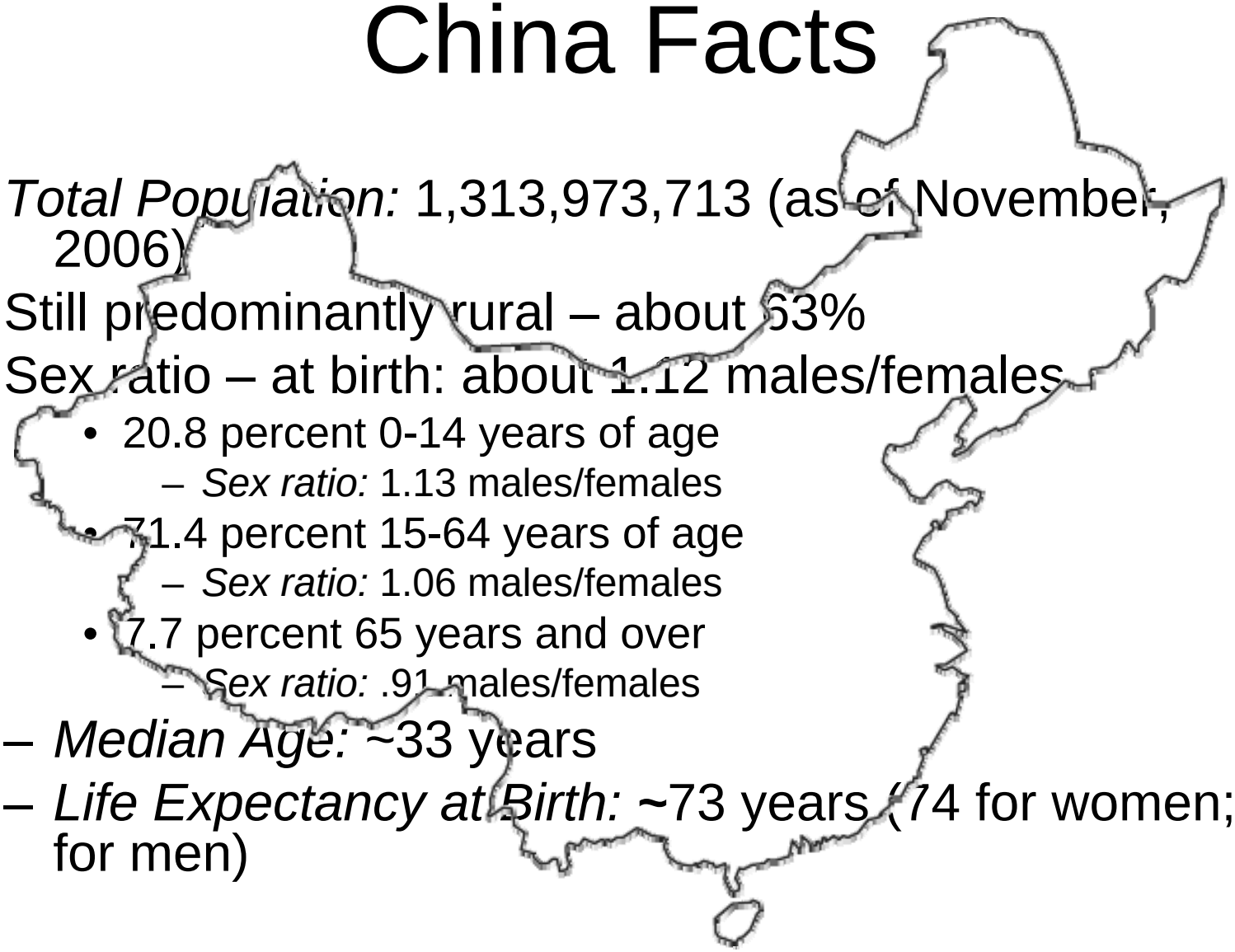
Health Cooperation and China

Erika Elvander

April 10, 2007

China Facts



Total Population: 1,313,973,713 (as of November, 2006)

Still predominantly rural – about 63%

Sex ratio – at birth: about 1.12 males/females

- 20.8 percent 0-14 years of age
  - *Sex ratio:* 1.13 males/females
- 71.4 percent 15-64 years of age
  - *Sex ratio:* 1.06 males/females
- 7.7 percent 65 years and over
  - *Sex ratio:* .91 males/females

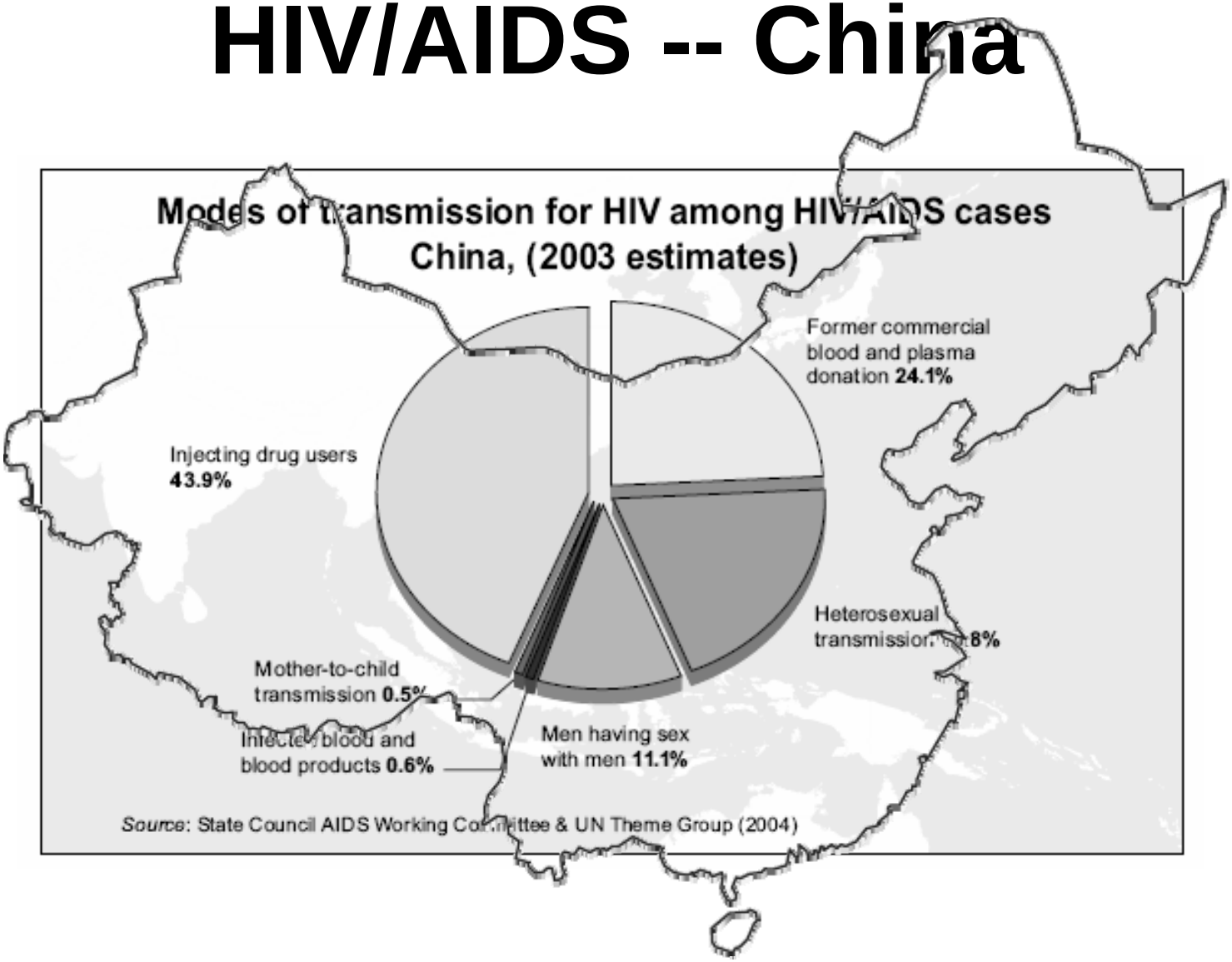
– *Median Age:* ~33 years

– *Life Expectancy at Birth:* ~73 years (74 for women; 70 for men)

HHS and China

- Relationship began in 1979 with the signing of the health protocol
- In FY 1990, NIH funding was about $5M
- In FY 2005, NIH funding was almost $32M
- In FY 2005 HHS funded almost $50M worth of activities with China including grants, contracts, and staff assignments
- In 1997, HHS had 3 HHS/CDC assignees to China; in 2007 HHS has 8 assignees, including one health attaché assigned to the U.S. Embassy

HIV/AIDS -- China



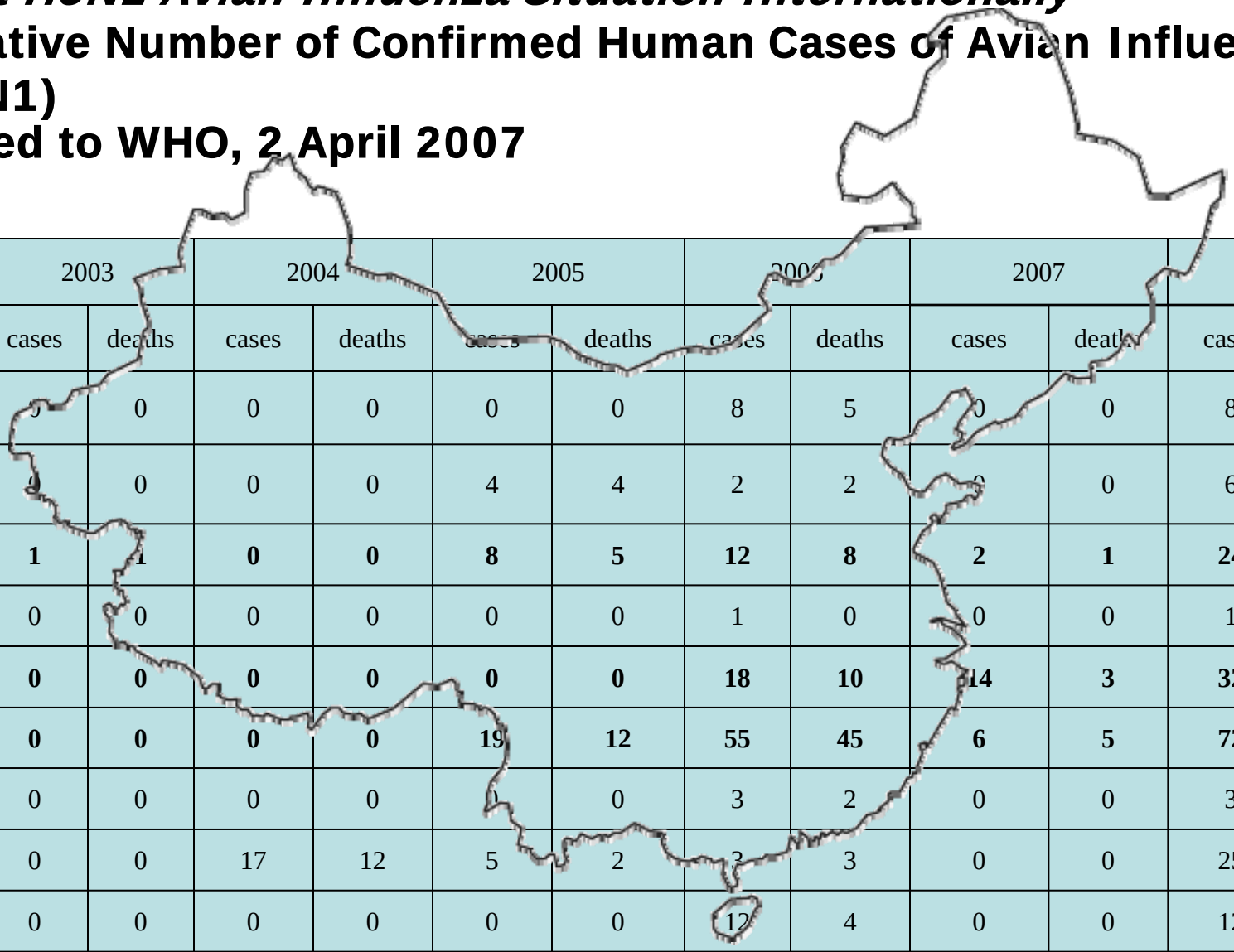
SARS

- February 2003
- 8000 cases
- 775 deaths
- 30 countries
- 6 continents
- **$20-25 billion economic losses**


NATIONAL GEOGRAPHIC
Killer Flu
nature
AVIAN FLU
BusinessWeek
THE NEXT BIG ONE
TIME
DEATH THREAT
FOREIGN AFFAIRS
The Next Pandemic?
TIME
BIRD FLU

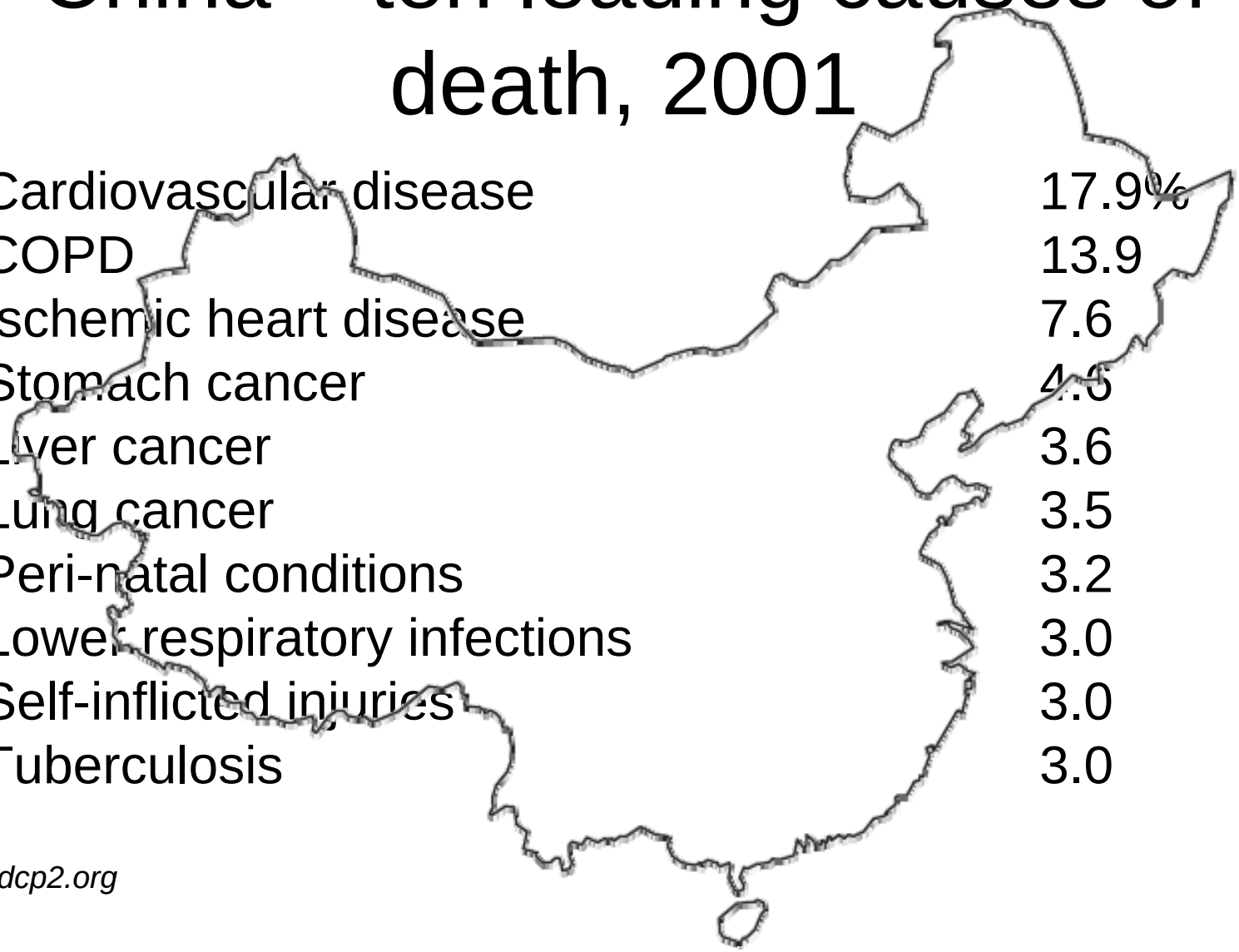
Current H5N1 Avian Influenza Situation Internationally

Cumulative Number of Confirmed Human Cases of Avian Influenza A/(H5N1)
Reported to WHO, 2 April 2007



Country	2003		2004		2005		2006		2007		Total	
	cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths
Azerbaijan	0	0	0	0	0	0	8	5	0	0	8	5
Cambodia	0	0	0	0	4	4	2	2	0	0	6	6
China	**1**	**1**	**0**	**0**	**8**	**5**	**12**	**8**	**2**	**1**	**24**	**15**
Djibouti	0	0	0	0	0	0	1	0	0	0	1	0
Egypt	**0**	**0**	**0**	**0**	**0**	**0**	**18**	**10**	**14**	**3**	**32**	**13**
Indonesia	**0**	**0**	**0**	**0**	**19**	**12**	**55**	**45**	**6**	**5**	**72**	**55**
Iraq	0	0	0	0	0	0	3	2	0	0	3	2
Thailand	0	0	17	12	5	2	3	3	0	0	25	17
Turkey	0	0	0	0	0	0	12	4	0	0	12	4
Viet Nam	3	3	29	20	61	19	0	0	0	0	93	42
Total	**4**	**4**	**46**	**32**	**97**	**42**	**115**	**79**	**25**	**12**	**288**	**170**

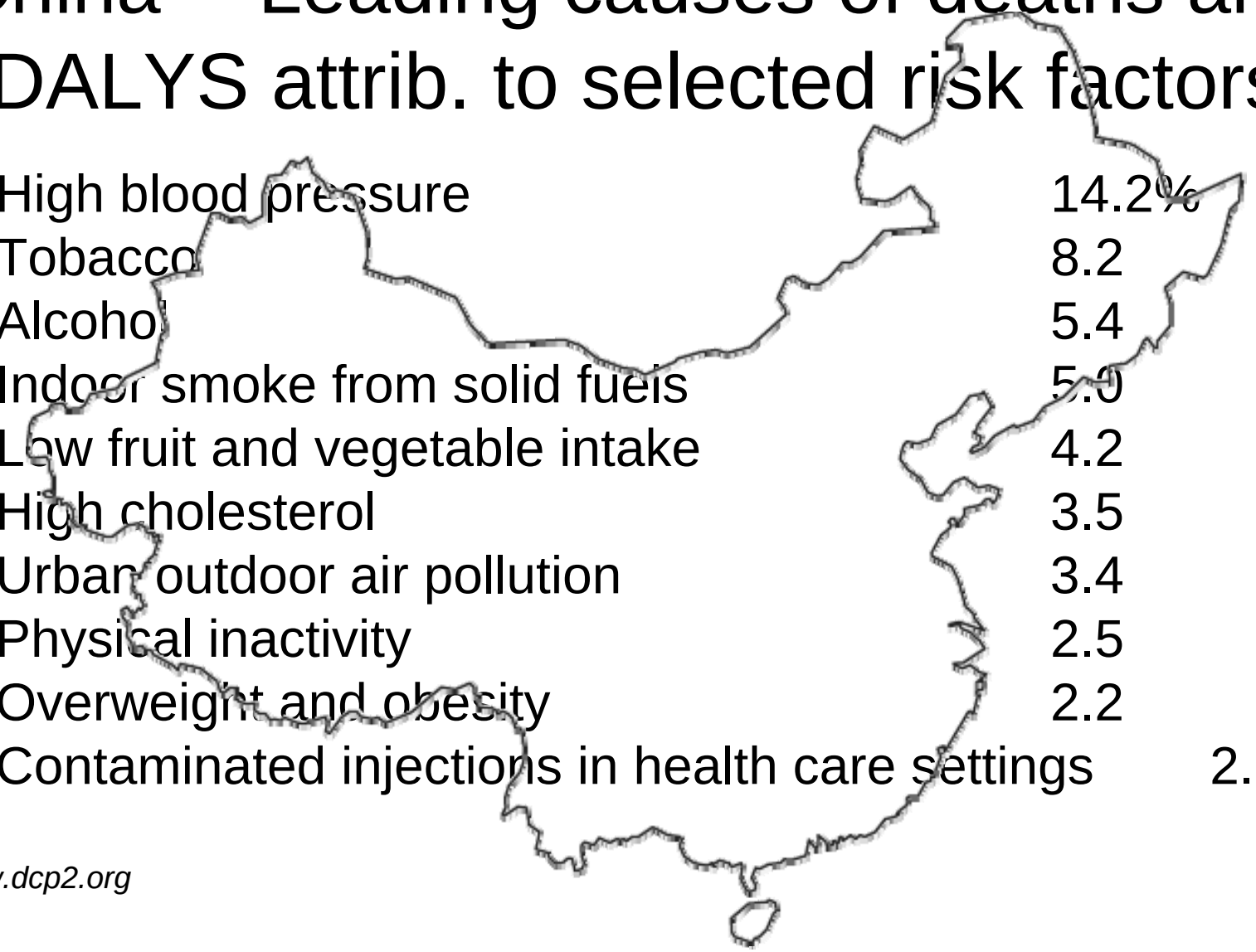
China – ten leading causes of death, 2001



• Cardiovascular disease	17.9%
• COPD	13.9
• Ischemic heart disease	7.6
• Stomach cancer	4.6
• Liver cancer	3.6
• Lung cancer	3.5
• Peri-natal conditions	3.2
• Lower respiratory infections	3.0
• Self-inflicted injuries	3.0
• Tuberculosis	3.0

www.dcp2.org

China -- Leading causes of deaths and DALYS attrib. to selected risk factors



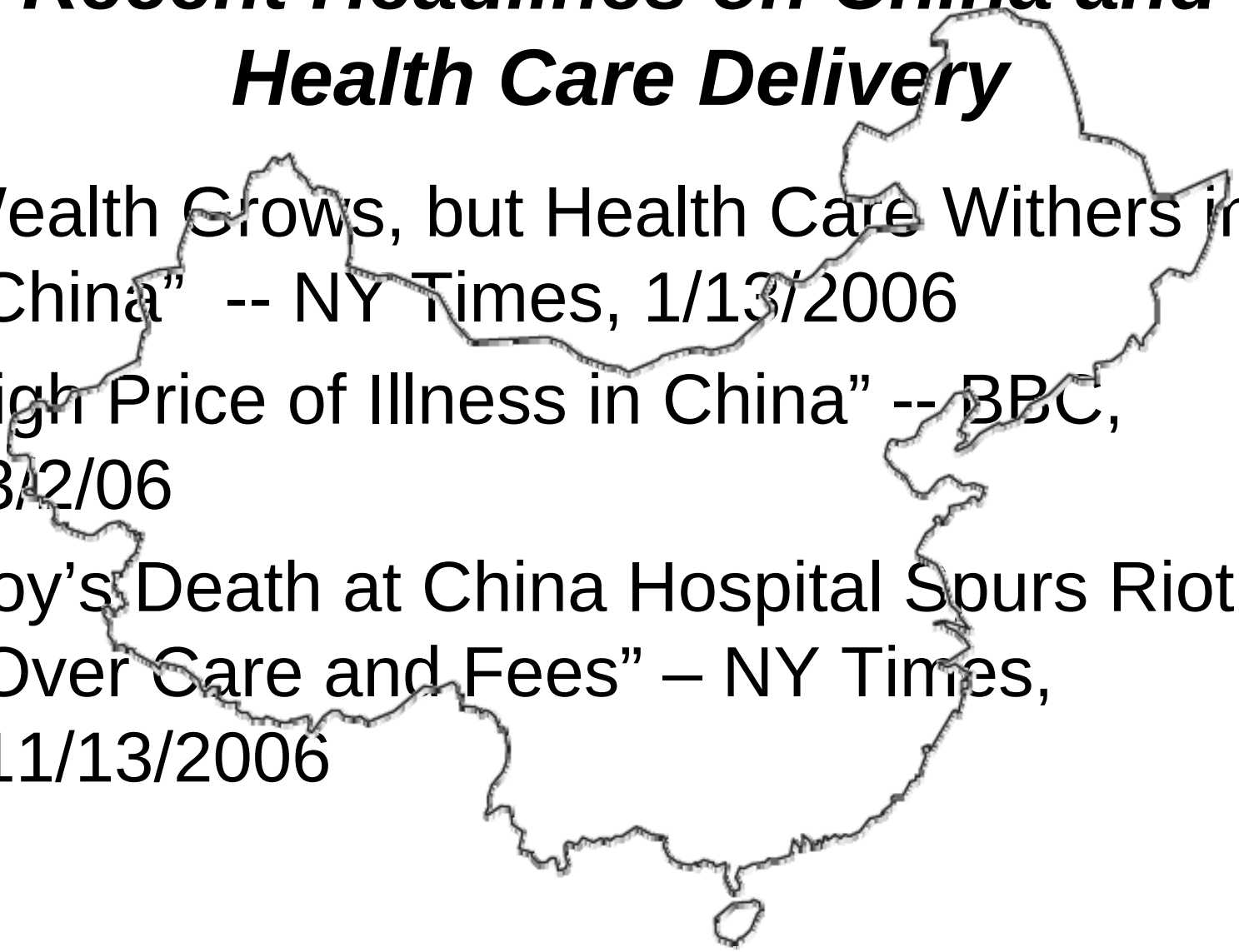
- High blood pressure 14.2%
- Tobacco 8.2
- Alcohol 5.4
- Indoor smoke from solid fuels 5.0
- Low fruit and vegetable intake 4.2
- High cholesterol 3.5
- Urban outdoor air pollution 3.4
- Physical inactivity 2.5
- Overweight and obesity 2.2
- Contaminated injections in health care settings 2.2

www.dcp2.org

Tobacco

- China is a signatory to the FCTC
- 1995 -- 60% of adult Chinese men smoke; 7% of adult Chinese women smoke
- 1998 -- 53% of adult Chinese men smoke; 4% of adult Chinese women smoke
- 1996 -- 61% of male physicians smoke; 12.3% of female physicians smoke
- Tobacco a large SOE
- China uses 30% of the world's tobacco, most of it home grown
- 320 Million smokers

Recent Headlines on China and Health Care Delivery



"Wealth Grows, but Health Care Withers in China" -- NY Times, 1/13/2006

"High Price of Illness in China" -- BBC, 3/2/06

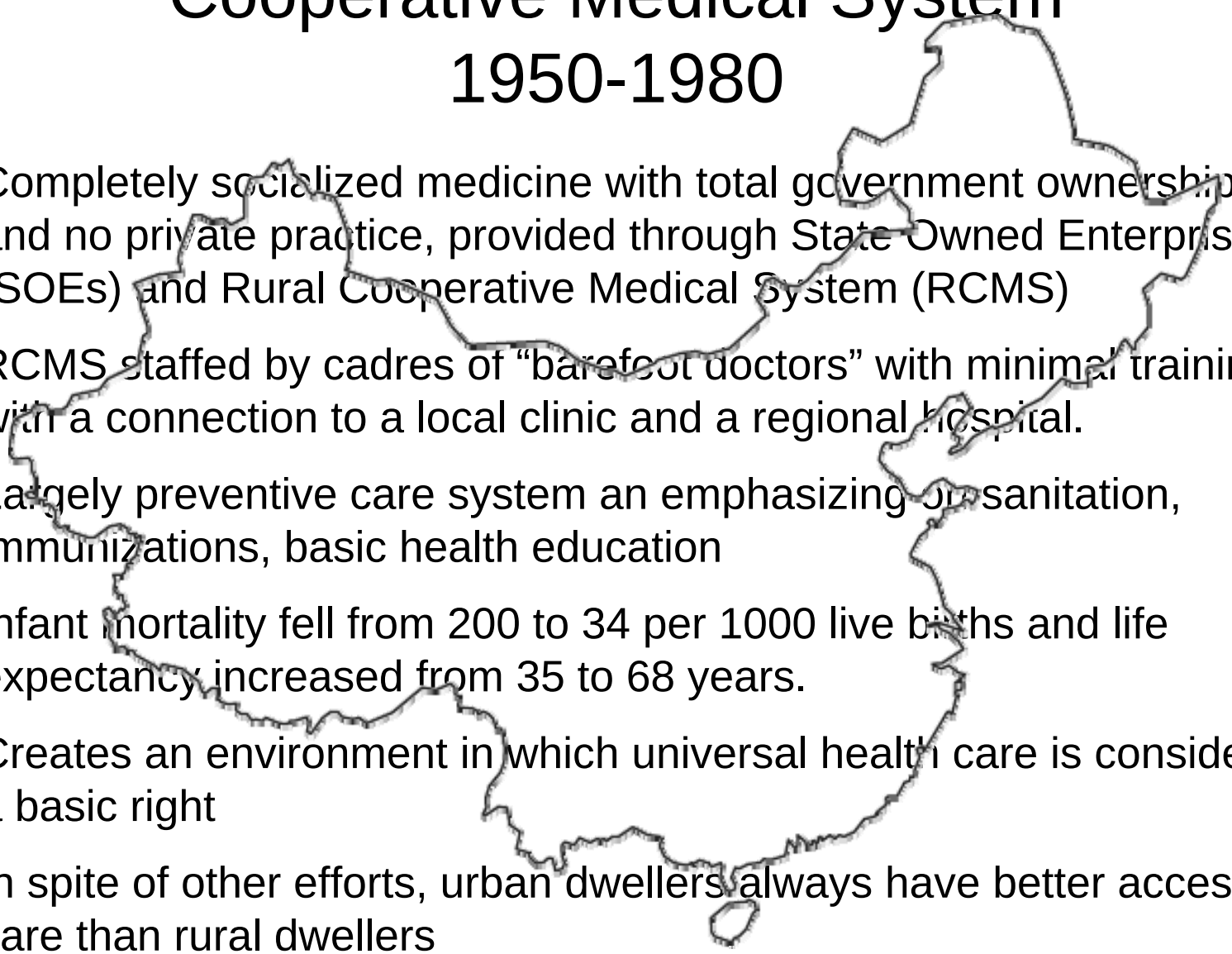
"Boy's Death at China Hospital Spurs Riot Over Care and Fees" – NY Times, 11/13/2006

Health Care Financing

March 6, 2006: Premier Wen Jiabao says

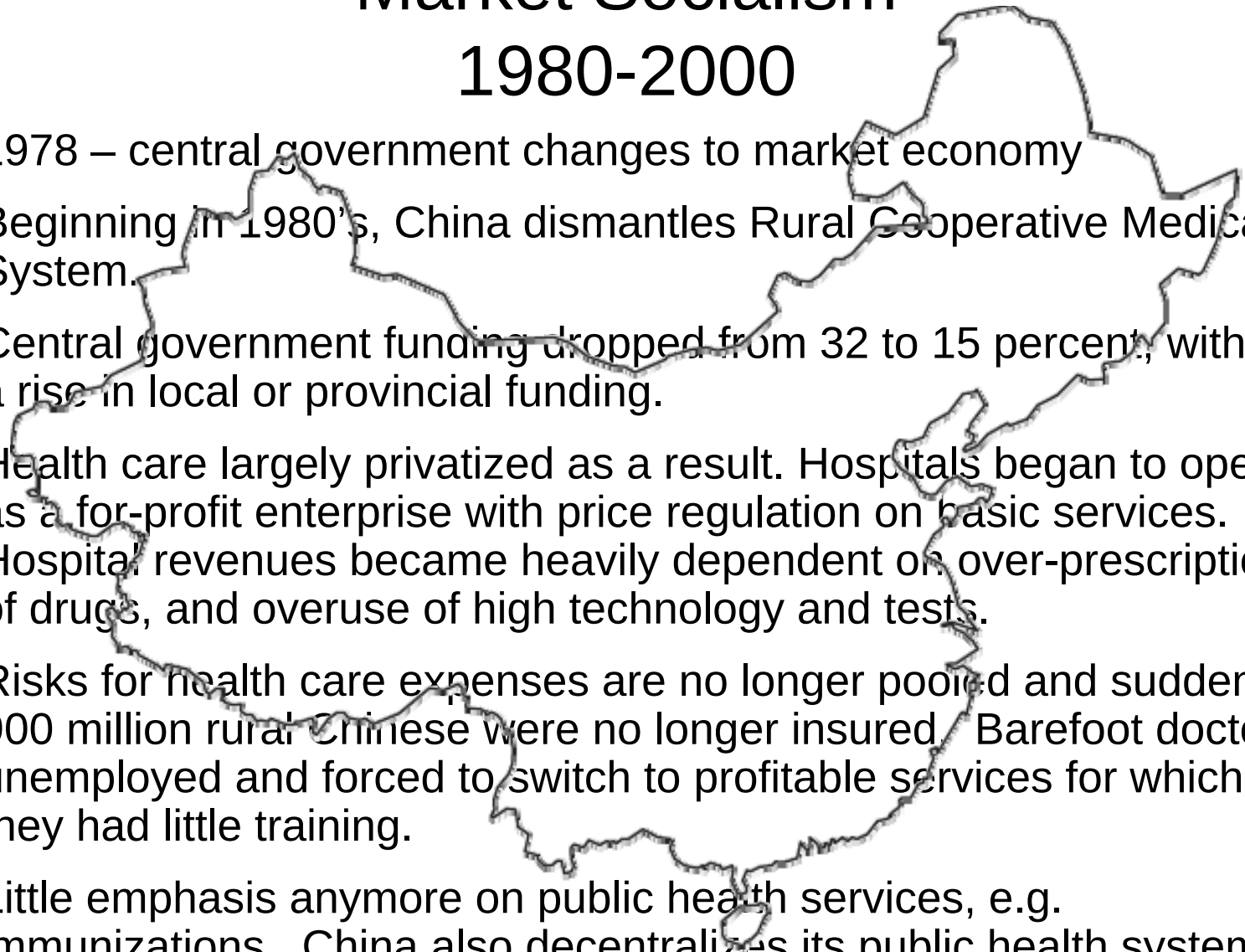
> “Some deeply seated conflicts that have accumulated over a long time have yet to be fundamentally resolved, and new problems have arisen that cannot be ignored … [China must] .. Pay more attention to social equity and social stability so that all the people can enjoy the fruits of reform and development”

Cooperative Medical System 1950-1980



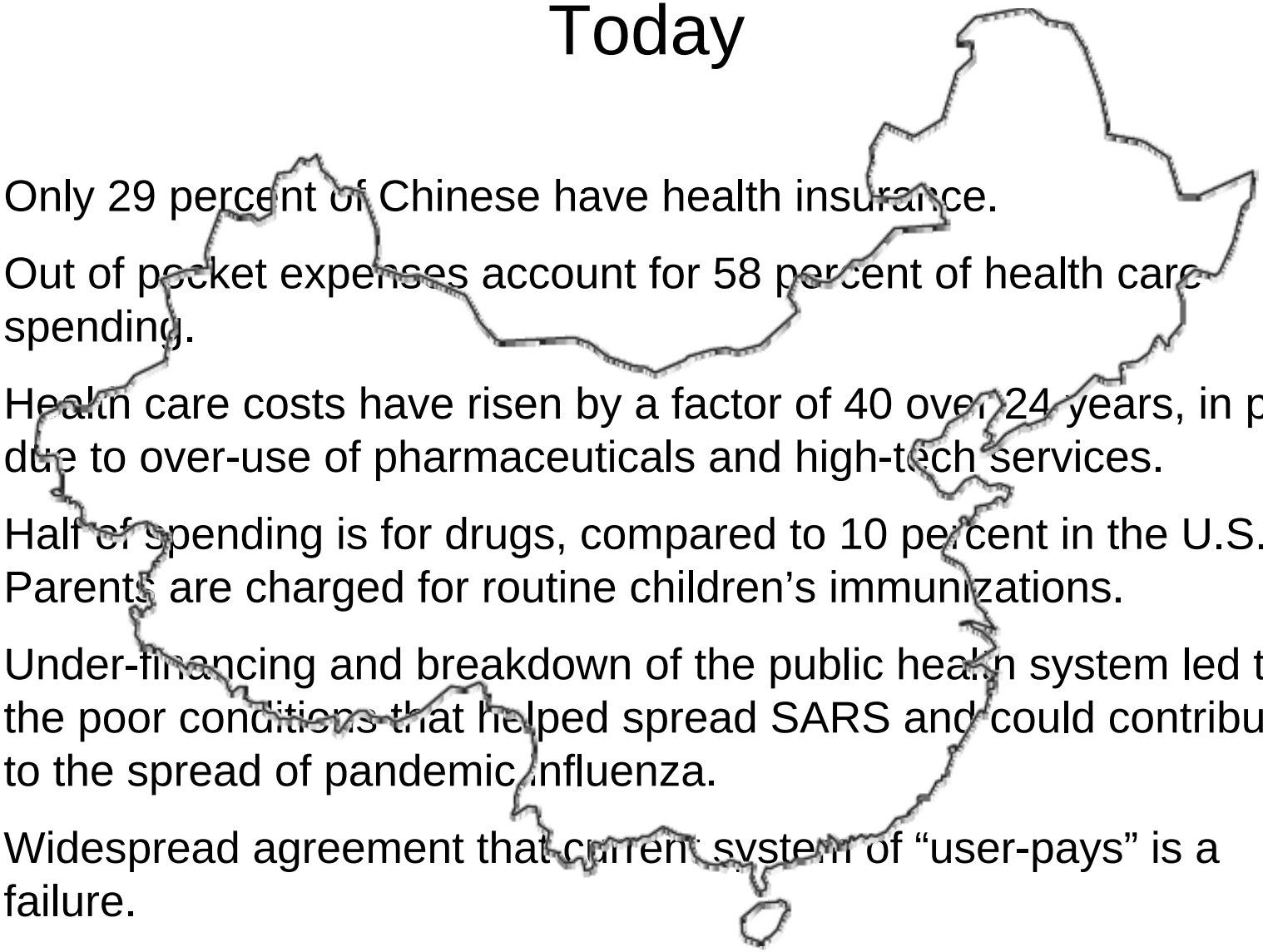
- Completely socialized medicine with total government ownership and no private practice, provided through State Owned Enterprises (SOEs) and Rural Cooperative Medical System (RCMS)
- RCMS staffed by cadres of “barefoot doctors” with minimal training with a connection to a local clinic and a regional hospital.
- Largely preventive care system an emphasizing on sanitation, immunizations, basic health education
- Infant mortality fell from 200 to 34 per 1000 live births and life expectancy increased from 35 to 68 years.
- Creates an environment in which universal health care is considered a basic right
- In spite of other efforts, urban dwellers always have better access to care than rural dwellers

Market Socialism
1980-2000



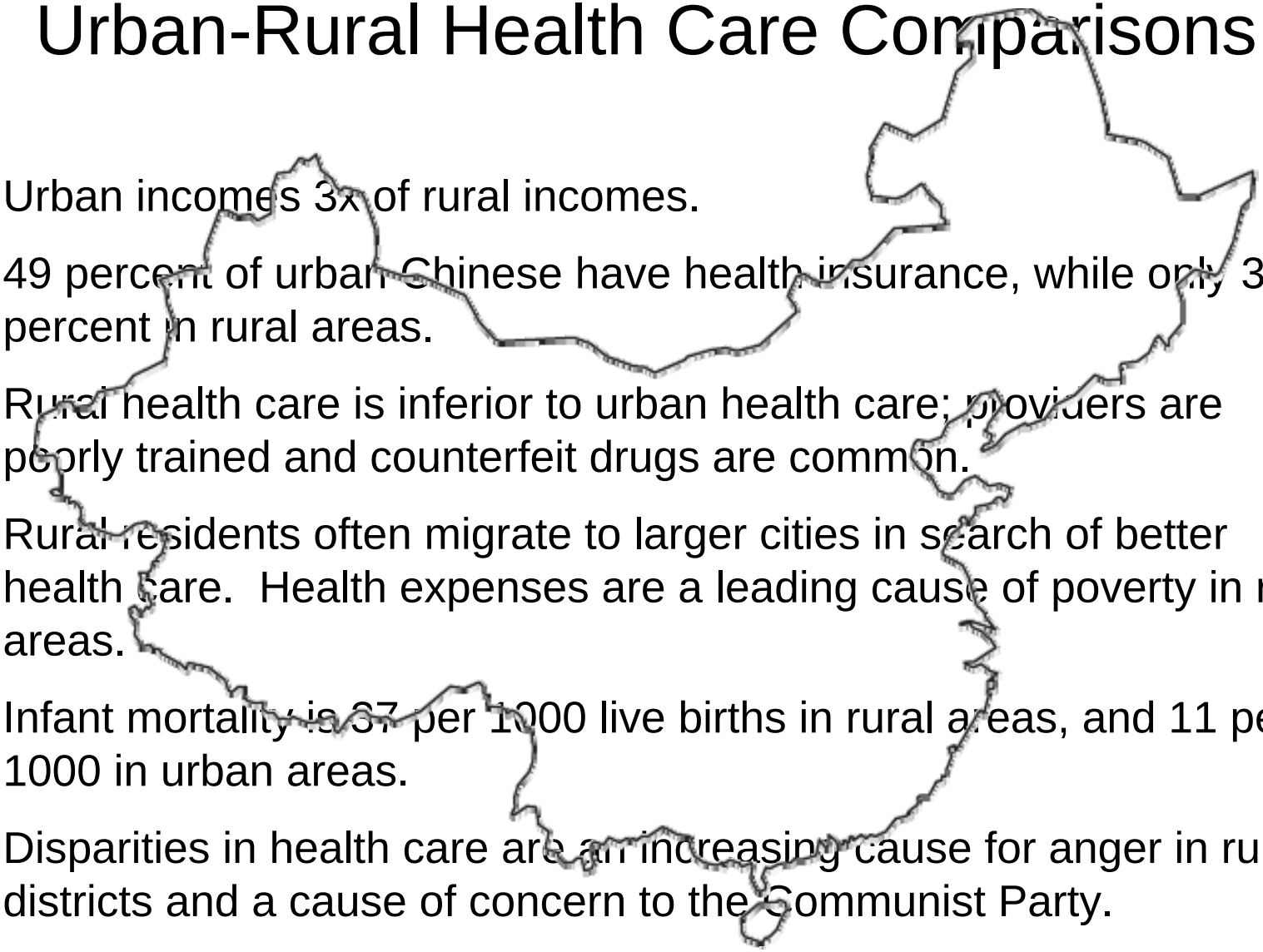
- 1978 – central government changes to market economy
- Beginning in 1980's, China dismantles Rural Cooperative Medical System.
- Central government funding dropped from 32 to 15 percent, without a rise in local or provincial funding.
- Health care largely privatized as a result. Hospitals began to operate as a for-profit enterprise with price regulation on basic services. Hospital revenues became heavily dependent on over-prescription of drugs, and overuse of high technology and tests.
- Risks for health care expenses are no longer pooled and suddenly 900 million rural Chinese were no longer insured. Barefoot doctors unemployed and forced to switch to profitable services for which they had little training.
- Little emphasis anymore on public health services, e.g. immunizations. China also decentralizes its public health system in order to reduce health expenditures at the central level.

Today



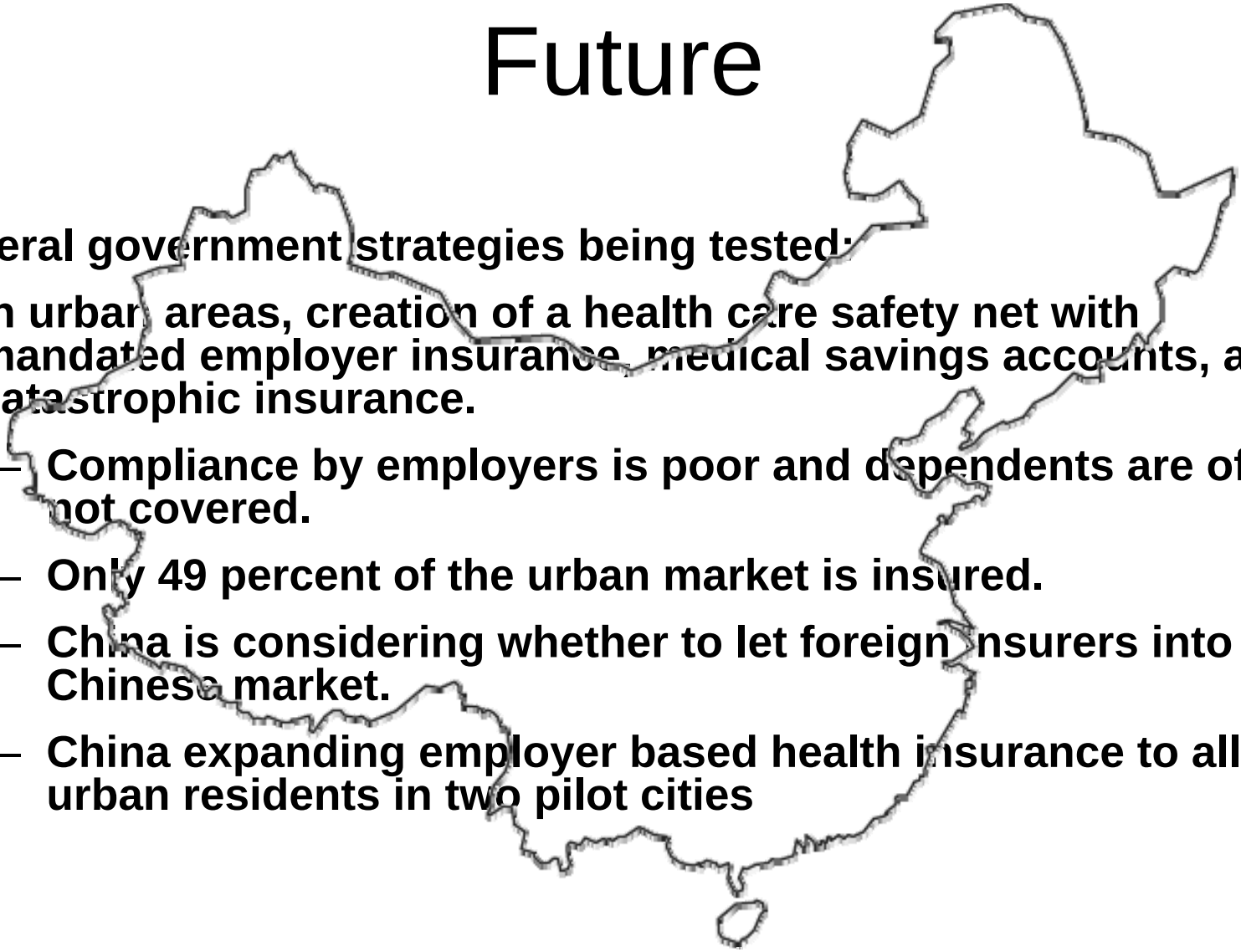
- Only 29 percent of Chinese have health insurance.
- Out of pocket expenses account for 58 percent of health care spending.
- Health care costs have risen by a factor of 40 over 24 years, in part due to over-use of pharmaceuticals and high-tech services.
- Half of spending is for drugs, compared to 10 percent in the U.S. Parents are charged for routine children's immunizations.
- Under-financing and breakdown of the public health system led to the poor conditions that helped spread SARS and could contribute to the spread of pandemic influenza.
- Widespread agreement that current system of "user-pays" is a failure.

Urban-Rural Health Care Comparisons



- Urban incomes 3x of rural incomes.
- 49 percent of urban Chinese have health insurance, while only 3-7 percent in rural areas.
- Rural health care is inferior to urban health care; providers are poorly trained and counterfeit drugs are common.
- Rural residents often migrate to larger cities in search of better health care. Health expenses are a leading cause of poverty in rural areas.
- Infant mortality is 37 per 1000 live births in rural areas, and 11 per 1000 in urban areas.
- Disparities in health care are an increasing cause for anger in rural districts and a cause of concern to the Communist Party.

Future



Several government strategies being tested:

- **In urban areas, creation of a health care safety net with mandated employer insurance, medical savings accounts, and catastrophic insurance.**
  - **Compliance by employers is poor and dependents are often not covered.**
  - **Only 49 percent of the urban market is insured.**
  - **China is considering whether to let foreign insurers into the Chinese market.**
  - **China expanding employer based health insurance to all urban residents in two pilot cities**

Future – continued

- **In rural areas, progress is difficult. A crude safety net is being tested in certain districts; scheduled to expand country-wide by 2010.**
  - **Government pays $2.50 per year for insurance, while peasants must pay $1.25 per year.**
  - **High deductibles and only inpatient care supported.**

However -- recent World Bank Study

- **notes new RCMS has increased hospital utilization among enrollees, but still hasn't reduced out of pocket expenses for families**
- **Still greater amount of unnecessary drugs and procedures, indication wasteful spending and potential harm to patients**