The China Health Policy and Management Society

China Health Review

Volume 1 Issue 2, December 2010

TABLE OF CONTENTS

Published December, 2010

China Health Review (CHR), published quarterly, is the official online magazine of the China Health Policy and Management Society (CHPAMS). The CHR is intended to promote health research, policy, practice, and education related to China and the general population health sciences by providing research and policy updates, topical reviews, and other appropriate information. Targeted audience includes (1) academic researchers within and outside of China; (2) policymakers within China; (3) other interested parties including nonprofit organizations and business leaders as appropriate.

Instructions for Authors

China Health Review (CHR) is soliciting submissions of manuscript for the following sections: *Topical Review*, *Perspectives*, and *History Speaks*.

Topical Review is systematic, critical review and assessments of literature and data sources pertaining to a topical issue determined as appropriate by the Editorial team. The articles generally should be kept within 2000 words. Manuscripts in the ***Perspectives*** section are short reviews that, in most instances, highlight an article(s) that appears in the same or recent issue of the CHR. Perspectives that are not tied to an article are narrower in scope than Topical Review articles and allow more lively and timely discussion of a topical issue. The articles generally should be kept within 1000 words. ***History Speaks*** is devoted to historical events and prominent figures of significance to population health among the Chinese people within and outside of China. The articles generally should be kept within 1500 words.

In addition, the CHR welcomes short submissions to two other sections, *Research Twitter* and *Policy and Practice Updates*. ***Research Twitter*** provides brief summary of most recent research reports appeared in academic journals and grey literature that are relevant to health issues in China and Chinese people. ***Policy and Practice Updates*** provides brief summary of updates in health policy and practice that appeared in relevant policy briefs, news release, and popular news sources. Submissions to both sections should be kept within 200 words per summary in general. Please contact section Editors listed below for questions, information or submission.

All submissions should be typed, double-spaced, as Word documents only. Manuscripts should conform to the style of the fifth edition of the Publication Manual of the American Psychological Association. All submissions should be submitted electronically to the attention of the Editor. Authors must ensure that their manuscripts are appropriately identified. All submissions, if accepted, shall indicate author's consent to assign CHR rights to disseminate in its final form. However, authors retain the copyright. In particular, publication in the CHR does not preclude authors to submit and publish an edited version of the manuscript in a peer-reviewed journal or as a book chapter.

Review Process: Submissions will be reviewed and edited by the CHR's editorial team.

Contact Information: Inquiries about the CHR and submissions can be addressed to the Editor-in-Chief, Dr. Zhuo (Adam) Chen (CHR@chpams.org). Submissions to the ***Research Twitter*** and ***Policy and Practice Updates*** should be addressed to Dr. Feijun Luo (frankie_luo@yahoo.com) and Dr. Xuezheng Qin (qin.econpku@gmail.com), respectively.

Acknowledgement: The China Health Review is made possible with a grant from the China Medical Board (Cambridge, Massachusetts). However, the opinions expressed in the editorials or in the articles are those of the authors and do not necessarily reflect views of the China Medical Board, nor of the institutions with which an author or a member of the editorial team is affiliated.

CHINA HEALTH REVIEW

VOLUME 1 ISSUE 2

A magazine of
the China Health Policy and Management Society

December 2010

EDITORIAL

When you are reading this issue of the Review, the year of 2010 is bidding farewell. The Review had a good start in August, was welcomed with applauses, and has grown since its inception. We have an expanded and passionate editorial team and you probably have noted new sections and style changes in this issue. A few highlights about this issue are as follows.

Venereal diseases had been kept at bay in China for several decades but have made an unwelcomed comeback. Professor Qi (Harry) Zhang delved into gender and socioeconomic disparities in sexually transmitted diseases (STDs) in China and pondered about the progresses and the challenges in preventing and containing STDs. A surprising finding is that the likelihood of having STDs is positively related to socioeconomic status in China.

Professor Gordon (Guoen) Liu is a familiar name to many. In an interview with Dr. Lu Shi, Professor Liu compared the progress of health care reforms in both U.S. and China, laid out the differences in focus areas, pitfalls, and prospects between the two reforms. His comments will likely to stimulate thoughts as well as debates. Professor Liu also shared his views on the challenges faced by the Chinese medical universities and his passions on the health services research in China.

The Research Twitter section showcased 14 studies on population health issues among the Chinese or ethnic Chinese populations. Among these studies, Babiarz et al. found that the New Cooperative Medical Scheme has partly corrected distortions in Chinese rural healthcare; however, it also surprisingly shifted uncompensated new responsibilities to village clinics. Using surveillance data of the mass vaccination campaign among 95,244 children and adults, Wu et al. concluded that the safety profile of a 2009 pandemic influenza A (H1N1) vaccine is similar to those of seasonal influenza vaccines and the H1N1 vaccine appeared to be effective against confirmed H1N1 virus infection in school-age children.

Policy and Practice Updates summarized debates on health care reform financing, medical insurance schedule, as well as challenges to the essential drug system in China.

You might be curious enough wanting to know more about the members of the CHPAMS. The section of About CHPAMS: Featured Member presents the profile of Ms. Shufang Zhang, a collegial, passionate, and hard-working doctoral candidate at Harvard University, who has been instrumental in forming the CHPAMS. Members' Update section provides you with the most recent career and professional changes of CHPAMS members, as well as their notable achievements.

Please also remember to check out the latest job announcement from the China Center for Health Development Studies, Peking University, in the News and Announcements section.

Best wishes of a healthy and productive New Year in 2011 from the editorial team of the Review!

TOPICAL REVIEW

Increasing Epidemic of Sexually Transmitted Diseases in China

Qi (Harry) Zhang, MA PhD, Old Dominion University

INTRODUCTION

Sexually Transmitted Diseases (STDs) were virtually eliminated in China in 1964 after Chinese government illegalized commercial sex and implemented active prevention and treatment programs among former sex workers (Chen et al., 2000). However, in the last three decades, the centralized economy in China made a transition to a more market-oriented economy, which brought significant changes in culture and social norms and dramatically influenced sexual attitude and behaviors among Chinese adults. One consequence of those changes is the significantly increasing prevalence of STDs in China (Abrams, 2001). The common STDs in China include gonorrhea, syphilis, AIDS, cervicitis, genital herpes, chancroid, lymphogranuloma venereum, and chlamydial infection.

Qi (Harry) Zhang, MA, PhD
Assistant Professor
School of Community and Environmental Health
Old Dominion University
Norfolk, VA 23529
Phone: 757-683-6870
Email: gzhang@odu.edu

Although STDs can cause significant morbidity, treatments for STDs in China were often inadequate (Choi et al., 1999). Chinese STD patients often relied on private unlicensed physicians rather than formally trained doctors in public hospitals due to stigma associated with STD at public venues (Lieber et al., 2006). This paper provides a review of the factors contributing to the increasing epidemic of STDs and the needs for effective policies and interventions to control the public health crisis of STDs in China.

GENDER DISPARITY IN INCIDENCE OF STDS

China's incidence of STDs dramatically increased in the last two decades. For example, syphilis incidence increased 100% every two years during the period of 1989 to 1998 (Chen et al., 2000). Gonorrhea incidence increased 260% during the same period. Although newly-diagnosed male patients were still more than newly-diagnosed female patients, the increase in rates was much higher among women than men (420% vs. 379%), which brought the gender ratio (male vs. female) of new cases from 2.0 in 1989 to 1.4 in 1998 (Cohen et al., 2000). To understand the gender disparity in the increasing trend, the background of gender inequality in Chinese society needs to be discussed.

There was a significant gender disparity in traditional Chinese society. The social status of women was generally thought of as inferior when compared to men. Traditional Chinese women's sexual attitude and behavior were conservative and restrictive compared with those in Western standard. The government has implemented a series of policies and actions to promote the equality between genders since 1949. However, the economic reform since 1978 has brought new gender disparity in the social norms in Chinese society. For example, it becomes more acceptable for men to visit night clubs or other venues in the name of conducting business and socializing. The relaxing sexual norms for men have created a large demand for commercial sex workers, who are mostly women. Since commercial sex is still illegal in China, it is difficult to provide an accurate estimate for the population. In 2004, the estimated population of sex workers was in the range of 4 to 10 million (Huang, 2004). Due to the poor protection against unsafe sexual behaviors in those venues, STDs became prevalent among female sex workers. Therefore, the increasing population of female sex

workers contributed to the increasing rate in STDs incidence. Studies suggest that extramarital sex also becomes more wide spread in China (Cohen et al., 2000). However, a recent study suggests that the median number of lifetime sex partners for Chinese women was one and 88.7% of Chinese woman had only one sex partner for their lifetime (Zhang et al., 2009).

SOCIOECONOMIC DISPARITY IN STDS

In Western countries, STDs are usually called as a disease of poverty, since STDs patients were concentrated in neighborhood with low income and low education. However, the likelihood of having STDs is positively related with socioeconomic status (SES) in China, since the majority of high-risk sexual behaviors occurred in commercial sex venues and only men with higher socioeconomic status (SES) have access to those venues. Moreover, Chinese men with higher SES are more likely to afford stable sexual behaviors with multiple partners. A study of the current population in China disclosed that among men who had unprotected sex with commercial sex workers, prevalence of Chlamydia among men with high income was 14 times greater than that among men with low income (Parish et al., 2003). Interestingly, the same study suggests that women who have a high income husband were 3 times more likely to have Chlamydia than women having a low-income husband. The finding suggests that high income men got infected with STDs while having sex with commercial sex workers and transmitted to their spouse later.

There is one social movement that might change the positive relationship between SES and STDs in China. One of the engines for Chinese economic development is the low-cost human capital that flows from less developed areas to developed areas. In 2006, approximately 131 million migrant workers moved from rural areas to urban areas for employment (State Council, 2006). Majority of those migrant workers were sexually active young men. Due to the long working hours and semi-military management in workplaces, it is difficult for them to develop healthy sexual relationship. Instead, they are looking for fast relationship with low cost. To meet the increasing demand from those migrant workers, more fast-food style sex venues were set up around factories and those venues charged lower fees with the economies of scale. Both the customers and the sex workers in those venues are less educated and less protected due to the cost constraint. Potentially they can be the time bomb of STDs in China in the new era with more and more factories rely on migrant workers for production (Yang, 2005).

PROGRESS AND CHALLENGS TO PREVENT AND CONTAIN STDS IN CHINA

For a long time, systematic prevention and interventions of STDS were missing in China, partially due to the government neglecting the fact that STDs have returned to China after almost twenty years. Due to the increasing severity of health outcomes associated with STDs, especially HIV, Chinese government has started to take more pragmatic approaches to actively prevent and contain STDs.

As early as in 1990, the Chinese Ministry of Education has implemented the basic requirement for sexual morality in health education. In 2004, the State Council ordered all levels of local government to “integrate HIV/AIDS into the routine government agenda…., which is a priority linked to the interest and benefit of China and its people” (State Council, 2004). Although commercial sex activities are still illegal in China, local governments adopted more practical interventions in those venues, such as distributing condoms, regularly screening sex workers, and educating sex workers about protection against unsafe sex.

The focus in the movement is to promote condom use in China. In 2002, the Ministry of Health reclassified the condoms from “sexual commodity” to “medical device”. The Chinese name of condoms also changed from “birth planning sheath” to “safety sheath”. Local governments adopted more targeted distributions among high-risk areas, such as night clubs, salons, college campus, and hotels. Vending machines of condoms were set up in those venues and free

condoms are more frequently distributed to those groups. All those actions promoted the positive experience of using condoms in sex, which is a cost-effective way to reduce transmission of STDs.

Although China has invested significant resources and made steady progress in STDs containment, there are a few challenges to be addressed.

Education is the primary challenge to prevent STDs. In the regular school system, sex education has very limited hours in middle schools and become optional in college. Therefore, most of the sex education obtained was from non-school environment, such as private conversations or the Internet, which may not correctly present the information about sexual attitude or sexual behavior. Lack of knowledge about sex has been a significant risk factor for STD infection and prevented right treatment (Zhang et al., 2009). Targeted sex education among sex workers is only pilot-tested in some developed cities and in some upscale venues. However, those sex venues serving migrant workers may not be covered by the existing sex education. A more systematic approach to cover all sexually active populations needs to be adopted.

Legalization of sex industry is always a controversial topic in any society, including China. Sex industry is still treated as "underground" in mainstream media and social norms. However, the booming sex industry in the last three decades presents huge business interests for stakeholders, including related organizations and agencies. Therefore, the current practice is to illegalize it on papers while regulating it as other entertainment business. This reflects a compromise between different parties in the society and the balance is difficult to maintain. The dilemma between legalization and illegalization may take long time to be resolved and may be motivated by another social movement in China.

It is still a long way to go for the society to reduce the stigma associated with STDs, STD patients, and their treatments. Patients with STD can be discriminated by their family members, friends, and employers, which push them to seek unlicensed care or self-care. For example, Zhang et al. (2009) found that college-educated Chinese women with STD symptoms were more likely to seek private, unlicensed care than those STD-symptomatic women with less education. Although college-educated women were more likely to have better knowledge about sex, stigma and fear of social pressure prevent them from seeking right treatment once the STD symptoms developed. The society should not encourage extramarital sex or promote commercial sex consumptions, but neither should it discriminate STDs patients.

CONCLUSIONS

China has become the second largest economy while being the most populated in the world. The public health crisis of STDs in China not only directly hit the Chinese, but the shock can be felt at every corner of the world. The increasing incidence of STDs and growing STD patient populations requires more thorough and open research, which will lead to more effective public health policy and interventions in China.

References:

Abrams HK. The resurgence of sexually transmitted disease in China. J Public Health Policy 2001;22(4):429-440.

Chen X, Gong X, Liang G, Zhang G. Epidemiologic Trends of Sexually Transmitted Diseases in China. Sex Transm Dis 2000;27(3):138-142.

Choi K-H, Zheng X, Zhou H, Chen W, Mandel J. Treatment delay and reliance on private physicians among patients with sexually transmitted diseases in China. I J STD AIDS 1999;10:309-315.

Cohen, MS, Ping G, Fox K, Henderson G. Sexually Transmitted Diseases in the People's Republic of China in Y2K: Back to the Future. Sex Trans Dis; 2000;27(3):143-5.

Huang Y. HIV/AIDS Risk among Brothel-Based Female Sex Workers in China: Assessing the Terms, Content, and Knowledge of Sex Work. Sex Trans Dis; 2004:31(11):695-700.

Lieber E, Li L, Wu Z, Rotheram-Borus MJ. HIV/STD stigmatization fears as health-seeking barriers in China. AIDS Behav 2006;10(5):463-471.

Parish WL, Laumann EO, Cohen MS, et al. Population-based study of chlamydial infection in China. JAMA 2003;289:1265-1273.

State Council. Research report on Chinese migrant workers. Shiyan Publishing House, p 3. 2006.

State Council Document No. 7, State Council Notice on Strengthening HIV/AIDS Prevention and Control. 2004.

Yang X. Does where we live matter? Community characteristics and HIV and sexually transmitted disease prevalence in southwestern China. Int J STD AIDS, 2005;16: 31-37.

Zhang Q, Lauderdale D, Mou S, Parish WI, Laumann EO, Schneider JA. Socioeconomic Disparity in Health-Care Seeking Behavior among Chinese Women with Geritourinary Symptoms. J Women Health, 2009; 18(11); 1833-1839.

INTERVIEW

FACING THE CHALLENGES OF HEALTH CARE REFORM: AN INTERVIEW WITH PROFESSOR GORDON LIU

Lu Shi, PhD, School of Public Health, University of California, Los Angeles

Dr. Gordon Liu is a professor of economics in Guanghua School of Management, Peking University; and Director of the PKU China Center for Health Economic Research (CHER). He was previously a tenured faculty at the University of North Carolina – Chapel Hill (2000 – 2006); and University of Southern California (1994 – 2000). Dr. Liu serves on the Chinese Ministry of Health Expert Commission for Emergent Public Health Events and Chair of the Asian Consortium for the International Society for Pharmacoeconomics and Outcomes Research (ISPOR). He was the elected President (2004-2005) of the Chinese Economists Society. For professional services, Dr. Liu serves as Co-Editor of the ISPOR official journal, *Value in Health*, and Editor-in-Chief of *the China Journal of Pharmaceutical Economics*. His primary research interests include health economics, health capital investment and economic growth, and pharmaceutical economics.

Dr. Gordon G. Liu

In this interview with Dr. Lu Shi (University of California, Los Angeles), Dr. Liu discusses the difference between health care reform in the United States and that in China, and noted several critical changes that may happen to China's health system.

1. Health Care Reform in the United States

Lu: As we know, the United States just passed a comprehensive health care reform bill. How does that compare to the ongoing health care reform in China?

Dr. Liu: The health care reform in the United States focuses more on containing healthcare inflation through universal insurance policy. To a large extent, it is a matter of health care finance.

About 16% of the American population do not have regular health insurance. These people, however, have access to health services via emergency care. In other words, many people who do not have health insurance tend to use emergency care even when they do not have urgent symptoms, leading to a very serious cost-ineffective mechanism for service delivery. Scholars from the United States talk of their 16% uninsured population as a failure case, yet it is inaccurate to say the U.S. does not have capability to provide all of its citizens with services. In fact, the U.S. health system does provide care to all residents regardless of insurance status, only in an inefficient way.

Why did health reform repeatedly fail in the U.S. since Franklin D. Roosevelt, while reforms of pension and unemployment insurance have been more successful? The answer lies in the basic American value that the individual liberty always remains the first priority, thus insurance mandate is not supposed to be imposed upon citizens until this recent reform. That is why the individual mandate in the recently passed health care reform bill has incurred considerable political cost for President Obama, who said earlier that he was willing to pay whatever a price it may take for this reform. Given what we see from the reaction to this reform, it is very likely that his reelection will be challenged or threatened by the Republicans for the passage of the health care reform bill.

Under the health care reform bill, insurance companies can no longer charge high premium for pre-existing conditions. This is actuarially very difficult, if not infeasible, for insurance companies to

operate, leading them to post a high premium for every customer as a result, which is not what we intend to see. This further drives healthier customers away from the insurance pool and force the insurance company to charge an even higher premium for the rest. Thus, the promise that every American has the same insurance as what congressmen have risks incurring a vicious cycle of "adverse selection." In any case, we see that the theme of the U.S. reform is around insurance policy design.

2. Health Care Reform in China

Dr. Liu: The challenge and focus for China's health care reform is quite different. The theme is supply shortage coupled with cost inflation. In terms of health care workforce, China has 1.5 physicians per thousand people, and the U.S. has 2.4 physicians per thousand people. Thus China has less aggregate physician supply than the U.S. But what we observe from the reality is still different from what the 1.5-2.4 contrast suggests. When you go to a physician appointment in the U.S., you usually need to wait for ten to twenty minutes before you go into a single room with the physician. An appointment typically takes half an hour. In China, an average physician would see several dozens of patients a morning, which means the physician has only about three or four minutes for each patient. With the room full of patients, you wonder how many questions the physician can really ask within three to four minutes. The numbers here do not match with what the physician density figure suggests, suggesting a highly inefficient bureaucratic system for medical profession where on-duty doctors are truly heavily overloaded while many others are not engaged in care workforce at all.

Furthermore, the reality is that, despite the low physician density in China, a lot of Chinese doctors are not in the practicing status. Chinese physicians are in a two-tier workforce. Among those in the big hospitals, a lot of doctors are working on the administrative affairs. So when we consider the physician density, it includes all those who have retired or semi-retired from their practice. This means that those who do practice are overloaded. For community hospitals, the quality of their training is low. Thus, better trained doctors are in big hospitals while second-tier doctors are in community hospitals which patients rarely choose to go to. These two groups of doctors do not interact or communicate with each other on a regular basis. As patients recognize this distinction, they go to the big hospitals all the time regardless of the severity of their symptoms, causing an inefficient physician labor supply.

China had not fully allowed physicians' multisite practice and thus there are no independent practicing doctors. To practice outside the hospital you work for required the permission from the hospital administration. This is one of the most flawed policies and has wasted lots of medical labor services. So the good news from China's state health reform roadmap is that multisite practice will be legalized and the doctors can now retain their job while practicing away from their full-time employers. If implemented, I believe that this reform will make a fundamental change leading to a more efficient allocation of physician supply in favor of community settings in China, which is exactly what we need at the moment. As I wrote in a book chapter[1] in 2009:

> "This approach could lead to fundamental improvements in both the incomes and professional status of the medical profession by allowing increased opportunities for career development, without the need to increase pressure on public finance, while also ameliorating confrontational political challenges from nonmedical officials who may create discontent otherwise when facing wage differentials. In short, the idea is to minimize government intervention in the micromanagement of service delivery for

[1] This is from a chapter contribution by Dr. Liu for *China's Capacity to Manage Infectious Diseases*, 2009, published by the Center for Strategy and International Studies (CSIC), Washington DC.

productive efficiency to allow greater government capacity for macroeconomic policy and regulatory responsibilities."

3. Challenges Facing China's Medical Schools

Lu: Considering the changes that need to happen in China's health care system, how do the Chinese medical schools live up to these challenges of this ongoing health care reform?

Dr. Liu: As we have discussed, supply capacity will be better if multisite practice becomes allowed. We will see more good doctors going to the community facilities, which also means that we will need many more primary care physicians. However, China's medical schools do not provide adequate training for family medicine and thus do not turn out a sufficient number of primary care physicians as needed by the society. So we will need reform in medical schools too to accompany the state overall reform.

4. China's Health Services Research Today

Lu: What about health services research in Chinese universities?

Dr. Liu: We still have not had a formal discipline of health services research (HSR) in China. Current HSR programs in China require years of clinical coursework and in some cases resident training, while we really need much fewer years of clinical courses but more health economics and policy trainings in an HSR program. The opportunity cost for multi-year clinical coursework is too high. But as much as we need to increase HSR core courses like applied econometrics, health economics, policy, and management, Chinese schools of public health are still unable to provide enough faculty manpower for solid training in those fields.

Of course, there is a historical reason for this situation. The traditional government-determines-all system does not leave much role for health services research to play in policy making or service management. But today under the so called scientific development approach as the guiding principle for China's development, we must need evidence-based research to support policy making and service management, and therefore it is a right time for us to start building a strong discipline of HSR in China.

But today under the so called scientific development approach as the guiding principle for China's development, we must need evidence-based research to support policy making and service management, and therefore it is a right time for us to start building a strong discipline of HSR in China.

—Dr. Gordon G. Liu
Peking University

RESEARCH TWITTER

***Yeung*, Albert, Irene Shyu, Lauren Fisher, Shirley Wu, Huaiyu Yang, and Maurizio Fava. "Culturally Sensitive Collaborative Treatment for Depressed Chinese Americans in Primary Care." *American Journal of Public Health* 2010, 100 (12): 2397-2402.**

This paper examined the feasibility and effectiveness of using culturally sensitive collaborative treatment (CSCT) to improve recognition, engagement, and treatment of depressed Chinese Americans in primary care. Chinese American patients in a primary care setting (n = 4228) were screened for depression. Of the study participants, 296 (7%) screened positive for depression, 122 (41%) of whom presented for a psychiatric assessment; 104 (85%) were confirmed with major depressive disorder, and 100 (96%) of these patients were randomized into treatment involving either care management or usual care. Patients in the care management and usual care groups did not differ in terms of their outcomes. CSCT resulted in a nearly 7-fold increase in treatment rate among depressed patients in primary care. The authors conclude that CSCT is both feasible and effective in improving recognition and treatment engagement of depressed Chinese Americans.

***Juang*, Linda P. and Alvin A. Alvarez. "Discrimination and Adjustment among Chinese American Adolescents: Family Conflict and Family Cohesion as Vulnerability and Protective Factors." *American Journal of Public Health* 2010, 100(12): 2403-2409.**

This paper examined racial/ethnic discrimination experiences of Chinese American adolescents to determine how discrimination is linked to poor adjustment (i.e., loneliness, anxiety, and somatization) and how the context of the family can buffer or exacerbate these links. The authors collected survey data from 181 Chinese American adolescents and their parents in Northern California, and conducted hierarchical regression analyses to examine main effects and 2-way interactions of perceived discrimination with family conflict and family cohesion. This paper found that discrimination was related to poorer adjustment in terms of loneliness, anxiety, and somatization, but family conflict and cohesion modified these relations. Greater family conflict exacerbated the negative effects of discrimination, and greater family cohesion buffered the negative effects of discrimination.

***Spencer*, Michael S., Juan Chen, Gilbert C. Gee, Cathryn G. Fabian, and David T. Takeuchi. "Discrimination and Mental Health–Related Service Use in a National Study of Asian Americans." *American Journal of Public Health* 2010, 100(12): 2410-2417.**

This paper examined the association between perceived discrimination and use of mental health services among a national sample of Asian Americans. The data came from the National Latino and Asian American Study, the first national survey of Asian Americans. The sample included 600 Chinese, 508 Filipinos, 520 Vietnamese, and 467 other Asians. The authors used logistic regression to examine the association between discrimination and formal and informal service use and the interactive effect of discrimination and English language proficiency. This paper found that perceived discrimination was associated with more use of informal services, but not with less use of formal services. Additionally, higher levels of perceived discrimination combined with lower English proficiency were associated with more use of informal services.

***Babiarz*, Kimberly Singer, Grant Miller, Hongmei Yi, Linxiu Zhang, and Scott Rozelle. "New Evidence on the Impact of China's New Rural Cooperative Medical Scheme and its Implications for Rural Primary Healthcare: Multivariate Difference-in-Difference Analysis." *BMJ* 2010; 341:c5617.**

This paper examined whether China's New Rural Cooperative Medical Scheme (NCMS) and the individual policy attributes have affected the operation and use of village health clinics. The data came from 100 villages within 25 rural counties across five Chinese provinces in 2004 and 2007, including 160 village primary care clinics and 8339 individuals. A difference-in-difference analysis with multivariate linear regressions was used, while controlling for clinic and individual attributes, and village and year effects. For village clinics, NCMS was associated with a 26% increase in weekly patient flow and a 29% increase in monthly gross income, but no change in annual net revenue or

the proportion of monthly income from drug revenue. For individuals, participation in NCMS was associated with a 5% increase in village clinic use, but no change in overall medical care use. Out-of-pocket medical spending fell by 19% and the two measures of exposure to financial risk declined by 24-63%. The paper concluded that NCMS provides some financial risk protection for individuals in rural China and has partly corrected distortions in Chinese rural healthcare. However, the scheme may have also shifted uncompensated new responsibilities to village clinics.

***Qian*, Juncheng, Min Cai, Jun Gao, Shenglan Tang, Ling Xu, and Julia Alison Critchley. "Trends in Smoking and Quitting in China from 1993 to 2003: National Health Service Survey Data." *Bulletin of the World Health Organization* 2010, 88:769-776.**

Using data from National Health Service Surveys conducted in 1993, 1998 and 2003, the authors estimated trends in smoking prevalence and cessation according to sociodemographic variables and analyzed cessation rates, quitting intentions, reasons for quitting and reasons for relapsing. The authors found that in China, current smoking in those > 15 years old declined 60–49% in men and 5–3.2% in women over 1993–2003. However, heavy smoking increased substantially overall and doubled in men. The average age of uptake also dropped by about 3 years. In 2003, 7.9% of smokers reported intending to quit, and 6% of people who had ever smoked reported having quit. Of former smokers, 40.6% quit because of illness, 26.9% to prevent disease and 10.9% for financial reasons. This paper concluded that smoking prevalence declined in China over the study period, perhaps due to the combined effect of smoking cessation, reduced uptake in women and selective mortality among men over 40 years of age. However, heavy smoking increased. People in China rarely quit or intend to quit smoking, except at older ages.

***Zhang*, Junhua, Hongcai Shang, Xiumei Gao, and Edzard Ernst. "Acupuncture-related Adverse Events: a Systematic Review of the Chinese Literature." *Bulletin of the World Health Organization* 2010, 88:915-921C.**

This paper aims to systematically review the Chinese-language literature on acupuncture-related adverse events. The authors searched three Chinese databases (the Chinese Biomedical Literature Database, 1980–2009; the Chinese Journal Full-Text Database, 1980–2009; and the Weipu Journal Database, 1989–2009) to identify Chinese-language articles about the safety of traditional needle acupuncture. The inclusion criteria were met by 115 articles that in total reported on 479 cases of adverse events after acupuncture. The most frequent adverse events were pneumothorax, fainting, subarachnoid haemorrhage and infection, while the most serious ones were cardiovascular injuries, subarachnoid haemorrhage, pneumothorax and recurrent cerebral haemorrhage. Many acupuncture-related adverse events, most of them owing to improper technique, have been described in the published Chinese literature.

***Yen*, Steven T., W. Douglass Shaw, and Yan Yuan. "Cigarette Smoking and Self-reported Health in China." *China Economic Review* 2010, 21(4): 532-543.**

The effect of cigarette smoking on self-reported or assessed health (SAH) has been considered in several studies, with some surprising results. In this paper the variation in an ordinal endogenous SAH variable is modeled with an ordinal endogenous cigarette smoking variable, using the copula approach to accommodate skewness in the error distribution. The empirical model is estimated for a random sample of adult males from nine provinces in the 2006 China Health and Nutrition Survey. The results suggest that heavy smokers are more likely to report excellent health. Government and those in health policy might target heavy smokers with the message that quitting does result in benefits, keeping in mind that self-reported health is itself a function of several factors.

***Jian*, Weiyan, Kit Yee Chan, Daniel D. Reidpath, and Ling Xu. "China's Rural-Urban Care Gap Shrank For Chronic Disease Patients, But Inequities Persist." *Health Affairs* 2010, 29(12): 2189-2196.**

This paper analyzes changes in the rural-urban gap for patients with chronic diseases based on national survey data from 2003 and 2008. Overall, there were substantial improvements at the national level in insurance coverage and the use of hospital services for both urban and rural residents with chronic diseases. There was also an overall reduction in the rural-urban gap in the use

of inpatient services. But the gains were uneven. The strongest evidence of the narrowing of the rural-urban gap came from central China, while the evidence is mixed for western and eastern China. This paper suggests that different approaches will be required to narrow the rural-urban health service gap in different regions of China.

***Feng*, Xing Lin, Guang Shi, Yan Wang, Ling Xu, Hao Luo, Juan Shen, Hui Yin, and Yan Guo. "An Impact Evaluation of the Safe Motherhood Program in China." *Health Economics* 2010, 19: 69–94.**
Using 11 years of county-level panel data, fixed effect models are estimated to evaluate the impact of the Safe Motherhood (SM) Program in China. Propensity score matching is used to select comparable factual and counterfactual counties. Out of 2013 counties in China, 283 are selected for the treatment group and 1051 for the control group. The results support the causal relationship between the program and its targeted outcomes and the partial effects increase as years of exposure in the program. Further modeling supports the conclusion that the program reduces maternal mortality ratio (MMR) by enhancing MCH care. This paper concludes that the SM Program is effective in reducing MMR through the enhancement of hospital delivery.

***Qian*, Dongfu, Henry Lucas, Jiaying Chen, Ling Xu, and Yaoguang Zhang. "Determinants of the Use of Different Types of Health Care Provider in Urban China: A Tracer Illness Study of URTI." *Health Policy* 2010, 98(2-3): 227-235.**
Using data from the fourth China National Health Services Survey (NHSS) that was conducted in 2008, the authors conducted a tracer illness study of urban people with acute upper respiratory tract infections (URTI) to examine factors of the use of different outpatient health care providers. The study addresses the demand for both public and private providers. The findings indicate that overall private clinics are important sources of medical care for low-consumption households, that insured patients are less likely to use private clinics and more likely to use Community Health Services Centers (CHC) and that children are more likely to see a high-level provider. City size and severity of illness were also found to play a role in determining provider utilization.

***Chen*, Chi-Chen and Shou-Hsia Cheng. "Hospital Competition and Patient-Perceived Quality of Care: Evidence from a Single-Payer System in Taiwan." *Health Policy* 2010, 98(1): 65-73.**
This paper examined the effects of market competition on patient-perceived quality of care under a single-payer system in Taiwan. Data came from two nationwide surveys conducted on discharged patients and National Health Insurance (NHI) hospital claim datasets in 2002 and 2004. Competition was measured by the Herfindahl–Hirschman Index (HHI). Quality of care was measured by patient-rated hospital performance including interpersonal skills and clinical competence domains. The results showed that HHI was significantly associated with a decrease in the perceived interpersonal skills, indicating increased interpersonal skill level in competition. A similar association was found for the perceived clinical competence. This paper concluded that quality of care from the patients' perspective is sensitive to the degree of competition.

***Wishnick*, Elizabeth. "Dilemmas of Securitization and Health Risk Management in the People's Republic of China: the Cases of SARS and Avian Influenza." *Health Policy and Planning* 2010, 25(6): 454-466.**
This paper looks at two cases in which the Chinese government securitized infectious disease (SARS and avian influenza) and examines the pros and cons of securitization. The article begins by examining the contributions of the Copenhagen School and sociological theories of risk to conceptualizing the security challenges that pandemics pose. The second section examines securitizing and desecuritizing moves in Chinese responses to SARS and avian influenza. Each case study concludes with an assessment of the consequences for health risk management in China. A third section draws out the implications of these cases for theories of securitization and risk. In conclusion, the article argues that alternatives to securitization, such as viewing health as a global public good, would require a prior commitment to risk management within affected states.

***Tiwari*, Agnes, Daniel Yee Tak Fong, Kwan Hok Yuen, Helina Yuk, Polly Pang, Janice Humphreys, and Linda Bullock. "Effect of an Advocacy Intervention on Mental Health in Chinese Women Survivors of Intimate Partner Violence: A Randomized Controlled Trial." *JAMA* 2010, 304(5):536-543.**

This paper explores whether an advocacy intervention would improve the depressive symptoms of Chinese women survivors of intimate partner violence (IPV). Assessor-blinded randomized controlled trial of 200 Chinese women 18 years or older with a history of IPV were conducted from February 2007 to June 2009 in a community center in Hong Kong, China. The intervention group (n = 100) received a 12-week advocacy intervention comprising empowerment and telephone social support. The control group (n = 100) received usual community services including child care, health care and promotion, and recreational programs. The intervention significantly reduced depressive symptoms by 2.66 (95% CI, 0.26 to 5.06) vs the control, less than the 5-unit minimal clinically important difference. Statistically significant improvement was found in partner psychological aggression and perceived social support, but not in physical assault, sexual coercion, or health-related quality of life. By the end of the study, more women in the intervention group found the advocacy intervention useful or extremely useful in improving intimate relationships and in helping them to resolve conflicts with their intimate partners vs. those in the control group This paper concludes that among community-dwelling abused Chinese women, an advocacy intervention did not result in a clinically meaningful improvement in depressive symptoms.

***Wu*, Jiang, Fujie Xu, Li Lu, Min Lu, Liang Miao, Ting Gao, Wenyan Ji, Luodan Suo, Donglei Liu, Rui Ma, Rui Yu, Jiazi Zhangzhu, Weixiang Liu, Yang Zeng, Xiaomei Li, Xuechun Zhang, Xinghuo Pang, and Ying Deng. "Safety and Effectiveness of a 2009 H1N1 Vaccine in Beijing." *New England Journal of Medicine* 2010, 363:2416-2423.**

The authors evaluated the safety and effectiveness of a 2009 pandemic influenza A (H1N1) vaccine in Beijing. During a 5-day period in September 2009, a total of 95,244 children and adults received the PANFLU.1 vaccine (Sinovac Biotech). The authors assessed adverse events after immunization through an enhanced passive-surveillance system and through active surveillance. To assess vaccine effectiveness, the authors compared the rates of reported laboratory-confirmed cases of 2009 H1N1 virus infection in students from 245 schools who received the vaccine (n = 25,037) with the rates in those who did not receive the vaccine (n = 244,091), starting 2 weeks after the mass vaccination. As of December 31, 2009, adverse events were reported by 193 vaccine recipients. Among unvaccinated students, 362 cases of incident neurologic diseases were identified within 10 weeks, including 27 cases of the Guillain–Barré syndrome. None of the neurologic conditions occurred among vaccine recipients. During the period from October 9 through November 15, 2009, the incidence of confirmed cases of 2009 H1N1 virus infection per 100,000 students was 35.9 among vaccinated students and 281.4 among unvaccinated students. Thus, the estimated vaccine effectiveness was 87.3% (95% CI, 75.4 to 93.4). Among 95,244 children and adults in Beijing, the PANFLU.1 vaccine had a safety profile similar to those of seasonal influenza vaccines and appeared to be effective against confirmed H1N1 virus infection in school-age children.

POLICY AND PRACTICE UPDATES

Vice Health Minister: Fiscal allotment isn't the key to the Health Reforms
Source: China Economic Times 2010-03-20
http://health.sohu.com/20100316/n270850618.shtml

"The primary problem should be the institutional reform of the Healthcare System." Said Huang Jiefu, the Vice Health Minister. Voicing a distinctly different tone from many of the Chinese People's Political Consultative Conference committee members of the Medical and Health Field, Huang stated that the Health Reforms cannot rely mostly on government investment. He also indicated his disagreement of the report submitted by of Committee Members, which applied for more fiscal allotment for public hospitals.

Huang expounded the Healthcare System Reforms, especially the reforms of public hospitals, as a reform integrated from three parts: management system reform, operation system reform, and service mode reform. The management system reform involves building the hospital governance structure, the administrator responsibility delegation, and the staffing system. The operation system reform involves establishing a pay-for-performance wage structure and a medical staff development system. The service mode reform involves building the social medical insurance system and a proper medical price schedule. He also emphasized on promoting the economic incentive and professional ethics among medical personnel, which is an essential part of a successful Healthcare System.

A Model of Merging Rural and Urban Medical Insurance
Source: Financial Magazine 2010-3-29
http://magazine.caijing.com.cn/2010-03-29/110405574.html

The New Rural Cooperative Medical System (NRCMS) and Urban Resident Medical Insurance (URMI) are currently administered by different government authorities. Many scholars proposed that the integration of the two health insurance programs should be the goal for the next round of health care reform. However, because of the vested interests, this proposal will be very difficult to implement in practice.

The purpose of the integration is to synergize the existing medical insurance resources, reduce administrative costs, and establish a universal and uniform medical insurance platform. However, NCMS is currently administered by the Ministry of Health and URMI by the Ministry of Labor and Social Security. The potential conflict between the two government bodies poses a hurdle of the integration as there are no clear guidelines as to which ministry will take charge of the issue.

Pilot reforms are being tested in some developed regions, such as Changshu, Jiangsu and Jiaxing, Zhejiang, where the rural-urban gap is less pronounced. However, it is reported that the pilot reforms will not be expanded for the moment, given the constraint in financial resources.

A 3 Billion RMB Gap in the "Zero Mark-Up" Policy
Source: 21st Century Economic Report 2010-04-13
http://www.21cbh.com/HTML/2010-4-14/zMMDAwMDE3MjYzMg.html

Shanghai Municipal Health Bureau recently released a detailed financial report on the revenue and cost of public hospitals in Shanghai. The report shows that the gross margin of these hospitals was about 3 billion in 2007. That is to say, if the new "zero mark-up" policy is to be implemented in Shanghai, approximately 3 billion RMB is required to make up for the loss of revenue.

The new medical reform program proposed three ways to compensate for the revenue loss of hospitals caused by the price-adjustment: implementing additional pharmacy service fees, adjusting the charging standards of diagnostic services, and expanding the government financial aid. Jin Chunlin, the Deputy Director-General of Budgeting and Finance Office under Shanghai Bureau of Health, suggested that a combination of the three measures is needed to address the revenue gap. He also mentioned extending health insurance coverage as a possible solution which could be combined with other remedial measures.

Since collecting the actual data of revenue and cost of public hospitals is necessary for assessing the impact of the new "zero mark-up" policy, public hospitals in a number of provinces are currently engaged in setting up elaborative costing and accounting framework and verification systems.

Public Dissatisfied with the High Drug Prices and Doctors' Under Table Remuneration
Source: Remin Net 2010-05-12
http://finance.sina.com.cn/g/20100512/08087919274.shtml

According to the Ministry of Health web site, Ma Wen, the director of the Central Disciplinary Inspection and Supervision Committee, recently pointed out that the people are still dissatisfied with some issues in the health care industry, especially with the high drug prices and doctor's accepting "red packets" and kickbacks.

The joint ministerial conference, held on May 4th, aimed to rectifying the unhealthy tendency in drug sales and medical services. Minister of Health, Chen Zhu, suggested that the Ministry of Health should be responsible for the cooperation of the relevant departments to ensure that the benefit of the rectifying efforts and health care reforms are achieved. He also pointed out that in the past year, an effective incentive mechanisms were formed through systematic health care reforms and comprehensive regulations. In respect of the current problems, Ma Wen requested more involvement of special administration in the health care reform and proper implementation of the current reform policies.

Minister Chen Zhu also emphasized the use of health economic evaluation in the reforms. By collecting comments from the manufacturers, the users, and the payers, and by building an economic evaluation institute, the effectiveness of drugs, devices and treatment options can be appropriately evaluated to ensure the investment in health care benefits people's health to its greatest extent.

Private Capital Investment Encouraged in the Health Care Industry
Source: Renmin Net 2010-05-13
http://politics.people.com.cn/GB/1027/11588907.html

The State Council has recently issued a document suggesting that private investment will be encouraged in the development of healthcare industry. According to the document, government investment will be supplemented by private investment in the formation of the social securing and public service system.

The new document has clearly pointed out that private capital is encouraged to flow into the infrastructure industries, such as communication, utilities, oil and gas, telecommunications, and mineral resources exploration. Moreover, it became clear that private capital is encouraged to be invested in hospitals, community health centers, clinics and medical institutions. Private investment is also supported to participate in the reforms of public hospitals as well as the establishment of private-owned medical institutions. Favorable tax subsidies will also be provided on the privately owned not-for-profit hospitals.

Retail Pharmacy Stores May Replace the Pharmacy Department in the Community Clinics
Source: China Pharmaceutical News 2010-05-17
http://health.sohu.com/20100517/n272168156.shtml

Ministry of Commerce lately released a discussion draft named "National Planning of Medicine Logistic Development". This draft proposed that community clinics will no longer own their pharmacy department if the area already have an established retail pharmacy store. It also suggested that the retail pharmacy store could play the drug delivery role under the essential drug system.

In line with the health care reforms, 80% of the essential drugs will be directly distributed through the community clinics. There will be about 3,700 community health centers and 11,000 community health stations involved by this policy. Building and maintaining such a large clinic pharmacy system will incur a large burden to the national fiscal authority, which can be easily avoided by allowing the local pharmacy stores to participate in providing the essential drugs.

Some have argued that this policy proposal is quite feasible. Firstly, since the pharmacy stores are profit-driven, they will provide better service and better management compared with the hospital pharmacies. Secondly, given that there are a large number of retail pharmacy stores, their participation in the essential drug system will make it more convenient for most of the patients to access the essential drugs.

After One Year and 390 Billion Yuan, Seeking Medical Care Still Remains Expensive
Source: Economic Observer 2010.5.21
http://finance.ifeng.com/news/special/xylgg/20100521/2220589.shtml

According to the National Development and Reform Committee, China has put 390.2 billion Yuan into the health care reform by February 2010, which led to a widened coverage of medical insurance to 1.2 billion people and the initial establishment of primary care health system.

But access to the medical care still remains a problem. "From drugs to hospital beds, getting treated is still quite expensive", said Wang Peng, a manager of a Beijing retail pharmacy. Wang's father spent 6000 Yuan during an 80-day stay in a town clinic in Anhui, which is only 1000 Yuan less compared with last year. Even though he admitted that it is more convenient now to see a doctor, the assertion of 30% reduction in price is a puff, Wang claimed.

In order to alleviate the pressure from a large number of patients flocking to big hospitals, new medical reform increased the reimbursement of township health institutions to 70%, while the large hospital reimbursement has been compressed. But some people are still unhappy about the current primary care health facilities, for only the drug expenditure can be reimbursed, while hospitalization and diagnostic costs are still paid by the patients themselves.

Dr. Xuezheng Qin, Editor of the Policy and Practice Updates Section, wishes to acknowledge excellent research assistance provided by Kimberly Zhang and Jiangjiang Quan.

ABOUT CHPAMS: FEATURED MEMBER

Shufang Zhang, MS, ScD Candidate

Shufang Zhang, MS

Shufang Zhang is a doctoral candidate in Health Economics at the Global Health and Population Department of Harvard School of Public Health (HSPH), and a Presidential Scholar of Harvard University. Prior to coming to HSPH, Shufang worked at the World Bank, managing training portfolios for senior Chinese government officials on poverty reduction and sustainable development. She worked in the World Bank Beijing Office on capacity building for policy makers in economic reforms, fiscal decentralization, education and corporate governance. Shufang also worked at the China Medical Board (CMB) on planning and managing of the CMB Tobacco Control Initiative and the advancement of the Lancet Series on Health of Southeast Asia, co-sponsored by CMB, *Lancet*, and Rockefeller Foundation. Shufang obtained her Master's degree in Environmental Economics and Policy from Duke University and is a Leadership for Environment and Development Fellow. She has served on the Board of Directors of the Chinese Economists Society and the Corporate Environmental Advisory Council of Dow Chemical Company. At Harvard, Shufang has been engaged in multiple research projects on China's health system, including the study and management of Rural Mutual Health Care, a pilot rural health insurance scheme in western rural China initiated by Professor William Hsiao. Shufang's research interests include health care financing, health intervention monitoring and evaluation, health and labor productivity, and smoking behavior. Her doctoral thesis aims to evaluate the impact of anti-tobacco interventions on smoking behavior among older Americans using micro-level longitudinal data. Shufang recently co-edited the book "Investing in Human Capital for Economic Development in China". She is one of the CHPAMS's founding members.

If you had not entered your current profession, what would you have liked to do?
Being a medical doctor or biologist.

What is the best piece of advice you have received, and from whom?
Opportunities always favor those who are prepared. From a good friend.

How do you relax?
Dancing Argentine Tango because the beautiful melody and attentive connection bring you to a different space, where you just forget about everything.

What is your greatest regret?
Could not fly home early enough to see my mother before she passed away.

What is your worst habit?
To spend a lot of time and energy that can only perfect things marginally.

What apart from your family is the passion of your life?
To discover new places and cultures all over the world.

What is your greatest fear?
Loose my physical freedom to go wherever and do whatever I want.

What one discovery or invention would most improve your life?
A timer or similar device that will put me to sleep on time so that I do not end up going to bed too late every night.

What keeps you awake at night?
Thinking about the social inequality faced by farmers and their children in rural China.

If you knew you had a week to live, how would you live those days?
To have a vacation with all my family in Greece.

ABOUT CHPAMS: MEMBERS' UPDATE

Career and Professional Appointments

Xuesong Han, PhD, was appointed as a Research Assistant Professor, Department of Nutrition at the University of North Carolina at Chapel Hill, and a Marilyn Gentry Fellow, American Institute for Cancer Research/ World Cancer Research Fund (AICR/WCRF).

Qi (Harry) Zhang, PhD, Assistant Professor, Old Dominion University, was recently appointed as an Editorial Board member of the *North American Journal of Medicine and Science*.

Xinzhi Zhang, MD PhD, Epidemiologist, the U.S. Centers for Disease Control and Prevention, assumes the role of Program Co-Chair (2010-2011), Vision Care Section, American Public Health Association.

Grants Received

Xuezheng Qin, PhD, Assistant Professor, Peking University, received a grant from the Ministry of Education, China to support his research examining the effect of health insurance on the choice of working locations by migrant workers in China.

CHPAMS Event

Jing Hao, MPH, PhD Candidate, University of Massachusetts at Amherst, organized a group dinner event for CHPAMS members at the American Public Health Association 2010 annual meeting in Denver, Colorado. The event provided an excellent networking opportunity for current members and for recruiting new members. It was attended by over 30 Chinese scholars and students with diverse backgrounds, from Mainland, Taiwan and across the US. ***Chiu-Fang Chou, DrPH,*** and ***Xinzhi Zhang, MD PhD,*** both at the U.S. Centers for Disease Control and Prevention, assisted in coordinating the event.

NEWS AND ANNOUNCEMENTS

JOB OPPORTUNITIES

Positions: Professor and Associate Professor of Health Policy and Economics at the China Center for Health Development Studies (CCHDS), Peking University, Beijing, China

The China Center for Health Development Studies (CCHDS) at Peking University seeks to hire several full professors and associate professors of health policy and economics. Peking University established the CCHDS in April 2010, with the mission to advance health development and health care system performance in China and globally, through academic excellence in research, education and training in health policy and systems studies. To achieve its mission, CCHDS is building a world class multidisciplinary group of faculty, fellows, and students. The CCHDS is directed by a Governing Board consisting of distinguished international and domestic professionals. More information on the mission, goals, research priorities and organization of the CCHDS can be found on: www.cchds.pku.edu.cn

Qualifications

Full Professors:

The successful candidate(s) are expected to play a leadership role in advancing the Centre's research priorities in health system research and in supervision of junior faculty and graduate students and in general play a collaborative role with researchers in other disciplines.

Candidates must have demonstrated leadership roles in research programs, ability to mobilize research grants and strong publication records. The candidate should hold a doctoral degree in economics or public policy/public health with a concentration in economics. Prior research experience related to health policy and health care systems in China and other low- or middle-income countries is also required.

Associate Professors:

The successful candidate(s) are expected to play a core role in advancing the Centre's research priorities in health transitions, determinants of health, and health system research.

Candidates must hold a doctoral degree in economics with an area of specialization in one or more of the following: health economics, applied microeconomics/econometrics, industrial organization, behavioral economics, development economics or evaluation science; or in public policy or public health with a concentration in economics. Candidates must have demonstrated a strong publication record and ability to work independently and with a team. Prior research experience related to health policy and health care systems in China and other low- or middle-income countries is highly desirable. Excellent written and spoken English skills are required.

Salary and Benefits

Full Professorship: university permanent academic position, RMB 300K-400K for basic annual salary and position reimbursement; and RMB 300K-500K support for research upon appointment.

Associate Professorship: university permanent academic position, RMB 200K-300K for basic annual salary and position reimbursement; and RMB 100K-200K support for research upon appointment.

Application materials and contact

Interested applicants should send a letter of application, including a CV, sample publications, a statement of current and future research interests, and the names of three referees by post or email to the following contact:

Mr Hou Jianlin

PO 505, XueYuan Road 38, Haidian District, Beijing 100191, China
China Center for Health Development Studies, Peking University
Tel: +86 10 8280 5684
Fax: +86 10 8280 5695
Email: houjianlin@bjmu.edu.cn

Short-listed candidates will be interviewed at the American Economic Association Annual Meeting in Denver, CO, January 6-9, 2011. For those who cannot attend the AEA meeting, interviews will be arranged in alternative ways. A panel consisting of faculty and governing board members of the CCHSD will be attending the AEA meeting and welcome the opportunity to have informal discussions with interested candidates as well.

Positions will remain open until filled.

Candidates interested in the positions can send inquiries to Professor Qingyue Meng (qmeng@bjmu.edu.cn), Executive Director of CCHSD, Dr. Winnie Yip (Winnie.yip@dphpc.ox.ac.uk), Reader in Health Policy and Economics at Oxford University and Professor of Health Policy and Economics (Part-time) at CCHSD.