

# China's Health Care System

## Prologue

In a six-year interval between visits, dramatic changes in technology, infrastructure, and consumer capitalism have taken place in China. Modern high-rise buildings fill the larger cities of Beijing and Shanghai — rivaling modern U.S. cities — where years before, a sea of more than a hundred giant building cranes stood. Where vintage bicycles once conveyed a major-

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ity of the workforce, new BMW's, Mercedes', and Audi's congest the overtaxed roadways. And massive projects continue. In near record time a huge workforce now constructs the new Olympic Village and the gargantuan "Bird's Nest" main Olympic Stadium for a 2008 deadline, and the 1.5 mile long, 40 story tall, Three Gorges hydro-electric dam has been structurally completed, displacing more than 1.5 million from their historical family homes.



*Dr. Ron Hansen standing on the Badaling section of the Great Wall of China.*

Changes seen span August 2000 through November 2006 — this most recent visit with members of the University of Minnesota's Cardiology Department for the 17th Great Wall International Congress of Cardiology in Beijing. The meeting, in conjunction with China University in Hong Kong, focuses on cardiac medicine and technology, and is a rare opportunity. From the University of Minnesota Hospital, we should appreciate the organizational efforts of David Benditt, M.D., Professor of Medicine and Director of the UM Arrhythmia Center, and Fei Lu, M.D./Ph.D., Assistant Professor of Cardiology, both of whom have worked many years cultivating unique and valuable opportunities for medicine in China. International venues allowing personal cultural and professional exchange are often eye-opening and opinion changing, and are not readily replaced by correspondence or conference calls, and as colleagues, we should appreciate these multi-disciplinary efforts of our academic medical community.

## Basic Economics

The scope of change in China in such a short time has been mind boggling. The New China

is increasingly critical to the world economy with each passing year. As a visitor, examining the underpinnings of the social contract for health care delivery through the shine of economic progress can be difficult. Perhaps the most challenging and destabilizing force in the Chinese economy is that the gap between rich and poor (in particular between rural and urban areas) is still growing. Many economic observers suggest this disparity is threatening social stability. Although rural incomes grew slightly more than urban incomes in the first quarter of 2006, they are still only a third of urban salaries. Average annual rural incomes in 2005 rose 6.2 percent to RMB 3,255 (\$406.31 U.S.) while average annual urban incomes, at RMB 10,493 (\$1,309.82 US), rose 9.6 percent. Moreover, unlike urban residents, most rural residents do not receive subsidized health care or education, and only a small percentage participates in pension systems.

A primary economic reality is that most of the financial wealth in China is disproportionately distributed to perhaps 5 percent of the population—the truly wealthy being a very small fraction of those. A majority of Chinese live in rural regions of interior China, far from the modern metropolis and economic prosperity of select downtown areas we see advertised as tourist destinations. It is this vast majority of rural China one would be unlikely to “see” as a tourist. In order to better understand the differences between the current state of financial equity and medical care delivery and expectations in China versus the U.S., it is helpful to understand the structure and size of the lesser-served workforce.

### Working Migrant Population

Rural migrant workers drive much of the relentless economic boom in China. Those building the Olympic infrastructure work 15 hours a day, or longer, seven days a week. They sleep often 12 to a small temporary wooden room, with no provided heat, in conditions that can reach subzero with freezing winds. These workers risk uncompensated injuries which can threaten livelihood and health, and may go years without seeing their families depending upon the demands of the building project. There are an estimated 2 million such migrant workers from rural China—and they are a formidable health care crisis. Pay

can equate to 50 cents per hour, and there are few (if any) workplace protections and little (if no), medical coverage. Such workers are often paid late, and sometimes not at all—with half a year’s wages often near \$400 U.S. Often, saved wages go to educating family children, with secondary education not free—estimating \$1,300 U.S. annually. Construction is dangerous, with fatalities exceeded only by coal mining deaths—with 2,607 officially reported in 2005. Many workers, due to their undocumented status in the city, will rely on illegal clinics, which are cheap but unsanitary, and are run by unlicensed doctors. The mayor of Beijing, Wang Qishan, indicates the health resources of the city are overstretched in attempting to provide some services to the vast army of migrant workers constructing mammoth projects in that city. In scope, currently Beijing has nearly 10,000 construction sites with 1.7 billion square feet under construction—an area exceeding three times the size of Manhattan.

Tour guides paint a broader picture of the health care and city economic infrastructure in China. They estimate income of comparably wealthy city inhabitants at near \$300 U.S. per year for some rural workers, and \$1,200 U.S. per year for city professionals. Estimates suggest that of 1.4 billion in China, 80 percent are rural farmers, with little economic opportunity. Western China is noted to be very poor, with little in the way of schools, clothes, food and basic utilities. Twenty-five percent (at most) of the population may have some form of insurance—some of it by private companies, some of it from employers.

### Health Care Structure

Chinese health care delivery has been described conceptually as having three tiers. So-called top tier is described as Western style, relatively modern, clean, and expensive private or University hospitals which are felt by the populace to provide rapid symptom related care.

Second tier is commonly government run or intermediate level hospitals, which tend to be overcrowded and less sophisticated in available infrastructure and technology. Some such hospitals have come under some legislative scrutiny as of late for (presumed unnecessary) over prescribing practices generating additional revenue for the facilities, and as a visitor we



*The Beijing 2008 countdown clock stands prominently in Tiananmen Square awaiting the next Olympic Games.*

are reminded that regional practices in some areas of Chinese government and business can remain less than transparent.

Lowest tier would be community/rural clinics, or traditional medicine, which may have little material and technology resources and may rely on traditional treatment methods (felt by many of the populace to have potential for slow complete cure). For most of the country, such third tier (or no health care) is all that is available.

The best possible scenario is being independently wealthy and going to a private pay-as-you-go facility. Relatively few fortunate Chinese (as Americans) have this as an option. A more realistic favorable position is to have employer provided insurance similar to Western concepts—however as a twist on the paradigm, co-payment for services may be on a sliding scale depending upon total cost of services and length of employment—and can vary from 10 – 90 percent of the total cost of services. Private insurance is also available—however this can cost upwards of \$60 U.S. per month, with an average of \$500 U.S. per year—unaffordable for a majority of working class Chinese. Antibiotics, are relatively inexpensive, at \$2.50 per half dozen, and

*(Continued on page 10)*

prescriptions are not required for such medications. Per similar unregulated environments, this contributes to antibiotic resistance in the region.

### Socioeconomic Barrier To Care

At almost all facilities—care is contingent upon demonstrating definite ability to pay. This is difficult for many Chinese given the economic disparity. Frequently, the uninsured must scramble to family members and neighbors to obtain funds for unexpected medical costs, with the severity or acuity of the condition typically not motivating whether the facility provides treatment. Any presumption as to right of medical care as we might consider in the U.S., is a less potent factor in the Chinese system, in which health care remains, for the moment, more of a commodity service.

Recently covered in the *New York Times*, at least 10 people were injured when police broke up a demonstration at Guang'an City No. 2 People's Hospital, in Sichuan Province.



Faculty members included: Seated from left: Alan K. Berger, M.D., FACC; David G. Benditt, M.D., FACC; Ronnell A. Hansen, M.D.; and Bogui Sun, M.D. Standing from left: Prof. Malcolm Underwood; Jianming Li, M.D., Ph.D.; Andrew J. Boyle, M.D., FACC; Prof. Cheuk-Man Yu; Li Wang, Ph.D.; Fei Lü, M.D., Ph.D., FACC; Dr. Jeffrey WH Fung; Dening Liao, M.D.; Prof. Gabriel Yip; and Yigang Li, M.D.

Unrest reportedly erupted after a 3-year-old boy died in the hospital, where he had been taken for emergency treatment after ingesting pesticides. Reports conflicted about how much medical care he had received. A human rights group stated that essential medical care had been denied the boy until his grandfather could pay. The boy reportedly died after the grandfather left to raise money.

Historically, the Communist Party-controlled government once offered rudimentary medical care for nominal prices in the countryside. Now, however, hospitals largely fend for themselves since the expanding market economy of the 1990s. Many have ceased providing even emergency care for people who cannot pay hospital fees in cash before treatment. The problem is challenging and socially divisive, and to date, the Chinese government has provided relatively little funding for hospital care in poor areas. It has experimented with social insurance for people who do not work for major companies—including most of the 800 million classified as peasants, but a national plan has not been introduced.

### Epilogue

Although China appears an emerging economic giant, health care access and delivery remains problematic for a majority of the population. The widening economic divide affects many areas of Chinese society, and the lack of access to health care is felt to contribute significantly to social instability. Coupled and compounded

with recent increasing social unrest protesting issues from land confiscation, environmental pollution, and official corruption—the future in China will be challenging indeed. In response, the Chinese government has promised to spend more on rural development, but residents still face weak or nonexistent public services and have regular disputes with local officials over a range of inequities. In perspective, it would be wise for the U.S. to continue to work on providing equitable health care to its own citizens—as the disparate alternative, regardless of GNP, may be perilous. ♦

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