestically financed change, but they are unlikely to be enough. Gansu has been given just 43 vans to cover the most remote dwellers in its 26 million population.

Under ministry regulations, the vans must be in use for at least 20 days a month. At Kangle, officials are still trying to work out how to make best use of their new vehicle—which has yet to hit the roads. Gao Youyi, director of People's Hospital at Kangle County, said it would serve as an emergency ambulance and a mobile health centre to back up the district's village clinics. Once
operational, the vans—painted white with a red cross—will journey through some of the most under-developed parts of the world. From the plains, the roads pass terraced fields, then rise up verdant hillsides to the furthest clinics more than 2 hours away. In Dongxian, the medi-vans bump along dusty roads of yellow loess, along ridges of mountains so arid and bare that they resemble a moonscape. Many of the roads are impassable.

The people who live in such places eke out a living on less than $1 per day. In many cases short of food and clothing, they are usually dependent on money sent by relatives who work as migrant labourers in faraway cities like Beijing and Shanghai. When they need medical care, it is a struggle to find the time, money, and means to travel to a clinic. Public-health workers—increasingly dependent on private sources of income—find less and less incentive to go to remote areas to talk about disease control and hygiene. As a result, tuberculosis and hepatitis B are making a comeback and HIV/AIDS is a growing threat.

Local doctors say the vans are an improvement. "Before, sick villagers usually had to go to the village clinic if they had small common symptoms or a country hospital for something more serious. Now, some treatment comes to them", said Ma Zhanbiao, director of Kangle County tuberculosis clinic.

Putting doctors on wheels is the latest response to one of the world's greatest health-care challenges: how to provide screening, education, and treatment for the biggest population on the planet. In the 1960s, the government raised an army of paramedics, who were given basic training in western disease control and traditional Taoist medicine. While opinions vary about the medical worth of these "barefoot doctors"—so called because some were so poor they walked from village to village without shoes—they are credited with having an important role in educating people in the basics of hygiene and infectious disease control.

Partly as a result of these efforts, the health of China's rural population was once one of the proudest boasts of the communist party. Government figures suggest life expectancy jumped from 35 to 65 years in the three decades after Mao Zedong took power in 1949. During the same period there were substantial declines in recorded cases of tuberculosis, hepatitis B, and schistosomiasis as well as improvements in infant mortality.

Most of these gains, however, have levelled off or even reversed since 1978, when rural cooperatives—which organised health insurance—were abolished, and doctors and health authorities were encouraged to find private sources of income. In the past 25 years, the share of medical spending borne by individuals has jumped from 20% to 60%.

The result, according to commentator Wang Shaoguang, is the "most market-orientated" health system in the world. Despite an impressive 7% annual rise in medical spending by the government in the past decade, basic care in village clinics has been neglected while expensive equipment in city hospitals is given priority. "The focus of medical care has moved quietly from rural to urban areas, from 'high on prevention' to 'high on treatment', from low cost to high tech, high cost", Wang writes in the journal *Dushu*. "The inequities ... offend even the basic sense of fairness ... For a country that calls itself 'socialist', this is unforgivably shameful."

Since 1993, Wang estimates that the rural share of medical expenses has dropped from 34·3% to 22·5%. In terms of beds, the country hospitals' share of the national total has fallen from 60% in 1982 to 34% in 2001.

WHO has monitored this decline with alarm. In a survey of health systems in 2000, China was ranked a miserable 144th out of 191 states. To the shock of the communist government it fared even worse in terms of access to medical care, coming fourth from bottom—beating only Sierra Leone, Brazil, and Myanmar. The effect of these inequalities is increasingly apparent. An
estimated one in ten of the 1·3 billion population is thought to be a carrier of hepatitis B. Tuberculosis, under control 20 years ago, is on the rise—earlier this year, the health ministry reported 4·5 million patients and an annual death toll of 130000.

Schistosomiasis, which the government claimed it had tamed in the 1950s, is also spreading. Estimates range from several hundred thousand cases to more than a million. AIDS cases are rising at a rate of 30% per year and SARS—though tamed for now—remains a fear.

Given such problems, Henk Bekedam—WHO's representative in China—says the mobile clinics are likely to have only a limited effect. Rather than build hospitals and provide better equipment, he said the priority should be to help patients afford services and to train medical staff to make better use of existing facilities and knowledge. "The main issue is not about the availability of resources, but access and utilisation", he told The Lancet. "China is putting a lot of resources into buildings and facilities, but we have to go beyond that. What is very bad in China is the financial barrier to access."

Since the abolition of the rural cooperatives, the health ministry has failed to find a replacement medical insurance system, which means more than 90% of China's rural poor have to pay for treatment. As a result, sickness is now the major generator of poverty in the countryside, according to a study by Harvard University. In Gansu Province it isn't hard to find evidence for this assertion. Ma Habi, a 23-year-old resident of Dongxian County was thinking of marriage before he was struck down with hepatitis. To pay his hospital fees, his parents borrowed RMB20000—equivalent to the family's entire income for 15 years. "I'm still not fully cured and with no money in my family, I can't think of getting married now", he said. "But it would be the same for anyone. No-one in my village has medical insurance."

Even the mobile clinics pose financial problems. Although diagnosis and care is free, patients will be asked to pay for medicines. Experience suggests this will mean many have to decline treatment. Local health officials are also worried that running the vehicles could prove burdensome. "The van is certainly very helpful for us", said Youyi. "But the petrol is now a bit too expensive for the county hospital to bear."

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哈市五部门联动管理事业单位

哈市传统的对事业单位的组织、人事、编制、财政、社会保障管理体制是计划体制下形成的，并基本参照机关管理和运转模式，机制不活，人浮于事。“五联动”可加强政府对事业单位的统筹规划，集合政府各部门加强对事业单位的管理、服务、监督和约束；强化政府对事业单位的宏观管理，管好事业单位的人员结构，合理控制编制总量；建立多部门协调制约机制，由部门分散管理转变到联动管理，把好事业单位人员入口关，畅通人员出口，改变过去以钱养人、因人设岗的局面，以期达到以事养人。在用人上将由人员调配转变为面向社会考试招聘或自主聘用。实施“五联动”后，原各部门分散管理事业单位的体制将被打破，相对分散的权力得到有效制约，事业单位的人员编制和人员结构、选人和用人、财政保障和工资分配、社会保障和干部管理等将为党委和政府所统一管理，确保了事业单位沿著公共事业服务方向健康发展。

此外，联动管理还将建立现代微机网络管理系统，集管理、统计、查询、检查和监督等功能于一体，有效避免暗箱操作。

《关于市直事业单位实施联动管理暂行办法》及《实施细则》文件于今天下发，自2005年1月1日起执行。其管理范围为哈市机构编制办批准实施“九定”的市属行政支持类、纯公益类、准公益类、经营类事业单位。

各区、县也将依据《关于市直事业单位实施联动管理暂行办法》制定细则。据哈尔滨市编制办综合处赵处长介绍，“五联动”将涉及市、区、县各级各类事业单位人员达20万左右。

哈市事业单位改革于年初启动，事业单位通过清底，实施撤、并、转、脱、留等机构整合以及职能调整，“九定(定机构名称、隶属关系、职责任务，机构规格、内设机构、人员编制、领导职数、经费形式)”)工作已近尾声。
昨日，省委组织部、省人事厅联合下发《关于进一步完善事业单位人事制度改革的意见》，列出了我省事业单位改革的框架和时间表。今年，事业单位除按照国家公务员制度进行人事管理的以及转制为企业的之外，其他事业单位全部实行人员聘用制度。到明年，全省事业单位聘用制度基本正常化、规范化。

据了解，这次事业单位人事制度改革的主要内容有：事业单位的人员全面实行聘用制，事业单位领导由以前单一的委任制施行在选拔任用中引入竞争机制，事业单位的中层领导实行岗位竞争上岗制度，补充人员实行公开招聘和人事代理制度等，并进一步扩大事业单位内部的分配自主权。

坚持党管干部原则，改革事业单位领导单一的委任制，在选拔任用中引入竞争机制，规范直接聘任、公开选聘、推选聘任、竞争聘任等办法。选择部分空缺的领导干部岗位，面向社会公开选拔。

公开选拔的领导人员，实行试用期制和任期制，部分岗位试年薪制。

竞争上岗的中层领导要签订聘任合同

事业单位中层领导岗位出现空缺，一般应通过竞争上岗进行补充。对于部分拟竞争的岗位，也可打破身份界限，允许符合任职资格、条件的人员参加竞争。

对通过竞争上岗的任职者，要签订聘任合同，聘期一般不超过5年。对晋升职务的人员，按照任期试用期的有关规定试用，试用期不超过一年。试用期满后，经考核胜任现职的，正式任职并享受相应岗位工资及福利待遇；对不胜任的，免去试任职务，一般按试任前职级安排工作或尊重本人意愿自谋职业。

新进人员实行公开招聘

事业单位除上级任命领导干部、政策性安置人员及涉密岗位等情况外，其他新进人员实行面向社会公开招聘。公开招聘工作必须在编制限额和人事部门下达的年度增人计划内，根据工作需要和岗位的要求，按照公开、平等、竞争、择优的原则，采取考试与考核相结合的办法进行。

补充人员的事业单位公开招聘方案经主管部门和同级政府人事部门同意后，考试前在本地有关媒体或河南省人事网上发布招聘公告。招聘应打破地域和身份界限，非在职人员符合招聘条件的应聘者一律同待。拟聘用人员要在一定范围内公示，以接受社会各界的监督。

用人需求相对集中的事业单位招聘人员，可由政府人事部门和用单位主管部门定期组织实施，集中进行笔试和面试，以规范用人行为。

新聘用人员实行人事代理
经考试、考核合格的受聘用人员，用人单位与其签订《河南省事业单位聘用合同书》。

非在职人员初次被聘用的，需填写省人事厅统一印制的事业单位初次招聘人员登记表，连同聘用合同书到同级政府人事部门审核。事业单位初次招聘人员登记表作为计算工龄、调资、晋升、流动的依据。新聘用人员，应当由当地政府人事部门所属人才服务机构进行人事代理。

有条件的单位可通过流动岗位吸引人才

有条件的事业单位应积极探索固定岗位与流动岗位相结合的设岗方式，实行专职与兼职相结合的用人办法。流动岗位主要用于柔性引进单位急需的高层次人才，以实现人才资源的科学配置。

1 (3)
辽宁事业单位改革 2 年内不增新编制不设新单位
CEIC000020041115e0bf0001y
263 Words
15 November 2004
中国资讯行-新闻频道 (简体)
Chinese (Simplified)
(c) 2004 中国资讯行．China INFobANK Limited
INFOBANK 讯 从 11 初开始，辽宁省在两年内冻结全省事业单位机构编制，全省镑地区、各部门不再设立新的事业单位，不再增加新的事业编制。辽宁人事部门还将在 11 月底前，将全省事业单位的空余人员编制收回。

据中新社 11 月 14 日电，对于承担一定行政执法监督职能的事业单位，要依照《行政许可法》予以审核和清理整顿，没有法律依据的要将行政职能收回政府部门，机构予以撤销；具有社会经济服务职能的事业单位要脱离政府，成为独立的社会服务中介机构；承担社会公益职能的事业单位，有的要重新审定职能、核定编制，有的要实行企业化经营管理；而对于经营性事业单位要全部改制转企。

1 (4)
长春市事业单位改革，3 年精简 4673 人
CEINCN0020041110e0ba000p2
502 Words
10 November 2004
09:27 GMT
中国经济信息网 (简体)
Chinese (Simplified)
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北京，2004 年 11 月 10 日 /中经网/ -- 从有关部门了解到，长春市自 2001 年全面启动事业单位机构、用人制度和分配制度改革后，3 年间全市精简事业单位机构 131 家，占机构总数的 28．9％，精简编制 5879 个，占编制总数的 17．9％，精简人员 4673 人，占总数的 15．4％。截至 2003 年年末，市属事业单位各项改革和县（市、区）、乡镇事业单位机构改革已基本完成。

长春市从 2001 年开始进行事业单位改革，在全市事业单位推行聘用制，到 2003 年年底，全市 310 家事业单位通过科学设岗、竞争上岗，实行了全员聘用制度，占事业单位总数的 86％：21998人签订了聘用合同，占现有人员总数的 78％，破除了事业单位人员能上不能
下，能进不能出的现象。

在实行聘用制的基础上，事业单位进人实行“凡进必考”，面向社会公开招聘，2001年至今，先后有15个部门42个事业单位面向社会公开招聘工作人员287人，优秀人才的脱颖而出为事业单位注入了活力。在专业技术人员资格评审上，评聘分开，取消了专业技术职务评审数额限制，实行资格评审。

背景资料：长春市事业单位改革始于2001年，首先从推行人员聘用制入手。聘用制是事业单位与职工在平等自愿、协商一致的基础上，通过签订聘用合同确定单位和个人的人事关系，使单位有自主用人权，个人有自主择业权。事业单位实行聘用制，不仅是事业单位用人制度的重大改革，而且是对传统终身制的彻底否定。

浙江省：共有4类事业单位不再拿“死工资”了

管理类事业单位：可有30%的活工资

对核定为监督管理类但未依照国家公务员制度管理的事业单位，其活工资部分应按30%的比例确定。对接受政府机关委托，承担经济社会管理职能或为政府行政行为提供政策研究、政策咨询等保障服务的机构，可依照聘用合同试行岗位工资或协议工资。

公益类事业单位：享受激励搞活部分收入

对社会公益类中的纯公益性事业单位，其收入分配可按基本保障部分和激励搞活部分相结合的办法进行管理。

对准公益性事业单位，激励搞活部分可有：

内部岗位津贴制。国家和地方政府规定的工资及地区性津补贴照常发放，单位用创收部分另建内部岗位津贴，按岗定薪、岗变薪变。

内部岗位工资制。即将国家和地方政府规定的工资项目和工资标准全部作为档案工资（供计发退休金时使用），单位根据工作人员的岗位和工作业绩，自主制订分配办法。生产要素参与分配。允许单位从科技成果转化收益中按比例提成，从科技服务、咨询收益中提成，用于内部搞活分配。允许专业技术人员在完成本职工作和不损害单位利益的前提下，在业余时间利用自己特长从事技术开发、信息咨询、技术服务和提供劳务等兼职工作，获取兼职报酬，兼职所得的收入应照章纳税。
特殊岗位工资制。对事业单位发展负有重大责任和作用的经营管理、专业技术及某些特殊岗位，可试行年薪制、项目工资制、协议工资制等。对有突出贡献的专业技术人员和管理人员，所在单位可给予重奖。

中介类企业：比照实行企业工资

中介服务类、生产经营类的事业单位应积极创造条件转企改制，转企改制后实行企业工资制度。完善生产要素参与分配的方法和途径，使工作人员的收入与其贡献、绩效挂钩，建立起岗位靠竞争、收入靠贡献的自主、灵活、激励的分配机制。

自收自支类企业：领导和员工收入差距可达5倍

改革后，自收自支的事业单位领导与员工间收入差距可达5倍。其主要负责人的收入分配形式可参照企业经营管理人员薪酬模式，试行年薪制和风险抵押金制度。基本薪金一般可为本单位平均工资的两倍，而年度奖金要根据该负责人的业绩来确定，原则上不超过本单位职工平均工资的3倍。但对不能完成工作任务，或发生重大、较大政治事故、安全生产责任事故的单位主要负责人，其年度奖金下不保底，还应扣抵风险保证金。

我省将事业单位分为四类

我省事业单位改革，把事业单位分为四类：监督管理类、社会公益类、中介服务类和生产经营类。监督管理类事业单位，如部门所属的执法大队，其履行的是国家管理职能，改革的方向是依照公务员的制度管理。社会公益类事业单位的情况比较复杂，将其分为三小类，即纯公益类、准公益类和虽有公益性质但接轨市场能力很强的一类。中介服务类事业单位，像会计师事务所、公证处、律师事务所等，原则上要与政府职能部门彻底脱钩。
则将采取渐进的办法稳妥进行过渡，以免造成太大的波动。此外，预计深圳还将适当收缩事业单位的规模，以减轻当地的财政负担。

江苏省关于省属生产经营类事业单位改革的实施意见

一、指导思想和基本原则

(一) 指导思想

以“三个代表”重要思想和党的十六届三中全会精神为指导，按照省委十届六次全会关于加快推
进事业单位分类改革的要求，坚持政事分开、事企分开的原则，遵循市场化、社会化、产业化方
向，积极推进省属生产经营类事业单位改革，充分发挥市场机制在资源配置方面的基础性作用，逐
步建立起与社会主义市场经济体制相适应、符合事业单位自身特点和发展规律的新型管理体制和运
行机制，促进国民经济和社会事业全面协调可持续发展。

(二) 基本原则

省属生产经营类事业单位改革遵循“四坚持、四确保”的原则，即坚持分类定位、分开管理、分
别改革，确保事业单位改革工作顺利进行；坚持国有资产处置公开、公平、公正，规范操作，确保
国有资产不流失；坚持老人老办法、新人新办法，确保离退休人员、在编职工的正当权益得到切实
维护；坚持政事分开、事企分开，明晰产权、转换机制，确保转企改制后新创立的企业规范运作，
加快发展。

二、实施对象和主要方式

(三) 实施对象

以营利为主要目的或具有经营和营利能力，面向市场从事生产经营或中介服务活动的省属生产
经营类事业单位。

(四) 主要方式

转企改制。对具备转企改制条件的省属生产经营类事业单位，将经评估后的净资产通过市场竞
标转让或协商转让的方式，公开转让给内部职工、法人或自然人，依法组建公司制企业、合伙企
业或个人独资企业。其中存量资产较大的单位，其部分国有资产、土地、商誉和资质等无形资产，
可按有关规定采用租赁方式处置，或投资入股组建公司制企业。

对需要调整或难以正常运转的事业单位，通过清理予以撤并重组。
三、国有资产的处置

（五）财务审计和资产评估

生产经营类事业单位改革按财政部关于事业单位财务、资产管理的规定，参照省国资委《关于规范省属国有企业改制工作的实施意见》（苏国资〔2004〕32号），依照省财政厅《关于明确省级国有资产产权管理工作程序和要求的通知》（苏财国资〔2001〕58号），由单位的行政主管部门委托具有法定资质的中介机构进行财务审计和资产评估。审计和评估结果由行政主管部门负责在转企改制单位内部公示，具体参照《江苏省财政厅关于省级国有企业改制资产与财务审计和评估结果实行内部公示的通知》（苏财国资〔2004〕13号）的有关规定执行。行政主管部门要对评估结果进行审核，以正式文件出具审核意见，连同公示的有关材料一并报省财政厅备案。涉及省级政府房产等资产的，应报省级机关事务管理局核准；涉及土地使用权的，由行政主管部门委托具有土地评估资质的中介机构进行地价评估，结果报省国土资源厅备案。

（六）资产的剥离、核销

转企改制单位在改制前需剥离的资产以及对剥离资产的处置办法，由行政主管部门报省财政厅审核批准后组织实施。剥离后的资产可委托改制后的单位代管，享受受托资产的有关权利，并承担相关义务，也可由行政主管部门管理。

转企改制单位的原债权、债务由改制后的企业承接，并办理有关法定转移手续。其不良资产，由具有法定资质的中介机构出具专项审计意见，经行政主管部门审核，对其中需要核销的资产，报省财政厅批准核销，并指定相应的机构进行清理和追索。

（七）资产的转让和租赁

转企改制单位的国有资产要按照公开、公平、公正的原则通过产权市场按规定程序转让。实行协议转让的，原则上参照苏国资〔2004〕32号文件有关规定执行。

转企改制中取得的省属事业单位国有资产转让收入，由原行政主管部门及时解缴省财政专户。

改制后企业保留的国有股权、租赁使用的原事业单位的国有资产，以租赁方式处置的，经省国有资产营运机构持有和负责，纳入其国有资产授权经营范围，由省国资委负责监管。

（八）划拨的土地使用权的处置

转企改制单位涉及的划拨的国有土地使用权可分别采用出让、租赁等方式处置。以出让方式处置的，按土地评估价的20%补交出让金；需要改变用途的，应经当地城市规划部门同意，按新的土地用途评估确认价的40%补交出让金。以租赁方式处置的，经省国土资源厅
批准，自改制基准日起3年内免缴土地年租金。

对改制时资产不抵债以及净资产不足以提留有关费用的单位，经省国土资源厅批准，可以划拨的国有土地使用权评估作价冲抵负债，具体冲抵的有关费用由省财政厅核定。对冲抵剩余的国有土地资产由改制后企业缴纳40%的土地出让金后取得土地使用权。国有土地资产具体处置程序按国家和省有关规定办理。

(九)改制费用的提留

对经中介机构审计评估后的净资产，经行政主管部门和有关部门审核，省财政厅批准，按下列事项提留有关费用：改制基准日前的工资及应缴未缴的养老、失业、医疗保险费（职工医药费）；离退休人员管理费、医药费及其它相关费用；改制单位调整劳动关系的职工安置费或经济补偿金；提前退休人员的有关费用；提取5%的坏帐准备金；国家和省规定的执行的其他费用。

转企改制单位的净资产（含土地资产）不足以提留各项费用的（不含坏帐准备金），由主管部门负责统筹解决。主管部门解决有困难的，报经省属事业单位改革办公室批准，由省财政厅在改制的省属生产经营类事业单位国有资产转让收入专户中统筹解决。

江苏省关于省属生产经营类事业单位改革的实施意见（3）

16 November 2004
07:52 GMT
中国经济信息网 (简体)
Chinese (Simplified)
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四、在编人员的安置

(十)法定退休与提前退休

依照本意见改制单位的在编人员，截止2004年12月31日达到法定退休年龄的，依照规定办理退休手续；未达到法定退休年龄，工龄满30年的，男年满55周岁、女年满50周岁且工龄满20年的，经本人书面申请，单位同意，省人事厅批准，可提前退休。

对提前退休的人员，改制前的单位应按事业单位标准，一次性向当地社会保险经办机构缴纳自办理提前退休手续至法定退休年龄期间应支付的养老金和应缴纳的各项社会保险费。

办理提前退休的职工，单位和个人不再缴纳住房公积金。已缴纳的住房公积金可凭退休证提取，同时注销个人帐户。

(十一)事业单位在编人员进入改制后企业

改制后的企业原则上应录用原事业单位全部在编人员，确保原事业单位的军队转业退伍人员、省级以上劳动模范、根据国家政策规定必须安排就业的在编人员在改制后的企业中就业(个人选择自谋职业的除外)。对在原事业单位连续工作满10年的在编人员，本人要求订立无固定期限劳动合同的，改制后企业应当与其订立。

对改制后的企业，首次录用原事业单位85%以上在编人员，且签订3年以上劳动合同的，可
按省有关文件规定予以鼓励。

五、职工劳动关系的调整

(十二)依法调整职工劳动关系

所有转企改制单位都应调整职工劳动关系。调整职工劳动关系，要按照《中华人民共和国劳动法》、《江苏省劳动合同条例》等法律法规和相关政策规定进行。对不进入改制后企业的职工，改制单位要依法与其解除、终止用人关系；对进入改制后企业的职工，企业依法与其签订劳动合同。

(十三)发放安置费或经济补偿金

事业单位转企改制，调整职工劳动关系，应根据《省政府关于进一步深化国有企业改革的意见》(苏政发〔2002〕135号)精神，对不再与改制后企业签订劳动合同的在编职工，国有资产全部退出的以及保留国有股份但非国有控股单位的在编职工，都要发放或提留安置费或经济补偿金。具体标准和办法，参照省国有企业改制调整劳动关系的有关规定执行。

六、职工社会保险关系的处理

(十四)统一实行城镇企业职工社会保险

转企改制后的企业及其职工，从2005年1月1日起，要依照国家和省有关规定，参加当地企业职工养老、医疗、失业、生育、工伤等社会保险，依法缴纳各种社会保险费。有条件的单位可为职工建立企业年金和补充医疗保险。

(十五)转企改制中养老保险关系的衔接

改制前已参加机关事业单位养老保险的单位，应按有关规定办理养老保险关系转移手续。转企改制前按规定未列入机关事业单位养老保险范围的，2004年12月31日前按规定可以计算的连续工作年限视同缴费年限，办理视同缴费年限证明。改制前按规定应参加而未参加养老保险或欠费的，单位转企改制时，应补缴清。

(十六)对转企改制后退休的原事业单位在编人员实行养老金补贴


(十七)改制中在编人员失业保险关系的处理

改制前事业单位的在编人员，已按国务院《失业保险条例》和省有关规定参加失业保险，并足额缴纳失业保险费的，改制前按规定缴纳失业保险费的期限(含实施失业保险制度改革前的视同缴费年限)连续计算。改制前未缴或欠缴的应予补缴。未进入改制后企业，依法进行失业登记的职工，符合条件的，按规定享受失业保险待遇。
七、离退休人员的待遇和管理

（十八）转企改制前已离退休人员的待遇

事业单位改制为企业前已经离退休（含提前退休）人员，原享受的离退休待遇不变。

有正常事业费的改制单位，当地社会保险经办机构按核定的所在地2004年12月企业人均养老金标准支付改制前离退休人员养老金，与原待遇差额部分由改制后单位或原主管部门从财政拨付的事业费中支付。2005年1月1日以后，其离退休待遇调整纳入国家统一的事业单位离退休待遇调整范围，由财政部门按统一的补助标准和现有经费渠道安排资金，由改制后单位或原行政主管部门负责发放。

没有正常事业费的改制单位，当地社会保险经办机构按国家和省规定的事业单位离退休待遇计发标准支付改制前离退休人员养老金。2005年1月1日后，基本养老金按国家的办法执行，所需经费从企业养老保险基金中支付。企业养老金调整标准与国家出台事业单位离退休费调整标准的差额部分，转企改制时一次性按人均2万元的标准留提，由改制后单位或原行政主管部门负责发放。

转企改制前离休人员的医药费，按离休人员医药费统筹标准，一次性提留10年；交由社会医疗机构统筹使用。

（十九）离退休人员的管理

转企改制单位的离休人员原则上由原主管部门负责管理；退休人员原则上由改制后单位或原主管部门负责管理，待条件成熟后再实行社会化管理。离退休人员管理经费按有关规定一次性提取5年，交由管理单位管理使用。

八、改制工作的组织实施

（二十）组织领导

省政府成立省属事业单位改革领导小组，统一领导省属事业单位改革工作。领导小组下设办公室，具体负责改革实施和推进工作。各行政主管部门的主要负责人对本部门下属单位的改革工作负总责，并建立相应的工作机构，完成对下属单位的改革。各改革单位也要建立专门的工作班子，负责本单位的改革工作。

（二十一）实施步骤

省属生产经营类事业单位改革按四个阶段进行：
1. 改制准备阶段。改制单位建立专门的工作班子，提出改制或清理撤销的总体方案，由主管部门报省属事业单位改革办公室审核同意后，由主管部门批复。

2. 资产评估阶段。根据批复的改制总体方案，由主管部门选定具有法定资质的机构进行财务审计和资产评估。

3. 改制实施阶段。主管部门负责指导改制单位制定改制实施方案和职工安置方案。改制实施方案要充分听取职工意见，职工安置方案要征得多数职工同意。经主管部门正式批复后的改制方案的实施，分别由省财政厅、机关事务管理局、人事厅、国土资源厅、劳动和社会保障厅进行资产处置、人员分流、社会保险关系衔接等工作；行政主管部门负责组织资产转让和指导、监督新企业做好组建的各项筹备工作；省编办办理事业单位法人注销登记；省工商局负责新组建企业的名称预核。

4. 企业创立阶段。新创立的企业，应持行政主管部门对改制方案的批复、省财政厅对净资产处置的批复、省劳动保障厅对调整职工劳动关系和接续社会保险提留费用的批复、省国土资源厅对划拨的国有土地使用权处置的批复、产权交易机构对国有资产转让的报告书等文件，依法办理工商登记注册和税务登记等相关手续。创立公司制企业的，还应按《公司法》和《公司登记管理条例》等有关规定，提交相应的登记材料。

(二十二) 党、团组织关系的衔接

转企改制单位的党、团组织关系原则上实行社会化管理，由当地按照同类企业来管理。如条件尚不成熟的，可暂时保持原有隶属关系和管理现状，逐步理顺关系。有关部门要及时做好转企改制单位的党、团等组织关系以及职工档案、职称评定档案等的移交接收工作。

(二十三) 严肃纪律

列入改制的事业单位，要严格遵守组织人事工作纪律、财经纪律、国有资产管理规定和廉政纪律，严格规范改制单位的审计和评估工作，加强档案资料管理。有关职能部门要加大监督检查力度，坚决杜绝和纠正有令不行、有禁不止的行为，确保政策畅通。对违反规定，阻碍改制，造成不良影响的，要严肃查处，追究责任。

对 2004 年底前列入改制而未进行改制的省属生产经营类事业单位，省财政厅停止拨付事业费或差额补助费，省编制、人事部门不再列入事业单位管理：省属生产经营类事业单位的改革情况，列入主管部门年度目标管理考核范围。

江苏省关于省属生产经营类事业单位改革的实施意见 (5)
对需要调整或难以正常运转的事业单位，经批准予以撤并重组。撤销单位的债权、债务和净资产（含土地资产）的处理，由主管行政部门负责。对有事业单位转企改制任务的主管行政部门，清理撤销单位的剩余净资产进入部门统筹；对无事业单位转企改制任务的主管行政部门，清理撤销单位因净资产不足产生的人员安置等费用差额，原则上由主管部门负责解决。

(二十五) 清理撤销单位的人员安置

清理撤销单位的在编人员，由主管行政部门按省政府办公厅《关于清理整顿省级党政机关所办宾馆饭店招待所和培训中心有关人员分流安置工作的实施意见》（苏政发[2003]43号），或本《实施意见》的有关规定分流安置。

清理撤销单位的离退休人员，由原主管行政部门负责管理。

已参加机关事业单位养老保险的清理撤销单位，其离退休人员的离休退，由省级机关事业单位社会保险经办机构按事业单位标准发放，经费从清理撤销单位净资产中一次性提留10年。清理撤销单位的离退休人员参加医药费统筹和医疗保险，分别按离退休人员医药费统筹标准、医疗保险缴费标准，一次性提留10年，交由社会保障部门统筹使用。

十、《实施意见》的适用范围

(二十六)《实施意见》的适用范围

本《实施意见》适用于省属生产经营类事业单位的改革。省属行政管理、社会公益等其他类别事业单位改革可参照执行。其他省属已改制的事业单位按原改制政策执行。各市、县（市、区）可根据实际情况，自行制定本地区生产经营类事业单位改革的具体政策措施。

本《实施意见》从发布之日起实施。由省发展和改革委员会会同省有关部门负责解释。

1 (7) -b

江苏省属生产经营类事业单位改革方案确定
CEINCN0020040721e07l000jb
904 Words
21 July 2004
中国经济信息网 (简体)
Chinese (Simplified)
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7月15日下午，我省召开省属事业单位改革动员会议。从会议上获悉，我省决定对事业单位改革分类推进，今年年底前基本完成生产经营类事业单位改革，对省属生产经营类事业单位具体的改革办法已经作出部署。

省编办对1006家省属事业单位进行了初步的分类，初步确定首期改革的生产经营类省属事业单位101家。9月15日之前要完成其中16家单位的试点改革，在试点的基础上，年底前基本完成这101家单位的改革。省属国有企业下属事业单位必须先行转企改制，列入转企改制的省属事业单位下属企业也必须先行改制。

主要方式是通过产权制度改革，使单位转变成真正的市场竞争主体，事业单位人员转变身份，变成企业员工。在明晰产权的基础上，鼓励国有资产全部或者大部退出，依法组成公司制、合伙制或个人独资企业。对需要调整或者难以正常运转的单位，通过清理进行撤并重组。

改制单位的所有在编职工都要调整劳动关系。改制后不再与企业签订劳动合同的，或者进入国有资本全部退出的单位和非国有控股单位的在编职工，都要发放或提留安置费或经济补偿金，作为身份置换的补偿。“发放或提留”的概念是，对改制时离开企业的职工发放；未离开的可以发放，也可以提留，待离开时发放。改革方案鼓励改制后企业多聘用原单位的在职职工。改制后的企业，首次录用原事业单位85%以上的在编人员，签订3年以上劳动合同的，可按省有关文件规定给予鼓励。按照社会保险属地化管理的原则，省属生产经营类事业单位改制后，社会保险由所在地管理。
确保离退休人员的正当权益得到切实维护是此次改革的原则之一。转企改制前离退休人员和转企改制时提前退休人员享受的离退休待遇不变。已参加机关事业单位养老保险的，要办理养老保险关系的转移手续。对转企改制后退休的部分人员实行养老金补贴。清理撤销单位中已经参加机关事业单位养老保险的，其离退休人员的离退休费，按标准在单位净资产中一次性提取10年，由省级机关事业单位社会保险经办机构按照事业单位标准发放。清理撤销单位离退休人员的医疗费统筹和医疗管理，交社会保险部门统筹管理，经费按标准一次性提取10年。对离退休人员的管理，明确转企单位离休人员原则上由原主管部门负责管理，退休人员原则上由改制后单位或原主管部门负责管理，待条件成熟后再实行社会化管理；清理撤销单位的离退休人员，由原行政主管部门负责管理。

Annex 2 (1)

青海农村3项建设全面到位（455）

ceic000020010914dwc1019pg
375 Words
01 December 2000
中国资讯行
Chinese (Simplified)
(c) 2000

任西岳

2000年青海省乡镇卫生院改造工程全面竣工，这标志着青海省用了10年时间，以乡镇卫生院、县防疫站、县妇保院三项建设内容为主的综合性基层建设项目全面完成。

青海省农村卫生三项建设在1991年启动。10年来，在卫生部、计委、财政部的大力支持下，青海省各级政府始终将农村三项建设作为整个卫生工作的战略重点之一，纳入国民经济和社会发展的总体规划，并把它作为振兴农村牧区卫生事业的重大战略举措，列入年度工作目标，层层签订责任制，做到领导到位，组织到位，措施到位，责任到位。

10年间，共投入建设资金7841.8万元，其中中央投资4670万元，省级、各州地（市）投资3171.8万元。共改造建设乡镇卫生院424个，房屋竣工面积174031平方米，其中中心卫生院60个，房屋竣工面积129045平方米，占应改造卫生院的100%；改造县级卫生防疫机构30个，房屋竣工面积44903平方米，占应改造卫生防疫站的85%；改造县级妇幼保健机构23个，房屋竣工面积20587平方米，占应改造妇幼保健院的90%。

中国资讯行

Annex 2 (2)

【观点】构建农村医疗安全网

XPHHCN0020030715dz7f00032
4592 Words
15 July 2003
新华社经济信息-中外医药卫生信息（简体）
Chinese (Simplified)
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新华社信息北京7月15日电 农村卫生薄弱的主要原因是什么？

我国农村医疗卫生服务存在的主要问题之一就是卫生机构服务质量不高，公共卫生和预防保健工作薄弱。很多地区农村卫生服务机构设施条件差，经济效益较差，难以吸引高素质的卫生人员。目前在大部分农村地区乡镇卫生院的卫生技术人员中，中专学历和未接受过专业培训的高中及以下
学历者分别占53%和36%，在贫困地区比例更大，大专学历者比例很低，大学毕业生更是凤毛麟角。

由于农村公共卫生服务资金严重不足，许多公共卫生服务项目必须通过收费弥补服务的成本，影响了计划免疫、妇幼保健等公共卫生服务项目的开展，导致近年来部分地区儿童计划免疫任务不能完成等问题。近年来，我国农民健康状况的改善以及健康水平的提高均有趋缓的现象。婴儿死亡率和孕产妇死亡率是反映健康水平改善的最敏感的指标，不仅能够反映卫生投入情况，更能反映卫生系统的运行效果。20世纪90年代中期之后，婴儿死亡率的下降出现了平台，从1995年的41.6‰下降到2000年的37‰，只下降了8.65%；孕产妇死亡率从1995年的76‰下降到2000年的69.6‰，下降了8.42%。农村中某些已经得到控制的地方病、传染病的发病率出现了反弹甚至死灰复燃。一些农村地区职业病和环境污染所致疾病明显上升，对农民健康造成新的威胁。

从总体来看，政府农村卫生投入（即各级政府部门对县及县以下农村医疗卫生机构的拨款和补助）严重不足。我国政府农村卫生资金投入从绝对量上是逐年增加的，按1990年的不变价格计算，投入量10年间只增加了48.5%，年均增长速度为4.49%，大大低于同期全国卫生总费用年均增长13.1%和全国农村卫生总费用年均增长12.8%的速度。按1990年的不变价格计算，1991年人均政府卫生支出为57.1元，2000年增加到7.95元，10年间仅增长了39.3%，年均增长速度仅为1.75%。农村卫生投入的增长速度没有实现1997年《中共中央国务院关于卫生改革与发展的决定》提出的目标。

农村公共卫生机构中，人员经费占政府公共卫生支出比重越来越高，由1991年的49.35%增长为2000年的88.98%。专项经费所占比重迅猛下降，由16.16%下降为1.63%，公务费和业务费所占比重也从34.49%下降为9.38%。农村卫生人力培养费在政府农村卫生支出中所占比重极低，2000年只有1.35%，而且主要用于人员经费。这说明，政府用于农村公共卫生的经费主要用于“养人”。

一般而言，随着经济的发展，政府在健康保障方面的作用也逐步加强，表现为政府卫生支出占卫生总费用的比例增加。然而，在我国，政府卫生支出在农村卫生总费用中的比例却不断下降。1991年-2000年我国农村卫生总费用中政府投入比重由12.54%下降到6.59%，社会卫生投入从6.73%下降到3.26%，而同期农民个人支出从80.73%上升到90.15%。

政府卫生预算支出在城乡之间的分配极不合理。1991年-2000年，政府农村卫生预算支出仅占政府卫生总预算支出的15.9%，政府卫生预算支出增加额中用于农村的卫生支出仅占12.4%。2000年居民个人卫生支出占总医疗费用比重已达到60%以上，而农民个人支付的医疗费用则达到90%。1990年-2000年，占中国总人口60%～70%的农村人口，只消耗了32%～33%的卫生总费用。以2000年为例，农民平均卫生总费用为188.6元，城市居民人均卫生总费用为710.2元，前者仅为后者的1.74倍。农村卫生事业费占全国卫生事业费的比重仅为32.7%。

政府应该加大农村卫生投入

目前，农村卫生投入的大头在地方政府，由于相当一部分县乡财政保工资都困难，每年对农村卫生增加的投入十分有限。事实证明，如果不从目前的卫生筹资体制进行根本性改革，政府所提出的所有的农村卫生目标的实现都要大打折扣，不同地区之间和城乡之间居民医疗卫生服务存在的巨大差距就不可能缩小。
为了做好农村的SARS防治工作，国家投入了大量的财力，用以完善农村尤其是中西部农村的医疗设施，对农民患者一律实行免费医疗，等等。这些投入不仅有利于当前农村的SARS防治工作，其形成的硬件和软件对于提高农村公共卫生条件也是有益的。

从长远看，我们建议加大中央政府和省级政府对农村卫生转移支付的力度。自1994年财税体制改革以来，在总体财政形势好转的背景下，县乡财政形势却令人担忧。尤其是在贫困地区，县乡财政持续出现严重入不敷出，面临著严重的公共财政危机。由于县乡财政税源有限，中西部地区县乡政府难以保证对乡镇卫生院的投入。90年代中后期，随着大批乡镇企业的转制，使农村乡镇卫生院和村卫生室既缺少政府财政的扶持，又难以依靠农村集体经济组织为农村卫生事业筹集资金。从2003年开始农村税费制度改革已在全国全面推进。农村税费改革后，县乡政府的财力增长又受到制约，尤其是乡镇一级政府预算外收入的增长大幅度下降，支持农村卫生的能力又进一步受到削弱。而税费改革后农村直接向农户集资，必须经过村民投票，而且集资额也受到严格的限制，这就使得县乡一级卫生筹资能力极其有限。

分税制改革后中央、省、市财政对本级直属卫生机构的投入有限，中央和省级政府农村卫生专项转移支付有限，加剧了不同地区之间尤其是中西部地区农村卫生服务的差距。目前，各地方政府实施的农村卫生项目中，中央财政支持的项目主要为农村卫生“三项建设”、农村卫生扶贫资金，以及农村居民使用碘盐以及 computation of public health conditions. In addition, from the perspective of building a reasonable health financing mechanism, it is necessary to strengthen public financial support for village health centers, which is a problem that must be reconsidered.

Furthermore, the rural health system faces another issue: the overlap of responsibilities between county and township health institutions. Currently, county and township-level medical and family planning service systems operate independently, resulting in inefficient resource utilization. How to integrate rural health financing institutions, improve rural health services, and address these issues remains a challenge.
使稀缺的卫生资源发挥最大的效益，也是中国农村卫生改革面临的一个重要课题。

**医疗保障制度是农民的“安全网”**

对农村卫生筹资体制进行根本性改革，这是中国农村卫生改革面临的首要问题。关键是卫生资源在城乡之间要进行公平分配，要完善中央对贫困地区的专项转移支付制度。改进农村公共卫生和医疗保障，绝不仅仅是卫生部门的事，也不仅仅是地方政府的事，如果不把它变成国家的最高决策，就有可能放任自流。

农民缺乏分担医疗费用的保险机制。改革以前，有85%的农民参加了合作医疗，但20世纪80年代以后，合作医疗大面积滑坡。现在只有10%的村有合作医疗，而且主要集中在发达地区。目前，广大农民缺乏基本医疗保障，基本上处于自费医疗的状态。

由于缺乏医疗保障体系，农民的医疗费用大幅度上升，明显超过了农民的承受能力。目前，受疾病模式变化、人口老龄化和医疗服务机构提供“诱导性”保健消费的影响，农民的医疗保健费用急剧上涨。1991年到2001年，农村卫生费用年均增长12.8%。而农民的收入增长率仅为7.7%。农民（尤其是贫困农民）的医疗负担相当重。1990年到1999年，农民每人次平均门诊费用和住院费用，分别由10.9元和473.3元增加到79元和2891元，增长了6.2倍和5.1倍。据调查，在贫困地区40%~50%应住院而未住院病例是由于经济困难；39%的病例因经济困难自己要求出院，即使是在富裕的农村地区该比例也达到20%~25%。目前，农民看不起病、因病致残、因病返贫的问题在贫困地区十分突出。

要提高农村公共卫生水平，就必须建立多层次、多类型的农村医疗保障制度。由于中国农村人口基数和需求量大而政府财力有限，短期内难以在农村建立覆盖面很宽的医疗保障制度，只能把有限的资金用于最急需的地方。对于广大农民来说，疾病威胁主要是重大疾病，这是他们无力承担的风险。发展大病统筹合作医疗是适应农民要求的。当前要建立以大病统筹为主的互助合作医疗制度作为完善农村医疗保障制度的重点。

政府确实承诺了对农村合作医疗的补贴。从2003年起，中央财政对中西部地区外的参加大病统筹合作医疗的农民，每年按人均10元安排医疗补助资金，地方财政对农民的补助每年不低于人均10元。但中央政府的转移支付是以地方政府的筹资为前提条件，而地方政府的筹资又是以农民的筹资为前提条件。对于经济发达地区来说，地方财政每年人均补贴10元没有太大的困难，但对于经济不发达地区而言，由于农村人口多，资金的保障是有困难的。个人缴费对低收入农民来讲，也是很沉重的负担。如果中央政府不预先提供新型合作医疗的启动资金，实现2010年建立以大病统筹为主的新型合作医疗制度的目标是非常困难的。大病统筹互助合作医疗制度的建立必须与农民的承受能力相适应，坚持自愿原则。经济发达的农村可以鼓励农民参加商业医疗保险。我国农村和城市的医疗保障是分离的。逐渐实现城乡基本医疗保障制度的并轨，应当是农村医疗保障制度改革的最终目标。

建立医疗救助制度，加强卫生扶贫工作是提高农村公共卫生水平的一项现实工作。医疗救助是医疗保障制度的一个组成部分。加强医疗救助制度建设，为最贫困的农村居民提供一定福利性的医疗保障，这是实现“人人享有卫生保健”的需要，更是摆脱“因病致贫”、“因病返贫”的需要。应当把经济扶贫与卫生扶贫结合起来，在国家扶贫资金总量中逐步加大对卫生扶贫的投入，帮助贫困地区重点解决基础卫生设施建设，改善饮水条件，加强妇幼卫生和防治传染病、地方病等方面的困难。

首先，对农村卫生筹资体制进行根本性改革，这是中国农村卫生改革面临的首要问题。关键是卫生资源在城乡之间要进行公平分配，要完善中央对贫困地区的专项转移支付制度。
其次，政府的财力是有限的，政府农村卫生工作的重点应突出抓好农村公共卫生。这次疫情的爆发，显示出农村应付重大疫情和公共卫生突发事件的能力很弱。事实证明，在目前的政策框架下，难以有效的解决农村公共卫生服务弱化问题。必须在中央和地方各级政府之间合理界定发展公共卫生的职责。

第三，中国政府重建农村合作医疗体制的努力没有达到预期目的，人们对2010年普遍建立大病统筹合作医疗制度的目标也存在疑问。必须在对目前进行的农村医疗保障实践作出评估的基础上，设计出适应农民需要的多层次的农村医疗保障模式。最后，在中国经济体制转轨的过程中，国家从农村医疗保障体系中退出，农村卫生完全取决于县乡基层政府的财政能力和自主决策，来自上级政府的转移支付十分有限。改进农村公共卫生和医疗保障，绝不仅仅是卫生部门的事，也不仅仅是在政府的事，如果不把它变成政府的最高决策，就有可能放任自流。当前，迫切需要根据新的形势对农村医疗卫生体系及农村医疗保障状况和农村卫生政策重新进行评估，并在此基础上提出一个推进农村卫生改革的总体框架。（完）（国研网）

Annex 3 (1)

中国首家经营国有医院股份制管理公司在河南新乡成立

CEIC000020040419e04j0005w
745 Words
19 April 2004
中国资讯行 - 新闻频道 (简体)
Chinese (Simplified)
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INFOBANK讯 中国首家经营国有医院的股份制管理公司——华源中原医院管理公司18日在河南新乡市正式挂牌成立。

据中新社4月19日电，国家卫生部的有关专家称：它标志着中国开始把国有医院由官办转向社会，是中国医疗卫生产业化、实现卫生行业体制和医院公有制改革的新尝试。

华源中原医院管理公司由中国华源生命产业有限公司以货币形式控股，新乡市国资经营管理公司以新乡市5家医院的资产参股合作成立。管理公司的两大股东一个是新型产业公司，一个是政府的国有资产产权代表。

该公司将对原新乡市中心医院、市第二医院、第三医院、市妇幼保健院和市中医院等5家医院实行集团化管理。

公司以新乡市政府的卫生区域规划为指导，以中原经济区人口为服务对象，以新乡市中心医院为核心医院，并按照渐进式过度原则，提高5家医院的医疗质量和病人满意度，强人员岗位职责意识，提高经济效益，最终实现新乡市区域性、城乡一体的医疗改革新模式。

公司负责人表示，他们将改变医院资源分散、无序竞争的现状，实行医院和学科的集团化、专业化管理，推行优势学科产品线管理模式，对人力资源配置、药材物资采购配送、后勤社会化保障等实行统一管理，并依靠华源公司在制药、医药流通、医疗器械、医疗健康的产业链，全面提高社会效益和经济效益，力争获得较好的投资回报率。

同时，通过整合当地医疗卫生资源，探索城镇医疗、社区医疗服务、农村合作医疗三位一体的医疗经营模式，促进新乡地区医院的改革与发展。还将吸引外资和商业医疗保险的共同参与，努力在医保、商保、资本3个市场探索建立市场化的医疗运营系统，利用国内外先进的医疗技术和管理
力量，让新乡地区和更大范围的人民群众得到实惠。

据知，这项医疗体制重大改革的方案是经中共新乡市委、人大、政府、政协和中国华源生命产业有限公司董事会审议通过后形成的。期间，5家医院还分别召开了职工代表大会，征询职工代表的意见并得到一致同意。

**Annex 3 (2)**

中国医疗系统翻天覆地（2）中国公共医院大刀阔斧进行改革
CHSLCN0020040331e03v00001
1150 Words
31 March 2004
朝鲜日报 (简体)
Chinese (Simplified)
(c) 2004 The Chosun Ilbo Co., Ltd.

在上海同济大学医院与美国医院合资创办的外国人专用医院，外国籍医生与中国医生进行讨论。

在中国实现医疗先进化的过程中，最显而易见的是公共医院的大改革。其改革核心是“出售不能盈利的医院”和“引进外国资本和民间资本，短期内提高医疗水平”。

民航医院位于上海市中心西北方向的新兴开发区虹桥。它是负责诊治中国25个航空公司飞行员和乘务员的公共医院。当记者18日访问该院时，民航医院为建设新健康诊断中心和牙科中心，正在进行修建工程。该医院与韩国“艺牙科医院”合作开办合资医院，筹集了修建费用。目前，民航医院同时推进10个合资医院计划，将利用美国、德国等外国资本改造心脏内科、整形外科、癌症治疗中心、妇产科等大部份诊断专科。院长颜惠根表示：“大部份的公共医院一直资不抵债。当今国家的医疗政策是，在公共医疗服务方面，由政府和民间共同参与，建设能盈利的医疗结构。”民航医院计划，利用外国资本建设18层高的新医院。颜惠根的工作从“医生”转变为“推销员”。

中国举国上下正在进行公共医院大改革。人口达65万的山东省烟台市为寻找收购市政府旗下牙科医院的投资者，上月访问了韩国。上海市武警医院也正在寻找投资者。位于北京的公共医院中日友好医院正在与民间企业联手建设具有600∼800个床位的疗养院。

不仅如此，上海市卫生部创办民间资本投资的上海卫生健康传播有限公司，由该公司来负责进行保健医疗对民宣传工作。从我国的情况看，相当于民间企业负责进行国民健康宣传活动。该公司总经理周解忠表示：“政府不应该承担公共医疗的负担。政府应对实现资金来源的多样化，事业的多元化，以提高公共业务的效率。”

同时，中国通过向外国医院开放医疗市场，不仅大力吸收先进医疗技术，而且对在华外国人提供更为便利的医疗服务，取得了显著的效果。

和睦家医院是中国与美国瑞德斯（音译）医疗企业合资成立的医院，是妇产科、儿科专门医院。大多当地外国患者喜欢到这家医院就诊。该医院位于北京市外国人密集居住的朝阳街。销售经理里奥（音译）表示：“虽然以美国医疗价格为标准收取高额诊费，但大部份患者都已加入美国保险公司的医疗保险，因此，可利用医疗保险费接受治疗。”这与连真正的外国人专用医院都没有的国内情况形成鲜明的对比。和睦家医院计划，今年在上海成立第二所医院。在北京和上海，外国诊所和医院分别有13个和28个。

位于上海浦东地区中心的同济大学医院在医院大楼第12层开办了美国合资医院，专为外国患者看病。在这里，外国医生主要给外国人看病。该医院的第13层是德国医院，主要诊治心脏病。同
济大学医院营销董事王新迪（音译）表示：“不仅向他们学习先进的医院经营经验，而且由于外国人的诊费比较高，还能增加收益。”

位于上海市中心区的新加坡临床国际医疗中心，拥有来自美国、日本和韩国等国的外国医生。他们主要为居住在上海市的10多万外国人看病。该院院长伊丽莎白（音译）表示：“在2年间，把诊所增加到了4个。外国企业或领事馆正在大量购买能够获得诊费优惠的会员卡。”

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Annex 4 (1)

卫生部发布开展按病种收费管理试点工作的通知
XPHHCN00200409001e091000mc
973 Words
01 September 2004
新华社经济信息-中西医卫生信息（简体）
Chinese (Simplified)
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为促进因病施治、合理检查、合理用药，减轻患者医药费用负担，卫生部办公厅日前发布开展按病种收费管理试点工作的通知。为保证试点工作的顺利开展，提出如下意见：

一、试点工作目标及要求

试点地区要在现有收费管理的基础上，积极研究制订按病种收费管理办法，在保证医疗服务质量的前提下，有效控制医药费用不合理增长。

（一）全面总结和分析现有按病种收费管理的经验和做法，并在此基础上形成各地具体的实施方案。

（二）在选择试点医院、确定病种及制定病种收费标准时，要结合当地实际情况，既要考虑具体方案的科学性，还要考虑可操作性。

（三）按病种收费管理直接涉及到患者切身利益，试点地区要协调有关政策，做好按项目收费管理和按病种收费管理两个办法之间的衔接，尽量避免产生纠纷。

（四）边实践、边总结，注重实效。按病种收费管理改革是一项非常复杂的工作，各地应制定阶段性目标，可在条件比较成熟的地区和医院首先试点，探索经验，再逐步推开。

二、开展按病种收费管理的基本内容

（一）选择病种

在选择病种时，原则上应当与医院目前使用的疾病诊断标准一致，即ICD-9或者ICD-10，并应考虑以下因素：

1、疾病发生频度较大，即常见病和多发病；
2. 疾病的经济负担较重，即在疾病频度相同的情况下，选择费用较高的病种；

3. 病种的临床治疗效果（诊断、治疗、转归）比较明确。

（二）制订病种收费标准

在制订病种收费标准时，可以当前病种实际费用为基础，组织专家对医药费用的合理程度进行评价，减扣不合理部分，增加应当提供的服务，调整病种费用。

病种费用数据的收集可以充分利用医院信息管理系统。在病例的选择上，应当采取科学的统计方法，尽量扩大选定病种的样本量（如当年病例数不够大，可以将样本扩大到最近几年），以提高病种费用数据的可靠性和稳定性。

（三）监督评价

实行按病种收费的医院应当建立内部监督和评价机制，明确监测和评价指标，监测病种收费的实施，评价服务质量，分析医院总的医药费用变化情况。如发现问题，要及时调整按病种收费方案，保证按病种收费管理目标的实现。

三、组织工作

试点省（市）卫生厅（局）要加强领导，并积极协调价格部门，组织本地区按病种收费管理研究探索工作。

（一）成立当地技术专家组，确定病种、测算病种费用和制订监测评价指标；

（二）选择进行病种收费管理试点的医院；

（三）组织监测和评价工作，特别是对按病种收费管理后医疗服务质量受到的影响以及费用转移情况（例如费用从住院转到门诊及推诿病人等问题）进行监测与评价。分析按病种收费管理的效果，并总结经验。

卫生部将协调试点有关工作，交流经验，并组织专家提供技术支持。（卫生部网站）

Annex 4 (2)

(11) 中国卫生部采取措施解决国民看病难问题

HKCNAC0020040726e07q0008e
427 Words
26 July 2004
香港中国通讯社 (简体)
Chinese (Simplified)
(c) 2004

（香港中通讯社北京七月二十六日电）中国卫生部继前一阶段要求各级卫生行政部门和医疗机构自查自纠医疗服务收费问题后，今年下半年将陆续推出一系列改革措施。其中包括降低药品价格、医院药品批零差价率、大型设备检查治疗费、高值医用消耗材料费用，和提高诊疗费，藉此解决百姓看病难、看病贵问题。
据北京官方报章今天报道，下半年陆续推出的措施有：

——全国各省市区今年内必须全部执行二00一年下发的《全国医疗服务价格项目规范》。明年，卫生部将对各地《项目规范》执行情况进行专项检查，并将检查结果通报全国。

——卫生部准备选择三十个病种，在七个省市开展按病种收费的试点工作，探索经验，降低医药费用。

——在医疗机构内部建立医院和科室，科室和医生、医生和病人之间互相监督、相互约束的价格管理机制。把价格管理工作纳入科室综合目标考核内容。督促医疗机构依据《临床诊疗指南》，制定严格的合理用药制度。加强对医生用药的培训和监督，定期公布各科室和医生用药情况。建立医生处方评价制度，科室和医生合理用药要作为考评的重要依据和医生职称晋级的重要条件。

Annex 5 (1)

想晋升 先下乡——安徽省出台城市医生下乡服务意见

在一个聘任周期内，如不到农村乡镇卫生机构工作满3个月，将不得晋升高一级专业技术职务。近日，安徽省卫生厅下发了《关于城市卫生技术人员到乡镇卫生机构定期服务的实施意见》。《意见》规定，从2005年起，安徽省将实施这一强制性措施，以促进卫生人才向农村流动，提高农村的医疗卫生服务水平。我国城乡之间卫生资源的差距，使城市卫生资源过剩，而农民却很难就近得到高质量的医疗卫生服务。安徽省此次规定，城市卫生技术人员到乡镇工作的主要任务是：协助开展卫生改革；为农民提供优质的医疗卫生服务；帮助乡镇培养技术骨干；开展健康教育，普及卫生知识，同时接受锻炼和教育，提高自身的政治和业务素质。选派对象为省市二、三级医院的医师和主治医师；下乡服务可以分段进行合并计算，但每次不得少于1个月；派出人员在乡镇工作期间，工资、待遇等与在职职工相同，补助费比照干部挂职锻炼执行；接受单位要对下派人员进行管理，工作结束时进行考核，结果记入本人档案。从现在起到2004年底前，到乡镇卫生机构工作的城市医生，在同等条件下优先推荐、晋升专业技术职务。2005年起，到乡镇卫生机构工作将作为晋升专业技术职务的必备条件。安徽省规定，选派工作要有计划地逐年安排，根据基层需要及选派单位实际情况进行。目前在乡镇难以发挥作用的少数专业性很强的医生，可以到中心卫生院或县级医院工作。此外，参加援外和援藏医疗队、青年志愿者活动、突发性急救、抗洪救灾等工作的时间，可视作下乡工作时间。

摘自2002年10月11日《健康报》

为卫生院选好院长——河南部分县市改革任用模式

近年来，河南郏县、新郑市等地卫生行政部门大胆改革基层医疗卫生人员的任用模式，公开选拔经验丰富、责任心强、懂管理的优秀人才到乡镇卫生院担任院长，使一些乡镇卫生院得到了迅速发展。郏县从县卫生局和县直医院选调一批年富力强、勇于开拓的年轻干部，充实到乡镇卫生院任职，并对下派干部实行“三个不变”，即原来所任职务不变，工资发放单位不变，组织关系不变。新郑市在乡镇卫生院收归县卫生局统管后，对具有管理才能的县直单位业务技术骨干和乡村名医担任院长。新郑市把选拔培养
好乡镇卫生院院长作为重要工作，先后从市直单位选拔 29 人到乡镇卫生院任职，并要求院长们努力做到懂管理、懂法律、懂业务，会核算、会交际、会做思想工作，树立质量观念、法律观念、市场观念。淮滨县通过考试考核、演讲答辩、组织审批，公开选拔 23 名正副院长充实到各乡镇卫生院。各地一批懂业务、善管理、思路清、有开拓精神的优秀院长的涌现，使乡镇卫生院焕发了新的生机和活力。
——摘自 2002 年 10 月 4 日《健康报》

青海省海西州卫生事业单位人事制度改革稳步推进

青海省海西州全面推进卫生事业单位人事制度改革，取得了较好的成绩。州级医疗卫生单位已全面完成院（所）长的考核、聘任及中层干部和专业技术人员的竞聘上岗工作；各县、市、行卫生单位人事制度改革正在进行。格尔木市已完成对 17 名院（所）长及 82 名科室主任的考核、竞聘工作，正在抓紧进行各科室人员的竞聘上岗工作；都兰县、大柴旦行委已完成《职位说明书》的编写，全面进入各级人员的考核、竞聘上岗工作，全州人事制度改革工作预计将于 9 月底全面完成。

乡镇卫生院人事分配制度改革全面启动，德令哈市、都兰县结合实际，制定了《乡镇卫生院人事分配制度改革方案》。德令哈市通过公开招聘工作，九月中旬将完成乡（所）卫生院人员聘用工作。都兰县各乡镇卫生院采取岗位工资与津贴工资相分离的方式，将工资总额的 70% 或 60% 作为固定收入，按月足额发放。将工资总额的 30% 或 40% 作为津贴部分由单位集中使用，按照不同的岗位兑现不同的岗位津贴，统筹考虑，突出优岗优酬。州卫生局将于 12 月初对全州各县（市、行委）卫生事业单位人事分配制度改革进展情况专门进行一次督导检查。

———选自第 24 期《青海卫生信息》

**Annex 5 (2)**

英阿斯利康公司与北大合作培养卫生经济管理人才

CEIC000020031204dzc40002p
554 Words
04 December 2003
中国资讯行-新闻频道 (简体)
Chinese (Simplified)
(c) 2003 中国资讯行

INFOBANK 讯，北京大学光华管理学院副院长张维迎与阿斯利康公司中国区总裁柯石谛 2 日在北京大学签署了双方合作培训中国卫生经济管理人才的意向书。

据中新社 12 月 3 日电，意向书明确：在今后 3 年内，阿斯利康公司将赞助 300 万元人民币在北京大学中国医药经济研究中心建立面向政府官员、医院与药房管理人员的研究、咨询及培训项目。

培训内容包括：邀请国外知名专家主持一系列专题研讨会，开展为期两年的交流奖学金计划（获奖学员将分别在光华管理学院和阿斯利康公司接受培训），以及全国范围的短期培训计划等。

张维迎称，目前中国需要培养大量医药经济领域的专业人才，以适应中国医疗体制改革。他表示“很高兴能得到阿斯利康这样的领先医药企业的大力支持。希望在双方共同把北京大学中国医药经济研究中心办成中国卫生经济人才的培育基地。”

阿斯利康公司首席执行官麦奇洛爵士表示，阿斯利康始终致力于在全球范围推动卫生保健领域的科学教育事业。他希望与北京大学的这一开拓性的合作项目能为中国卫生经济领域造就未来的决策者与核心人才。

签字仪式后，麦奇洛爵士向光华管理学院的师生做了主题为“推动创新把握良机”的专题演讲。

总部设在英国伦敦的阿斯利康公司是全球五大制药公司之一，主要从事处方药品和医疗服务的研发
发、生产和销售业务，2002年销售额超过178亿美元。

北京大学副校长郝平教授出席了今天的合作签字仪式。

Annex 5 (2)
医科生毕业后不能立即当医生
669 words
25 January 2005
中国医药报 (简体)
14
Chinese - Simplified
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日前，从在南方医科大学举行的今年首场医药类专场校园招聘会上传出消息：根据卫生部近期召开的会议精神，广东省将加强对医学类高校毕业生的住院医师规范化培训；我国今后将实行未接受住院医师规范化培训不得评职称的制度。这一消息意味着广东省未接受住院医师培训的医学类高校毕业生的铁饭碗即将被打破。

据了解，目前我国的医学本科毕业生都是先分配到医院，工作一年后通过考试就可获得医生执照，独立为病人诊疗。由于手里已经捧着“铁饭碗”，这些“新手”医生到医院后往往缺少自我提高的动力，而分配到基层医院的学生因条件限制，也常常得不到正规培训。

这种情况导致患者不信任刚毕业的医生，要求经验丰富的老医生诊疗，而怕碰见“新手”医生。为了迎合患者需求，医院则倾向于从社会上招聘高水平、有丰富经验的医生，导致医学本科毕业生就业形势十分严峻。日前，在南方医科大学举行的这场招聘会上，共有97家用人单位进场招聘，吸引了近3000名医科毕业生应聘。但除了护理学、医学影像学等专业毕业生较受欢迎外，很多大型医院甚至包括不少基层医院均表示，对临床医学专业本科生不感兴趣。

据有关医学专家介绍，在国外，病人看病无需顾虑医生知识和经验是否不足，因为国外早已实行专科医师培养与准入制度。据南方医院副院长张树军介绍，日前召开的中国医师协会第三次工作会议已经提出，我国应加快医师毕业后医学教育管理工作，并完善专科医师培养与准入制度。

目前广东省省人民医院、南方医院、珠江医院等已成为广东省住院医师规范化培训基地，这些基地将对医科毕业生进行“3+X”的规培计划。

张树军表示，南方医院将在南方医科大学、同济医科大学等国内著名医科院校，择优录取30名毕业生作为“住院医师规范化培训”的培训对象。

Annex 6 (1)
中国2006年将基本实现处方药凭处方销售
421 words
12 January 2005
中国产业每日新闻 (简体)
Chinese - Simplified
Copyright 2005. Beijing Xinhua InfoLink Development Co Ltd/CINIC. All Rights Reserved.
国家食品药品监督管理局宣布今年将分批公布必须凭医师处方销售的处方药品种，2006年基本实现处方药凭处方销售。同时要对一些长期需靠药物维持治疗的慢性疾病的用药问题进行专题研究，以进一步方便群众就医用药。

2005年底之前，符合药品分类管理要求的零售药店，可以继续销售处方药与非处方药。达不到药品分类管理要求的零售药店，只能销售甲类非处方药和乙类非处方药，或只能销售乙类非处方药。

今年国家食品药品监督管理局将进一步协调卫生部门，促进药品分类管理的实施。为此，今年国家食品药品监督管理局将组织起草《处方药与非处方药分类管理条例》草案，争取列入国务院立法计划，推进药品分类管理工作向前发展。

1998年以来，我国已初步建立了药品分类管理制度和模式，先后公布了4400多个非处方药品种。目前销售处方药的地市以上城市零售连锁企业和大中型零售企业已基本达到分类管理要求，零售药店所有注射剂和未列入非处方药目录的抗菌药物必须凭医生处方才能销售，到2004年底执业药师人数已超过11万人。