Guest Editorial

Healthcare reform in China and the challenges for public health education

The papers in this minisymposium address some of the issues in public health which are facing China at this important point of time as the country radically reforms its healthcare system. Some issues are unique to China but many other problems and lessons are relevant to other countries, in particular to developing countries. The innovations in China are important and interesting to watch and to learn from.

These papers were first presented at the symposium organized by the School of Public Health and Primary Care, the Chinese University of Hong Kong in December 2009. Building on the platform produced by an even earlier meeting, the progress and challenges of the changing landscape of health services in mainland China and their implications for public health education remain a hot topic for discussion. This is reflected by Li Ling who sets the scene, describing the three periods of healthcare reform since the creation of the People’s Republic of China in 1949. The newly established political order introduced comprehensive state organized healthcare systems, which placed strong emphasis on prevention and were strengthened by the National Patriotic (Public) Health Campaign Commission, organized by the Ministry of Health but with the same or even higher level of leadership. In the rural areas bare foot doctors delivered low cost primary care with wide population coverage whilst in the cities and urban areas healthcare was provided on an organization or factory basis. The impact was dramatic and life expectancy rose exponentially.

With the economic changes introduced by Deng Xiao-ping, the second phase of national development began and the healthcare systems were reshaped by market driven changes in line with the changing economic philosophy. Whilst the overall economy of China benefitted, the health system did not. With only 10% of public funding and permission given for development through utilisation of market forces, hospital care saw increasing costs and deteriorating relations between doctors and their patients. Inequities in access and cost grew and whilst 70% of the population lived in rural areas, only 20% of the healthcare resources were available to them. Sixty percent of healthcare spending was out of pocket and healthcare costs were often catastrophic for families.

The third and current phase of reform was initiated in October 2006 when President Hu Jintao declared the right for all to enjoy basic healthcare services – the blueprint for which was laid out in by the State Council in the HealthCare Reform Plan of 2009 which promised to spend 850 billion Yuan (c123 billion U.S. dollars) in three years in addition to the current regular spending to provide universal primary medical services to the country of 1.3 billion people. Large central funds have been made available to develop a health security as well as healthcare system to address the problems faced by a hospital dominated, largely unregulated, medical system. These reforms emphasise the need to develop universally accessible community based care which prioritizes prevention and primary care and strengthens public health systems. The guiding principles laid out by the state healthcare reform plan and further developed in Healthy China 2020 are based on four systems: the medical service system which will be improved, the public health service system which will be further strengthened, the medical security system which will be built up, and the pharmaceutical supply system which will be secured.

Implementing the reforms is also the theme of the paper by Ling and colleagues, who focus on the inequalities which exist between urban and rural communities and describe the progress made to address the inequalities gap between them, one that has always existed but has been exacerbated over the years of market reform. Citing the growing difference in GDP between rich and poor provinces, a gap increasing from 7 to 13 times between 1990 and 2002, they describe the impact of the imbalance of care which favours urban over rural communities. In addition, the devastating impacts of high costs of care, increasingly a disincentive to seeking care, are having potentially catastrophic effects, hitting rural communities hardest. The inequalities and hardships caused to the public by, in essence, a market based system, have had a further adverse impact by enhancing the commercial role of hospitals, stimulating overuse of diagnostics and promoting inappropriate excessive prescriptions, supported by kickbacks from big pharmas. These issues are now being tackled under the new reform strategy which places emphasis on community based care, and development of Community Health Centres as well as training of general practitioners and introduction of new insurance systems especially in the countryside.
But implementing such changes is by no means straight forward, as described by Zhang et al.\(^5\) in their paper which describes the healthcare reforms in Shenzhen in Southern China, just across the border from Hong Kong. As an experimental centre for economic development, the city has a unique population structure. The majority of residents in Shenzhen are not born locally, are young and tend to keep close social and economic links with their hometowns and families.\(^7\) In 2009, of the population requiring services, estimated between 9 and 13 million, 80% were migrant workers, some officially registered and others described as ‘floating’.

This large migrant workforce reflects the rapid expansion of Shenzhen, currently celebrating its 30th anniversary as a city, and its highly mobile population. The authors highlight the problems posed for developing and implementing legislation and policy to support the healthcare system for such a fluid population, and the particular difficulties of attempting to ensure equality of health service delivery. For example, young and less educated women who are paid less are more likely to be uninsured and therefore to pay out of pocket for their care than any other groups in the population. Many migrant workers face mental health problems and living in dormitories and temporary accommodation increases the risk of communicable diseases. As in other parts of China, efforts to improve care give the highest priority to the establishment of the Community Health Centres network to ensure the provision of high quality community based basic medical and public health services.

Developing high quality services require appropriate training, writes Li Liming and colleagues based on Li’s keynote lecture of the symposium, which was focused on the need for integration in medicine.\(^8\) China faces threats of both non communicable and communicable diseases and their epidemiology is related to many social, psychological and economic factors. Current medical student training focuses inappropriately on disease and disease mechanisms. New perspectives and methods for integrating medical and public health education are required, which reflect the need for a series of integrations: of concepts, policies, resources and measures, as well as changes in the organization of healthcare including public health, prevention and treatment. Such integrations will need a systematic process and social mobilization, advocacy, promotion, and attention of the entire society. Integration between clinical and preventive perspectives and between the individual and population approaches is important for medical students since they will be the main drivers to implement integration of medicine and public health in practice in the future. Such integration should also take into account not only western medical practice but also traditional Chinese medicine, attempting to resolve the dialectic that exists in approaching health from different perspectives. Thus integration in China will have a particular feature: how to creatively and mutually integrate western medical practice and traditional Chinese medicine, which is legitimately and widely used across the country for mutual benefit. To avoid these integrations, there will be significant challenges to China’s current public health education system which is shaped largely by the old Soviet bio-medical model with its five core health disciplines and focus on sanitation and hygiene.

The final paper in the series by Wei Bo and colleagues\(^9\) describes a very meaningful attempt to meet such challenges. Yunnan and Guangxi are among the poorer provinces in China and face many challenges for resources. With multiethnic populations, a high rate of communicable as well as growing rates of non communicable diseases, and a lower resource base than the affluent areas on the Eastern sea board, integrated models of public health education are essential, not only between clinical and preventive medicine but also between academic and service communities. In their critique, the authors assert that schools of public health seem to have an educational goal which departs considerably from that expected by the service sector and thus the educational objectives do not fully reflect the need of public health practice. Many schools of public health, in particular the leading ones, seem to place more emphasis on producing research-oriented graduates and pay less attention to the knowledge and skills required in public health practice, which may partly be a result of the impact factor competition among universities. To redress this problem the Director of the Centre for Disease Prevention and Control (CDC) in Yunnan province has been jointly appointed as the Dean of the School of Public Health at the local lead University. Integrating academic and service leadership has enabled the school to understand better the need of real public health practice, develop a more practice-oriented curriculum, and have teachers with experience in public health field work. In addition, it has also led to a variety of other opportunities to bridge the gap. For example, joint appointments of staff between the CDC and the School have been made. Seminars and joint learning opportunities are thus created and students can also more easily undertake relevant projects in the field. This is helping to reshape public health education and to reflect the needs and implications of the new bio-psycho-social medical model and the ecological model for the determinants of health. It also provides an opportunity for the development of a multidisciplinary public health workforce, rather than hygiene and disease control technicians. While maintaining public health as a medical degree, such innovation could enable the development of multidisciplinary public health in recognition of the contribution to public health from many other disciplines.

This collection of papers highlights the renewed public health focus of the healthcare reform agenda in mainland China. Whilst progress is being made, both in community service development and in public health education, there remains a long way to go.

In the past three decades, China has been pragmatic in her policies, a strategy which was set by Deng Xiao-ping and vividly expressed in his famous saying that to cross the river we have to grope our way over the stones. So changes and the unexpected are anticipated in the course of the reforms. The next ten to twenty years will be a critical period to watch.

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REFERENCES


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