"The Current Situation of Health in China"
May 8-9, 2012
Harvard Center Shanghai

SUMMARY

TUESDAY, MAY 8

Keynote Speech

Minister Chen opened the symposium by highlighting China's Health Care Reform begun in 2009, when basic health services were acknowledged as public goods that should be accessible to all citizens. He reviewed the framework of four systems put in place to provide primary healthcare for the country (public health, medical care, health insurance, and drug supply). Progress to date: the expansion of basic health insurance has reached approx. 98% of the rural population, covering almost 1.3 billion citizens in total, and government subsidies for urban residents and farmers has increased dramatically, thus reducing out-of-pocket payments by individual patients. The mark-up of drug prices has also been discouraged thanks to new purchasing/distribution methods. One of the major efforts of the reform is to implement a standard training program by recruiting 9,000 licensed doctors and waiving tuition fees for 5,000 medical students who wish to become general practitioners. Another intensive effort is underway to reform hospitals at the national and provincial level by evaluating management/customer service, compensation practices, payment services, quality/safety concerns, and improving the overall perception of these facilities as reliable places in which to seek treatment and care.

Panel #1: The Lessons of China's Health System Reforms for the World

XU Hengqiu spoke of the challenges faced by Anhui's Health Department – rural healthcare services cannot keep up with patient demand; finances and staffing are limited; and the overall service quality and efficiency is low. She discussed a tiered system for healthcare, beginning with government-funded township hospitals to provide basic medical services, supported by village-level clinics. As part of the national reforms mentioned by Minister Chen, Anhui seeks to improve its personnel system by training doctors/physicians, eliminating the practice of pay-for-performance, standardizing drug procurement and distribution policies, and increasing financial subsidies from the local government to cover basic expenditures.

LIU Yuanli stressed China's Health System challenges of access (overcrowding), affordability (over-prescription of drugs), and appropriateness (safety and doctor-patient trust). By improving health information systems (IT), patient data becomes more accessible and reliable, health patterns/trends are more easily monitored, and coordination between varying levels of care is possible. In Minhang District, patients are issued an electronic health card to aid with registration/payment, to facilitate computerized medication dispensing, and to standardize patient record upkeep and retrieval.

Bill Hsiao discussed the Chinese citizens' lack of trust and confidence in the lower level hospitals (village/township), thus causing the burden of overcrowding at the level three hospitals in the city. China's healthcare expenditure has risen at an inflated rate of 15% compared to GDP (10%) as a result of hospitals needing to earn revenue to pay their doctors and staff to keep pace with the volume of patients. This 'for-profit' mentality has become a major issue – how to restore ethical behavior and

implement medical guidelines? Human resources are important along with the governance structure of hospitals. China needs to figure out how to synchronize healthcare financing with its staffing capabilities in order to provide safe, responsible, preventative services.

Panel #2: Major Health Challenges

Barry Bloom outlined China's five major health challenges as follows: 1) infectious diseases, 2) chronic diseases, 3) unnecessary epidemics, 4) disparities in health, and 5) health systems. A recent increase in life expectancy and a reduction in morbidity/mortality is certainly good news, but smoking remains a serious issue with 1/3 of the current male smokers predicted to die by 2025, resulting in three million annual 'tobacco deaths'.

WANG Lixia reported that the DOTS Strategy (Directly Observed Treatment, Short-course) is being utilized for the prevention and treatment of TB, combining the free diagnosis and registration of approx. 900,000 TB patients annually with access to first-line anti-TB drugs (also free). The central government has increased its funding significantly, with additional global funds available from the Gates Foundation. Despite these resources, China remains a high-burden country (ranked #2) with an uneven TB prevalence by region (rural vs. urban) and limited personnel who are trained to use the necessary technology.

Megan Murray explained the routes to drug-resistant TB and the current gaps: 1) diagnosis is slow and can be expensive, 2) treatment is highly variable based on access, 3) surveillance can be challenging – need to identify high-risk populations (prisoners, diabetics, smokers, poor/malnourished) and use spatial mapping to identify "hot spots". Priorities include developing a database of drug-resistant mutations, encouraging early and active diagnosis, and using molecular/spatial surveillance to identify and track the routes of transmission.

Joe Tucker discussed the increased number of reported syphilis cases in Shanghai and the Guangdong Pearl River Delta region and the social devastation that has resulted: minimal tracing of sex partner contact, widespread homophobia, devolution of family structure and loss of face, and a large commercial sex sector attracting high-risk businessmen. In 2010 China launched a National Syphilis Prevention and Control Plan to integrate screening with other pre-natal testing and to encourage culturally appropriate responses through local networks of physicians, public health officials, and social entrepreneurs.

David Christiani and **WU Tangchun** highlighted the five leading causes of death in China (lung cancer, cerebrovascular disease, heart disease, respiratory disease, and trauma/poisoning). Treatment costs have increased and social, economic, and environmental changes are all to blame (not just genetics). Encouraging physical activity such as tai chi and dancing can help combat side effects – individuals must take charge and not rely solely on government response.

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Paul Farmer shared his belief in Accompaniment as a cornerstone of care – the role of community healthcare workers is equally if not more important than the services provided by doctors in hospitals. Using examples from Haiti, he discussed public-private partnerships to rebuild the rural healthcare infrastructure and the need to consider horizontal, vertical, and diagonal methods of treatment following the earthquake in 2010. Global health delivery must and should include partnerships between for-profit organizations, government ministries, international agencies, medical institutions, non-governmental organizations, and academia, among others.

Panel #3: Mental Health in China

Arthur Kleinman provided an overview of the global burden of mental disorders, stating that 10% of adults suffer from mental illness and often don't seek care due to stigma, lack of awareness, or lack of available services. Families therefore bear the brunt and their caregiving is not always guaranteed. Out of the total health budget, the WHO estimates a median mental health budget of approximately 2%, compounded further by a shortage of trained psychiatrists and an inappropriate trend in recent years to over-diagnose.

Michael Phillips described the challenges to providing mental health services in China as follows: unequal access in rural vs. urban settings; services provided by specialists not general physicians (yet limited number of clinical psychologists, social workers, mental health nurse practitioners); legal framework for protection/supervision of mentally ill isn't complete; mental health research is limited and of poor quality. The Chinese Ministry of Health first released mortality statistics and conducted a national psychological autopsy study in the 1990s – high rates of suicide became public knowledge. Projections estimate there are 173 million adults with mental illness in China today, including 158 million of whom have never sought treatment, and a quarter of whom are moderately to severely disabled because of their condition.

XIAO Zeping highlighted healthcare reform as the top priority out of China's five largest public issues. And while health expenditures have increased to address this issue, out-of-pocket costs have risen faster than government spending and the distribution of healthcare spending still favors urban over rural settings. In the last 60 years, mental health resources have increased (more hospitals, more beds, and more psychiatrists). As part of the 2009 health reform, a national strategy on mental health is being developed to reconstruct services (from a specialty to community-based system) and expand the field (combine health promotion and education and create a service network).

XIE Bin reported that the 1990s saw a significant percentage of mental health legislation passed around the world. This same period was a good window of opportunity for China, but despite promotion/advocacy through media in the 2000s and beyond, the agreement of stakeholders and overall motivation has weakened as society focuses on economic development and healthcare reform.

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Since 2000, China has begun to rethink mental health provision from automatic institutionalization to developing standards/procedures for involuntary treatment. Changes are needed in the overall perception and care of the mentally ill, including advocating for due process, individual rights, shared responsibility, and morality.

Panel #4: Aging Challenges in China

Joan Kaufman discussed China's demographic situation and the worrisome implications, including low fertility levels; an aging population (particularly in rural settings as youth migrate to cities); an increasing prevalence of non-communicable diseases as life expectancy improves; and an increasing burden on families (particularly those with one child). Elderly people 60+ constitute 12% of current population (166 million) but by 2050 will increase to 30% of total population (400 million). The tradition of filial-piety and the legacy of the one-child policy make elder care more challenging in the future, particularly as China's total labor force decreases and the 'cost of aging' escalates and falls on the shoulders of families and their (minimal) offspring.

CHEN Hongtu spoke about the impact of urbanization, marketization, and China's aging population in the next 20 years. Projections show there will be 122 million additional elders (65+) by 2030, meaning 38 million additional elders in need of long-term care for chronic conditions such as mental illness, stroke, dementia, and severe disabilities. Of the current options for long-term care (hospitals, nursing homes, and day centers), only 2.3% of Chinese elders are in nursing homes due to refusal of treatment, lack of adequate care, and a waiting list of 5-10 years.

PAN Tianshu described Chinese elders as the heroes who keep the model community together. These "granny cadres" have the time and energy to devote to service, whereas until recently, the younger generation was less likely to respond through similar spontaneous volunteerism. After the 2008 Sichuan earthquake, the government loosened restrictions on NGOs and youth participation in volunteer efforts began to increase. Society should create space for neighborhood organizations and NGOs involving both young and old alike.

PENG Xizhe emphasized the difference in caregiving for healthy and disabled elderly. In Shanghai, there are 50,000 caregivers in hospitals and 600,000 home-based caregivers. The number of trained social workers is more than the number of trained doctors/nurses – need to better integrate resources and services. The retirement age for women is 50, meaning a loss of social capital if these women live another 30 years when they could have been working. The aging process is based on deteriorating health conditions, not on an individual's actual age.

Jeanne Shea discussed the overgeneralization of elderly as non-contributors and burdensome to society. Rather it's a complex partnership where elderly often provide caregiving themselves (from one spouse to another; for their own adult children or even grandchildren). Given the tradition of filial piety, today's elderly still wish they could rely on their own children for care and support, but the younger generation

is no longer socialized to do so and this moral crisis and breakup of family networks will have major consequences.

ZHAO Yaohui reported on China's Health and Retirement Longitudinal Study (CHARLS), a biannual survey done of all Chinese residents 45+, and the value of these findings as China experiences rapid demographic and economic changes. A pilot study was launched in 2008 in Gansu and Zhejiang provinces, helping to establish a national baseline in 2011-12. The questionnaires included an accounting of household members, biomarkers, assets, education level, insurance coverage, work/retirement/pension among other details. The survey was funded by NIA, the World Bank, the Natural Science Foundation of China, and Peking University.

WEDNESDAY, MAY 9

Panel #5: Ethics in Medicine, Public Health, and Biotechnology

Arthur Kleinman provided a brief definition of *morality* (having values, negotiating relationships with others, engaging in local context) and *ethics* (aspiration to go beyond local to transparent, provide professional discourse/language for understanding). Samples of current moral/social issues in Asia include: decline in familial/filial ties (horizontal ties more important than vertical); rise of individualism and materialism; deepening corruption; conflict between private gains and public welfare; inadequate regulatory structures/legal systems. Ethical codes of conduct and training in Asia have often been based on Western frameworks – should instead call upon local traditions of virtue-based ethics found in Confucianism, focusing on moral self-cultivation and virtues of the individual, and relating to real world problems. Caregiving defines humanity (taking responsibility for another), and should not be viewed as a burden but a way of being.

NIE Jing-Bao described bioethics as a multidisciplinary, diverse set of paradigms rooted in theology during the 60s-70s and later influenced by philosophy in the 80s and empirical evidence/anthropology in the 90s. While many ethical issues have remained the same, the context has changed and a major debate has ensued between external medical morality (Hippocratic Oath, legal profession) and internal medical morality (social ethics, personal experience). Several questions remain: how much from global practice should be transplanted to China? What is the relevance of local tradition (Confucianism, Daoism, Buddhism, Christianity, Socialism, Islam)? How to address moral pluralism (Western vs. Chinese outlook)? There is a fundamental ethical difference between misfortune and injustice, as is evidenced in the structural inequalities between rural/urban settings. The moral ends of a good, healthy society include promoting social justice, safeguarding human rights, and respecting human dignity.

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SUN Chao gave an overview of the Minhang District's medical reform currently underway and the challenges inherent in serving this large population (3 million) with limited resources and lack of standards for quality care. Rather than building more hospitals and raising the cost of health insurance to pay the doctors, Minhang has chosen to use information to make medical services affordable, accessible, sustainable, and of higher quality. Implementing these transparent, democratic policies has helped Minhang achieve higher than average life expectancy and lower than average infant/maternal mortality rates, and has resulted in more patients served and increased early detections while reducing out-of-pocket fees when compared with other districts in Shanghai.