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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.

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

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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.

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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.

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China Health Review

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EDITORIAL

The spring 2011 issue of the Review features the debut of a new section, Perspective. In our first opinion article, Dr. Lu Shi and Ms. Donglan Zhang outline the challenges to China's family planning commissions. They also discuss the potential new missions for the family planning commissions at this critical moment when China's economic development has been accompanied by a dramatic population transition.

We are very fortunate to have the opportunity to interview Dr. Jeffery P. Koplan, former director of the U.S. Centers for Disease Control and Prevention. Dr. Koplan's work and passion on public health in China could be summarized by two numbers: 32 years and over 50 trips to China. He played a critical role in creating the China Center for Disease Control and Prevention by advocating with his Chinese colleagues for such an institution since early 1980s. Among many professional services, Dr. Koplan serves on the Board of Trustees of the China Medical Board, an independent American foundation for advancing health in China. In the interview with Drs. Zheng Li and Feijun Luo, Dr. Koplan discusses his work on tobacco control in China and shares with us his views on China's public health systems.

Research Twitter summarizes nine published papers. Among those studies, Feng, Li, and Varma assess China's surveillance system for endemic infectious diseases and conclude that China need to invest far more in pathogen-based disease surveillance. Professor Ling Li of Peking University offers a brief discussion of the challenges to China's healthcare reform. Other studies examined H1N1 vaccine and obesity issues. Look for the full citation information if you are interested in the details of these studies.

Policy and Practice Updates provides timely summaries of recent reports related to training of rural health workers, public hospital reform, and many other critical population health issues in China.

Please meet one of our CHPAMS members, Prof. Yuhua Bao, who won the John M. Eisenberg Article of the Year Award for excellent original research in healthcare policy in 2007. In Featured Member section, she shares with us her secret technique of relaxing and the career path she envisioned for herself in an alternate universe.

Be sure to let us know if you have any comments or suggestions, or if you wish to submit your work to the Review. Thank you!

PERSPECTIVE

Refocusing China's Family Planning Commission in the 21st Century

Lu Shi, University of California, Los Angeles
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ABSTRACT

China's entry into an aging society calls for a transition of its population policy. The State Family Planning Commission (SFPC) could concentrate more on many essential health and human services for the next few decades. Prevention of birth defects and reduction of unnecessary cesarean births are cost-effective interventions that would enhance the health of the upcoming generations. Research and evaluation of modern contraceptive technologies are needed to promote reproductive health and help both the SFPC and users make well-informed decisions. Human Immunodeficiency Virus (HIV) and Sexually Transmitted Diseases (STD) testing and counseling deserve the joint efforts of the government, health services, and the society at large. Further, the SFPC's collaboration with the Ministry of Health, Ministry of Agriculture and the National Women's Federation can help to reinforce its role in the treatment of infertility and maternal diseases, the provision of public services for low-income families, and the prevention of domestic violence. The SFPC can also play a role in China's increasing foreign aid, particularly in those countries where artificial contraception and HIV/STD prevention are needed.

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INTRODUCTION

With the rapid aging of China's population (Chen and Liu, 2009), an overhaul of China's family planning service has become a major topic in the country's public debate. Total fertility rate (TFR) has been steadily declining since the 1970s (Morgan et al, 2009), which already led to a continuing decline in high school graduates every year despite the improvement in educational infrastructure (China Radio Broadcasting Net, 2010). The decline in child births is projected to accelerate by 2020 as the gender imbalance at birth after the 1970s (Poston and Zhang, 2009) is translating into a substantial gender imbalance of those who will have reached the age of fertility.

This demographic trend means that China's annual inflow into the working-age population has already peaked and now entered a downward trajectory. Meanwhile, the increase in life expectancy, coupled with the technological development in medical service, indicates that the country will witness a fast growing dependency ratio (Hesketh et al, 2005) and medical expenses per capita. By taking the working population's time away from their occupations and forcing them to focus on care giving, and by taking personal savings away from investing and transferring them to medical expenses, the aging process poses a serious threat to the country's economic development.

Currently the debate about Chinese population policy has become less of a question of whether it needs a reform, but more about how and when. Various reform plans have been proposed by Chinese demographers. Professor Yi Zeng (Peking University), for example, discusses several "soft-landing" options for gradually reforming the birth control policy (Zeng, 2007). One of Professor Zeng's proposals suggests a window for women to have their second child between age 32 and 35, and then reducing the lower boundary of that window every two years until all women between 28 and 35 are eligible for having a second child. While this proposal represents a gradualist approach that could look more feasible for a transition in the government's family planning policies, its proposed pace of change might not increase the TFR fast enough given the urgency of China's

aging problem. In places like Shanghai, from 2008 to 2009, the number of students taking the College Entrance Exam declined more than 20% within a year. The "soft-landing" options discussed in Professor Zeng's article were proposed prior to 2007. What might have been adopted in 2006 as a smooth transition approach is no longer adequate to address the threat of accelerated aging today. Relaxing the birth quota to two for women aged 32-35 is now unlikely to result in a substantial increase of TFR. It must be considered that, due to the high expense of raising a second child in today's China, not many women legally eligible for a second child are willing to have a second one (Hvistendahl, 2010). Plus, given the country's concern of birth defects, it is not optimal for women in their 20's to wait until 32 to have a second child (Zhang et al, 2008).

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While a gradualist approach is important to win support from the State Family Planning Commission (SFPC, the main government body that implements birth control and some maternal service), it is not the only way to ensure that the SFPC keeps functioning as an important government branch after a population policy overhaul. Even though the main role of the SFPC is perceived as implementing the current birth control policy, it has been providing a variety of public health services: premarital screening and counseling, pre-pregnancy screening, safe motherhood counseling, etc. Though these services are vital to population health, many of them remain severely underfunded and cannot effectively address the aforementioned health challenges at the society level. Increasing funding for these family health initiatives will not only reduce the society's economic burden, but also keep current family planning employees engaged in health and human services after a possible population policy overhaul. Below we will briefly discuss some specific SFPC services that might need additional funding and thus require enhanced intervention from family planning services across the country.

POSSIBLE AREAS TO REFOCUS FAMILY PLANNING COMMISSIONS

Birth Defect Prevention

Around 4%-6% of Chinese newborns are born with birth defects (Su et al, 2008)—a figure that is notably higher than developed nations. Treating folic acid deficiency is a proven intervention to prevent neural tube defects (NTD) (De-Regil, 2010), a birth defect that leads to high infant mortality, leg paralysis, etc. China's state and local family planning commissions have been distributing folic acid supplements to pregnant women under the joint efforts with health care departments, yet this practice is not universally carried out at the grass roots level. This folic acid intervention is a cost-effective policy that will benefit both the SFPC and China's newborns (Chen et al, 2007). Therefore, allocating more resources to the SFPC for expanding this much-needed service could be a good investment from the government and the society's perspective.

Fengshui is still part of the reason why a lot of Chinese women request a cesarean section on a particular "auspicious" day (Leung et al, 2001), despite the fact that even a late preterm birth is associated with poor health outcomes (Bird et al, 2010). Disproportionally high numbers of cesarean births in China have led to a high expenditure on non-essential care (Bogg et al, 2010). Although obstetric care is not within the SFPC's jurisdiction, the SFPC could still play an important role in advising against medically unnecessary cesarean sections. This practice would almost certainly save money for the public and private insurers.

Reproductive Health: Researching, Promoting, Testing, and Counseling

Contraceptive services have been and will continue to be one of the most important primary care services. Modern contraceptive methods improve people's quality of life by helping women prevent unintended pregnancy and reducing the risk for side effects from older birth control methods (Toby et al, 2005). Further, with the rapid development of modern contraceptive technologies, more cost-effective choices for contraceptive methods have become available. Zhang's study (1993) comparing the stainless steel and copper Intra-Uterine Device (IUD) influenced the government and practitioners to introduce the copper IUD in the 1990s and saved public resources. The SFPC currently has a research arm (Institute of Science and Technology, SFPC) that performs and funds scientific and technological research in reproductive health. This institute can expand its funding scope to cover research and evaluation on newly developed contraceptive technologies and to disseminate the innovations among the public, especially among adolescents and younger adults.

China's family planning services, along with hospitals and clinics, have taken considerable measures to curb the Human Immunodeficiency Virus (HIV) and Sexually Transmitted Diseases (STDs) epidemics. Yet given the migrant worker population, China's changing norms of sex among adolescents and young adults (Parish et al, 2007) and the strong social stigma attached to HIV/STD positives, it remains a daunting task to increase the detection rate for people with HIV and STDs. Free and anonymous HIV testing has become available in some large cities, but the geographic coverage of these anonymous testing services is still far from completeness. The existing family planning network, if well-funded for providing free and anonymous HIV/STD testing and counseling, can presumably promote the early detection of these STDs. The unique advantage of family planning services in detecting HIV/STDs lies in the fact that a person's visit to the service site is often not perceived by others as indicative of getting an HIV/STD test. Thus, the visitor could be less concerned about social stigma than those visiting HIV/STD testing sites (Hutchinson et al, 2007). Similarly, the SFPC has a unique advantage in preventing mother-to-child HIV transmission given its traditional role in prenatal and peri-natal screening and counseling.

Evidence shows that detecting and treating current STD patients can significantly lower the incidence of HIV positives. Therefore, an enhanced testing and counseling service from family planning service has the potential to both increase the disease survival and decrease the disease incidence (Hutchinson et al, 2007).

Collaborations or Mergers with Other Health and Human Services in China

A typical SFPC-run family planning facility (FPF) in China today provides contraceptive surgeries, infertility treatment, etc. These functions overlap with the country's maternal and child care hospital (MCCH) network. An interesting option could be combining MCCHs and FPF into one system, and enhancing some underfunded services such as infertility treatment, screening and treating gestational obesity, gestational diabetes, and preeclampsia, etc. Some of these programs could charge a fee for elective services (such as infertility treatment), while others could operate more as a welfare program.

With rapid economic growth, stunting has become less and less of a public health threat in China but prevalence estimates approximately 6.4% are still reported from rural secondary schools (Sharma et al, 2010), which suggests that prenatal and peri-natal nutrition services provided by government agencies are useful and necessary . China's SFPC could consider partnering with the Ministry of Health, Ministry of Agriculture, and the food industry to build a national program similar to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) in the United States (Rush et al, 1988a; Rush et al, 1988b). Such a program could provide nutritious and healthy food to low-income families with children under 5 in China, and thus indirectly subsidize healthy food production for the country's agricultural sector and food industry.

A case of domestic violence, before it becomes an issue involving law enforcement, is under the jurisdiction of the Women's Federation, a semi-governmental organization focusing on gender equality and the protection of women and children. A 2005 study reports a 46% prevalence of domestic violence victims among Chinese urban women (Xu et al, 2005), which suggests that government enforcement against domestic violence might be inadequate in some areas. As the family planning services in Korea and Japan have taken on domestic abuse interventions in recent years, it is reasonable for China's family planning commissions to assume similar enforcement roles in collaboration with the Women's Associations, particularly because many local family planning commissions had experiences in enforcement.

International Aid

Both safe-motherhood and HIV/STD interventions are badly needed in places like Myanmar, Indonesia, and sub-Saharan Africa. As an active investor in sub-Saharan Africa's infrastructure development, the Chinese government has been building hospitals and dispatching medical teams to African nations. So far international aid to battle public health challenges in Africa has yet to present sustainable benefits. With additional training on foreign languages and culture, China's family planning commission can step up its international assistance efforts and share their skills about safe motherhood counseling and infectious disease prevention and detection with people from other countries.

CONCLUSION

In drafting their reform proposal, planners need to minimize the proposal's negative impact on the groups that will be most affected by the change. The idea that China's family planning system will somehow be dismantled after relaxing birth control failed to recognize the SFPCs' important tasks aside from population control. The SFPC plays an invaluable role in reproductive health, infertility treatment and prenatal services. All of these health and human services will only see increasing demand in the near future. These administrative roles should be better funded and supported by more collaboration with other government agencies and nonprofit organizations. In addition, the major reason why China might need a population policy overhaul is labor shortage, and so it is both economically unlikely and ethically unsound that current SFPC workforce would be idled after a population policy overhaul. As the classic slogan from SFPC goes, "control the population quantity and improve the population quality." Now that the over-population issue seems less of a threat, the SFPC could shift the focus from population control to improving the population's quality of life.

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INTERVIEW

INTERVIEW WITH JEFFERY P. KOPLAN, MD MPH

Zheng Li, PhD, U.S. Centers for Disease Control and Prevention
Feijun Luo, PhD, U.S. Centers for Disease Control and Prevention

Dr. Jeffery P. Koplan was the Director of the U.S. Centers for Disease Control and Prevention (CDC) from 1998 to 2002, and is currently the Vice President for Global Health at Emory University and the Director of Emory Global Health Institute. Dr. Koplan began his public health career in the early 1970s, and has worked on virtually every major public health issue, including infectious diseases, environmental health issues, chronic diseases and the health toll of tobacco, both in the United States and around the globe. Recently, Emory Global Health Institute received a $14 million, five-year grant from the Bill & Melinda Gates Foundation and established the China Tobacco Partnership program. Dr. Koplan is the principal investigator of the grant and is leading the partnership, which is devoted to reduce the burden of tobacco use in China.

Dr. Jeffery P. Koplan

In this interview with Drs. Zheng Li and Feijun Luo, Dr. Koplan talked about the Tobacco Partnership program, his over 30-year of involvement in public health in China, his observation on the changes occurred in China, and the differences between the public health systems in the United States and that in China.

1. Tobacco Control Partnership in China

Zheng: Last week I heard your interview with the National Public Radio about the newly established China Tobacco Control Partnership. Can you tell us a little about that project?

Dr. Koplan: It is a program that we have funding from the Bill and Melinda Gate Foundation. In some way it's another chapter of the work that I have done before with the World Bank — Health Loan #7 from a series of health loans that the World Bank granted to China. It was a health promotion project that included HIV/AIDS, also a tobacco control program in seven cities from late 1980s through mid-1990s. The program showed some success in cities such as Shanghai, Luoyang and Tianjin, which gave us some indication of the type of work that could be done on tobacco control in China. So with colleagues in China we obtained this grant. We currently are working in 17 cities, and we are working with 5 universities with the goal of establishing academic units that concentrate on tobacco control.

Zheng: It sounds that this project has a longer history than the recent grant and partnership program?

Dr. Koplan: Well, my own experience with tobacco control in China goes back years, and so is the Chinese effort on tobacco control. Therefore it has been ongoing for a while, but it certainly has its ups and downs over the years. There are formidable challenges, such as, as you know, the huge amount of smokers in China and the tobacco monopoly. Therefore, it is a huge task and definitely need more people than what we have currently to achieve the goal of tobacco control in China.

There has been a lot of research on tobacco products and their health effects. For example, the Environmental Health Laboratory at CDC has been very helpful in showing the considerable differences in chemical components post combustion of products made in different parts of the world. So comparing the same brand of cigarette sold here in the U.S. to those in China or in Johannesburg, South Africa, you got very different products.

Zheng: It's a very complicated issue.

Dr. Koplan: On one hand, it's not complicated at all. If you smoke, it's bad for you, it'll make you sick and it can kill you. That part is easy. But everything else is very complicated.

2. Over 30-years of working in China on public health front

Zheng: Judging from what you said, I can tell that you have been involved in numerous projects in China for many years. What made you so interested in China and how did you get started?

Dr. Koplan: I started in 1979, so it's been 32 years working in China, with over 50 trips to China and lots of collaborations. It has been very enjoyable and satisfying. My first project was the U.S.-China collaboration on public health and health services. It came out of the initial breaking of the impasse between the two countries after Nixon's visit to China in 1976. In 1979, I visited China as a member of an official US government team to look at potential collaborations. A year later I was asked to be the chairman of the team and from there it led to more involvements and projects. We were able to establish the primary (public health) institution in China, what was then the Shanghai Number One Medical College, later named Shanghai Medical University, now became part of the Fudan University. Prof Yang Ming-Ding, a very distinguished professor at Shanghai, was my counter-part. We did a lot of projects together, e.g. a scientific research study in Shanghai County, which at the time was a semi-rural area on the edge of the city of Shanghai, now it is incorporated as part of the metropolitan. That project involved multiple trips, lots of publication, and a whole issue of *American Journal of Public Health* was devoted to that study [1982, Volume 72, 9 Supplemental Issue]. At the same time, I started to work with the World Bank on many projects in China. Then I became heavily involved in the anteceding organization of the China CDC -- first the National Center for Preventive Medicine, which became the Chinese Academy of Preventive Medicine, later became the China CDC. So I had close ties to administration at China CDC from the beginning.

Feijun: So public health was one of the first top priorities between China-U.S. governments when the two countries just formalized their bilateral relationships in the late 1970s!

Dr. Koplan: Yes, it was one of several focus points between the two countries.

Feijun: Many Chinese were not aware of China CDC until the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003. So I thought that public health was an unfamiliar concept in China before 2003.

Dr. Koplan: Well, China had had major public health undertakings, such as malaria control, eradication of leprosy, and lots of population-wide programs that were really public health, or a mixture of public health and preventive medicine. For example, community level of disease defense started out at the "bare-foot doctors" in villages. Their roles involved not only clinical care, but also responsibilities such as water and sanitation which is primary public health, infectious diseases and vaccination program which are a mixture of clinical care and public health. So there has been attention on this throughout the time, even goes back to before the revolution. There were active public health communities in Chinese institutions before the liberation occurred and there has been a strong thread of public health in the past 100-120 years of Chinese history. Sometimes it has been more prominent, and sometimes it almost disappeared, but it has always been there.

3. China and Public health in China: Changes, Strength and Challenges

Zheng: Over the past 30 years, do you see any changes in China and any changes on the public health front?

Dr. Koplan: There have been remarkable changes. For one, the economic system has completely been revolutionized, from the Marxist Maoist economy to a free enterprise capitalist system. The changes occurred include the level of industrialization, the shift from government-owned industries to private-hands, the closure of economically non-viable business, and the growth of

products that China is providing to the world. The growth of infrastructure in the country is immense and really unparallel — roads, trains, airports, bridges and dams.

However, the wealth happened primarily along the east coast and southeast, and less so as you go further west. There is a greater urban-rural gap in development. Also in my opinion, there has not been a remarkable shift in gender roles, i.e., the limited role of women in business and government. I know that there's saying in China that "Women hold up half of the sky". Women may be holding up half sky, but they are not sitting up there at the top controlling the clouds.

There are changes in other fields too. From the health perspective, the epidemiologic transition from primarily infectious issues to more chronic diseases has occurred in most parts of the country. Of course in some areas such transition is far from complete, still with lots of tuberculosis and acute respiratory diseases. Nevertheless, the transition towards the chronic diseases is pretty notable in many parts. The life span in China, particularly on the eastern part of the country, is very much like the U.S. and other developed countries. The major causes of death, like everywhere else, are cancer, heart disease and stroke, etc.

While there are huge improvements on overall health status and life span, there are also factors that affect health negatively. Among those are changing dietary pattern, decreased levels of physical activity, ongoing exposure to environmental pollutants, and tobacco addiction by the male population in the country. Diabetes was very hard to find in China 30 years ago, as was overweight or obesity. That has changed dramatically. There are multiple studies showing that people are taking in more total calories, more calories from fat and animal fat, and high amount of sodium. With these came higher incidences of heart diseases, stroke, diabetes, certain types of cancers, etc.

Government policy, to some extent, has caused a reduction on physical activity among the population, such as encouraging ownership of automobile and limiting bicycle lanes on the roads. The shift towards automobile is huge, but with it came with a lot of headaches, especially from health and environmental perspectives.

While there are huge improvements on overall health status and life span [in China], there are also factors that affect health negatively. Among those are changing dietary pattern, decreased levels of physical activity, ongoing exposure to environmental pollutants, and tobacco addiction by the male population in the country.

—Dr. Jeffery P. Koplan

Emory University

Dr. Koplan receiving consultation from a Traditional Chinese Medicine practitioner in Gonghe County, Qinghai Province.

4. Differences between the public health systems in China and the U.S.

Zheng: How is the public health system structured in China?

Dr. Koplan: China has a very developed public health infrastructure. It can be a very good example to many other developing countries at a similar stage. China's public health system is marketed through the name of "CDC". There are CDCs at different levels, for example, Hangzhou CDC (city), Zhejiang CDC (province), and China CDC (country). There is a good division of responsibility that goes from the local level to the provincial level and to the national level. The system has steadily improved itself over the years. At the beginning, like many other systems, there were many weaknesses and holes in it. As we discussed earlier, the SARS event played some role in strengthening China's public health system and catching people's attention to public health. I can tell you more in a few months since I will be reviewing China CDC as an external reviewer now that China CDC is 10 years old.

Feijun: What are the strengths of public health systems in each of the two countries?

Dr. Koplan: The U.S. has a longer time of operation and a better working relationship between different levels, even though there is still room for improvement. I think in some ways there are more defined distinctions between services provided from (CDC headquartered in) Atlanta and from the state health departments. U.S. CDC provides expertise to states. Every state can do epidemiology investigations on its own, but when problems reach certain level, CDC can come to help. It is very important to establish a collegial partnership between CDC staff and states and this is well understood by CDC teams. It would not work well if you say "[W]e are better than you, we are smarter than you, and we are more sophisticated than you." It is important to develop a relationship where one side may have more expertise in an area than the other but does not act in a way that makes people feel bad about it. That's part of the reason U.S. CDC is successful. CDC people cannot do investigations in states unless they are invited in by state health officials. Suppose you read big news about cholera outbreak in Louisiana, you can call Louisiana and ask what is going on. If they say they got the situation under control and they do not need you, you cannot go. I think China CDC probably can come in without requests from local provinces.

Another related factor is that U.S. CDC provides a lot of funding to state health departments. If you have a chance to visit a state health department, you will find many people working there are on salaries, funding, or projects from CDC. In China, the budget of China CDC is from the central government and the budget of Guangdong CDC is from Guangdong province. These can affect the relationships between CDC at national level and local CDC or health departments.

One thing I think we can learn from China is its surveillance systems. China has set up almost real-time surveillance systems in many places. If I see a patient in one of the city hospitals in Guangdong province, the information can be sent almost in real time electronically to Guangdong CDC and then to China CDC for analysis. So the electronic surveillance system is much better in China. Chinese visitors to U.S. CDC are surprised that the U.S. surveillance system still uses paper in some cases.

During a recent meeting, I said to the officials of the Chinese Health Ministry in an informal way that their system is much better than ours for getting something done in public health, "[Y]ou don't have to ask for permissions from a lot of people and you can get things done quickly." They said one would think that is the case, but between Beijing and some rural areas, there are a lot that get dropped out. I can relate it to a saying in Qing dynasty, something like "[T]he village is here and the emperor is far away."

5. Interest in Chinese Culture

Feijun: You are very familiar with Chinese culture and we heard several Chinese sayings or proverbs during our conversation. Can you tell us how you feel about Chinese culture and what is your favorite place in China to visit?

Dr. Koplan: I like to read Chinese history and literature, but my big regret is that I have never learned the language. The more I work in China, the more I learn how little I knew before. I never get tired of learning more about Chinese culture, history, and literature. China has incredibly rich culture and history. I went to the Symphony Hall in Beijing and attended music concerts and I like Beijing opera. I travelled around China and visited many places and found many different cultural items. I love Yunnan Province because of the minority groups who are colorful and friendly.

At altitude of 3600 meters outside of Xining, Qinghai, Dr. Koplan, in Boston Red Sox cap, meets two field workers harvesting fungi from hillside. One of them was wearing the cap of the New York Yankees, a fierce rival of Red Sox.

Disclaimer: The findings and conclusions in this interview are those of the participants of the interview and do not necessarily represent the views of the Centers for Disease Control and Prevention.

RESEARCH TWITTER

Feng, Zijian, Wenkai Li, and Jay K. Varma. "**Gaps Remain in China's Ability to Detect Emerging Infectious Diseases Despite Advances Since the Onset of SARS and Avian Flu**." *Health Affairs* 2011, 30(1): 127-35.
Early detection of emerging infections in China is critical to the health of the 1.3 billion Chinese people and to the world. China's surveillance system for endemic infectious diseases has improved greatly since 2003, but the country's ability to conduct surveillance for laboratory-confirmed infections remains underdeveloped. This is dangerous for China, the world's most populous country, which has been the focus of global attention since outbreaks of severe acute respiratory syndrome (SARS) and avian influenza. The paper describes China's public health advances since the 2003 SARS outbreak and concludes that China must now invest far more in pathogen-based disease surveillance. An enhanced disease-detection system in China will help prevent and contain outbreaks before they cause substantial illness and death in China and other countries.

Lu, Jui-Fen Rachel, and Tung-Liang Chiang. "**Evolution of Taiwan's Health Care System**." *Health Economics, Policy and Law* 2011, 6(1): 85-107.
This study presents an overview of the evolutionary policy process in reforming the health care system in Taiwan, through dissecting the forces of knowledge, social-cultural context, economic resources and political system. It further identifies factors that had a significant impact on health care reform policies in Taiwan through illustrative policy examples. One of the most illuminating examples highlighted is the design and implementation of a single-payer National Health Insurance (NHI) program in 1995. The NHI is one of the most popular social programs ever undertaken in the history of Taiwan. Despite high satisfaction ratings, Taiwan's health care system today is encountering mounting pressure for new reforms as a result of its rapidly aging population, economic stagnation, and imbalanced NHI checkbook. Nevertheless, Taiwan's experiences in reforming its health care system for the past few decades may provide valuable lessons for countries going through rapid economic and political transition.

Leon-Gonzalez, Roberto, and Fu Min Tseng. "**Socio-Economic Determinants of Mortality in Taiwan: Combining Individual and Aggregate Data**." *Health Policy* 2011, 99(1): 23-36.
There is a very large literature that examines the relationship between health and income. Two main hypotheses have been investigated: the income inequality hypothesis and the absolute income hypothesis. Most of previous studies have been criticized for estimating an aggregate model that does not account for non-linear links between health and income at the individual level. This paper follows a novel approach to avoid this bias, combining aggregate mortality data with individual-level data on socio-economic characteristics. It tests the income inequality and absolute income hypotheses using county-level mortality data from Life Statistic of Department of Health and individual-level data from Taiwan census Family Income and Expenditure Survey for 1976–2004. It finds evidence to support the absolute income hypothesis but not income inequality hypothesis. It also finds strong evidence that education does have significant effects on individuals' health.

Liang, Xiao-Feng, Li Li, Da-Wei Liu, Ke-Li Li, Wen-Di Wu, Bao-Ping Zhu, Hua-Qing Wang, Hui-Ming Luo, Ling-Sheng Cao, Jing-Shan Zheng, Da-Peng Yin, Lei Cao, Bing-Bing Wu, Hong-Hong Bao, Di-Sha Xu, Wei-Zhong Yang, and Yu Wang. "**Safety of Influenza A (H1N1) Vaccine in Postmarketing Surveillance in China**." *New England Journal of Medicine* 2011, 364(7): 638-47.
The authors aimed to assess the safety of the 2009 pandemic influenza A (H1N1) vaccination program that China began administering on September 21, 2009. They designed a plan for passive surveillance for adverse events after immunization with the influenza A (H1N1) vaccine. Physicians or vaccination providers were required to report the numbers of vaccinees and all adverse events to their local Center for Disease Control and Prevention (CDC), which then reported the data to the Chinese CDC. Data were collected through March 21, 2010, and were verified and analyzed

by the Chinese CDC. A total of 89.6 million doses of vaccine were administered from September 21, 2009 through March 21, 2010 and 8067 vaccinees reported having an adverse event, for a rate of 90.0 per 1 million doses. The age-specific rates of adverse events ranged from 31.4 per 1 million doses among persons >=60 years to 130.6 per 1 million doses among persons <= 9 years, and the manufacturer-specific rates ranged from 4.6 to 185.4 per 1 million doses. A total of 6552 of the 8067 adverse events were verified as vaccine reactions; 1083 of the 8067 were rare and more serious, most of which (1050) were allergic reactions. Eleven cases of the Guillain–Barré syndrome were reported, for a rate of 0.1 per 1 million doses, which is lower than the background rate in China. To conclude, no pattern of adverse events that would be of concern was observed after the administration of influenza A (H1N1) vaccine, nor was there evidence of an increased risk of the Guillain–Barré syndrome.

Zheng, Wei, Dale F. McLerran, Betsy Rolland, Xianglan Zhang, Manami Inoue, Keitaro Matsuo, Jiang He, Prakash Chandra Gupta, Kunnambath Ramadas, Shoichiro Tsugane, Fujiko Irie, Akiko Tamakoshi, Yu-Tang Gao, Renwei Wang, Xiao-Ou Shu, Ichiro Tsuji, Shinichi Kuriyama, Hideo Tanaka, Hiroshi Satoh, Chien-Jen Chen, Jian-Min Yuan, Keun-Young Yoo, Habibul Ahsan, Wen-Harn Pan, Dongfeng Gu, Mangesh Suryakant Pednekar, Catherine Sauvaget, Shizuka Sasazuki, Toshimi Sairenchi, Gong Yang, Yong-Bing Xiang, Masato Nagai, Takeshi Suzuki, Yoshikazu Nishino, San-Lin You, Woon-Puay Koh, Sue K. Park, Yu Chen, Chen-Yang Shen, Mark Thornquist, Ziding Feng, Daehee Kang, Paolo Boffetta, and John D. Potter. "**Association between Body-Mass Index and Risk of Death in More Than 1 Million Asians**." *New England Journal of Medicine* 2011, 364(8): 719-29.
The authors performed pooled analyses to evaluate the association between Body Mass Index (BMI) and the risk of death among more than 1.1 million persons recruited in 19 cohorts in Asia. The analyses included approximately 120,700 deaths that occurred during a mean follow-up period of 9.2 years. In the cohorts of East Asians, including Chinese, Japanese, and Koreans, the lowest risk of death was seen among persons with a BMI in the range of 22.6 to 27.5. The risk was elevated among persons with BMI levels either higher or lower than that range. A similar U-shaped association was seen between BMI and the risks of death from cancer, from cardiovascular diseases, and other causes. In the cohorts comprising Indians and Bangladeshis, the risks of death from any cause and from causes other than cancer or cardiovascular disease were increased among persons with a BMI of 20.0 or less, as compared with those with a BMI of 22.6 to 25.0, whereas there was no excess risk of either death from any cause or cause-specific death associated with a high BMI. To conclude, underweight was associated with a substantially increased risk of death in all Asian populations. The excess risk of death associated with a high BMI, however, was seen among East Asians but not among Indians and Bangladeshis.

Tian, Li-li, Wei-xian Shi, Ying-Deng, Xing-huo Pang, Peng-Yang, Fang-Huang, Shu-juan Cui, Xin-Zhang, Dai-tao Zhang, Quan-yi Wang. "**Serologic survey of pandemic influenza A (H1N1 2009) in Beijing, China**." *Preventive Medicine* 2011, 52(1): 71-4.
This article examines the frequency and distribution of antibodies against pandemic influenza A (H1N1 2009) in populations in Beijing. In January 2010, a randomized serologic survey of H1N1 2009 was carried out. Six districts were randomly selected with a total of 4601 participants. The overall seropositive rate for H1N1 2009 antibodies was 31.7% among the 4601 participants. The seropositivity prevalence in participants who received the pandemic H1N1 vaccination was 60.9%. Only 53.1% of the H1N1 2009 seropositive individuals who had not received the vaccination experienced respiratory tract infection symptoms. Multivariate logistic regression revealed that factors such as age, occupation, dwelling type, whether the participant's family included students in school, and the vaccination history with H1N1 2009 were associated with antibody titers. The article concluded that almost 30.0% of the residents had appropriate antibody titers against H1N1 2009 in Beijing and these titers may provide an immune barrier.

He, Qi-qiang, Tze-wai Wong, Lin Du, Zhuo-qin Jiang, Tak-sun Ignatius Yu, Hong Qiu, Yang Gao, Wei-jia Liu, and Jia-gang Wu. "**Physical Activity, Cardiorespiratory Fitness, and Obesity among Chinese Children**." *Preventive Medicine* 2011, 52(2): 109-13.
This article investigates the relationships of cardiorespiratory fitness (CRF) and physical activity (PA) with the risk of overweight/obesity in Chinese schoolchildren. A total of 1795 children aged 8–13 years at baseline were followed-up for 18 months from 2006 to 2008 in Guangzhou, China. Data on self-reported PA were obtained. CRF was determined by the 20-meter multistage fitness test, and the sex-specific median values were set as the cut-off points for the classification of high and low CRF. Significantly higher CRF was found in children with normal weight or physically active children compared with the reference group. CRF was inversely associated with the kg/m2 change in BMI. Significant association of baseline CRF with overweight/obesity was found in boys, whereas the association was marginally insignificant in girls. The results showed a strong negative association between CRF levels and children's BMI and weight gain.

Li, Ling. "**The Challenges of Healthcare Reforms in China**." *Public Health* 2011, 125(1): 6-8.
China is in the process of a new round of healthcare reforms. The Chinese Government has launched ambitious healthcare reforms aiming to achieve equitable access to basic health services; and to build a safe, effective, convenient and inexpensive healthcare system for both urban and rural residents. This paper will provide a brief overview of China's healthcare reforms, and describe the challenges and opportunities facing these reforms.

Ling, R. E., F. Liu, X. Q. Lu, and W. Wang. "**Emerging Issues in Public Health: A Perspective on China's Healthcare System**." *Public Health* 2011, 125(1): 9-14.
China's expenditure on healthcare has increased dramatically over the last 20 years, and three broad trends are seen in the associated health outcomes. First, limited improvements have been achieved to aggregate high-level health outcomes. Second, widening health inequalities are associated with disparate wealth between provinces and a rural–urban divide. Finally, the burden of disease is shifting from predominantly communicable diseases to chronic diseases. Reasons for the limited gains from investment in healthcare are identified as: (1) increased out-of-pocket expenditure; (2) a geographical imbalance in healthcare spending; and (3) the commercialization of healthcare without adequate attention to cost control. Recently, the Chinese government has initiated widespread reform and proposed three key policy responses: (1) establish rural health insurance; (2) develop community health centers; and (3) aspire to universal basic healthcare coverage by 2020.

POLICY AND PRACTICE UPDATES

Educating the Future Rural Doctors for Free
Source: The Caixin Online 2010-06-10
http://www.caing.com/2010-06-09/100151171.html

Rural doctors, a particular group of health workforce that work for village and township clinics, are now in a serious shortage. According to a survey conducted by the Development Research Center of the State Council, only 1.9% of the rural doctors in 118 villages and townships hold a college degree, 70.6% have a technical school degree, and the other 19.2% have no degrees.

In order to meet the challenge, the Chinese government recently launched a program which offers free education for the future rural doctors. The program details were published online on June 8th, saying that about 5000 people can benefit from this program in 2010. Most of the participants will be medical students from countryside. Students who want to participate in the program should first take the college entrance examination and then choose this program as a special major. Also, they have to sign an agreement with the local health bureau promising that they will work for the rural primary care institutions for 6 years after graduation. The students will then be able to enjoy a free college education without paying tuition or boarding fees. Qualified candidates can also receive living subsidies for about 6000 Yuan each year.

Zhenjiang – the Only City that Meets the National Health Reform Criteria
Source: People's Daily 2010-07-01
http://unn.people.com.cn/GB/14748/12025982.html

The city of Zhenjiang has launched the medical insurance transferability program, thus becomes the first to fully achieve the national requirement. According to the Ministry of Social Security and Human Resources, from July 1, 2010，migrant workers in other provinces can move to Zhenjiang with their medical insurance. On June 28, China Central TV reported the Zhenjiang experience.

Zhenjiang first implemented its health reform in 1995. Since then it has continuously put forward innovative health policies. Most recently, Zhenjiang has focused on removing the barrier of population flows, establishing the basic medical insurance systems, and building the interchange between basic medical insurance systems.

Several lessons can be learned from the Zhenjiang experience. For example, a "human focused" medical insurance system is needed to balance the development between the urban and rural areas; the insurance transferability problem may be solved through the market power, with a unified platform for insurance policies.

Minister of Health on the Main Challenges of the Healthcare Reform
Source: Xinhua News Net 2010-07-15
http://news.sohu.com/20100714/n273508522.shtml

The Minister of Health, Chen Zhu, recently visited public hospitals in Beijing such as Chaoyang Hospital and Jingsong Community Health Center. During his visit, he outlined 5 key tasks to meet the challenges of the current healthcare reform.

First, he emphasized that the mission of public hospitals is to offer public medical service, not to seek profit. He mentioned the payment system reforms as a key measure. Second, he stressed on the financial challenges of many hospitals, citing that 57% of the medical service items ended up losing money in the 11 hospitals he visited. "How to properly finance the public healthcare and let the medical prices reflect the true cost is an important issue", Said Minister Chen. The other three

challenges are: designing the right policies to encourage the development of private hospitals, building an effective preventive care and gate-keeper system, and covering the migrating population, especially the rural migrant workers, with the public health insurance system.

Roadmap for Healthcare Reform – 30 Provinces in Comparison
Source: 21st Century Economic Report 2010-07-24
http://www.21cbh.com/HTML/2010-7-26/5NMDAwMDE4ODQ5Nw.html

After the roadmap for the healthcare reform was published in 2009, provincial and municipal governments have been working hard on their plans for health reforms on the local level. Recently, 30 provinces have made their plans public in response to requests by the Ministry of Health. According to the Research Group of Health Care Reforms, several issues remain with these local plans. First, the arrangements have mostly focused on how to reform the basic medical insurance, and seldom explained how the other research efforts will be taken. Second, many plans simply copied the contents of the national roadmap, without putting out corresponding countermeasures to intensify the reforms. Third, few provinces made specific arrangements on resolving such common health reform problems such as the essential drug policy and public hospital reforms. In their conclusions, the research group commented that the local plans were lack of positive initiatives and exploratory acts.

Prescription Drug Dispensing Fee Launched in Dispute
Source: 21st Century Economic Report 2010-08-17
http://www.21cbh.com/HTML/2010-8-17/3MMDAwMDE5MjM3MQ.html

At the end of July 2010，Guangdong province started to collect the prescription drug dispensing fee among six pilot cities/regions that launched the experimental charge. This means that the long-disputed fee schedule has finally been put into practice, but it is still largely unclear what items should be charged, how much should be charged, and how the money should be used to compensate for the cost of public hospitals. This enormous uncertainty makes it extremely difficult to implement the drug dispensing fee reform. The journalist contacted many hospitals at Shenzhen and Zhongshan city, and all the interviewees suggested that they are still waiting for the further policy clarifications from the authorities. Meanwhile, a report from Beijing pharmaceutical advocates that it is time to discuss the implementation details of the dispensing fee reform rather than still arguing whether the fee should be made as standard charge across the nation.

New Policy on Privately Funded Hospitals: Tax Benefits for Basic Medical Services
Source: First Finance Journal 2010-11-10
http://finance.ifeng.com/news/20101110/2854086.shtml

A new policy proposal is currently under consideration by the State Council. The proposal aims to encourage more involvement of private capital in providing the basic medical care to the public and enhancing the public health services. The new policy offers generous tax benefit for private capital investment in the health care industry. For example, any medical institutions run by private capital which provides sufficient basic medical care will be exempted from sales taxes. Moreover, if the pretax profit is used on medical treatment and public health, the corporate income tax will also be exempted. However, if the profit is used for bonuses, the corporate income tax will be levied.

Li Keqiang, China's Vice Prime Minister, has stressed the importance of establishing viable market and competitive mechanisms in the seventh plenary session of the party. He encouraged innovative ways of running medical institutions and promote orderly competition in the industry. Spokesman of Ministry of health, Deng Haihua expressed in a news conference that the health reform pilot cities have had steady progresses, and new pilot projects addressing public hospital reforms, social security and the New Rural Cooperative Medical Insurance Scheme reimbursement schemes will be underway soon.

ABOUT CHPAMS: FEATURED MEMBER

Yuhua Bao, Ph.D.

Yuhua Bao, Ph.D.

Dr. Yuhua Bao is Assistant Professor in the Division of Health Policy in the Department of Public Health at Weill Cornell Medical College. She is a health economist specializing in mental health policy and is a recipient of a National Institute of Mental Health Mentored Career Development Award. Her current research focuses on payment and performance evaluation policies to promote integrated behavioral health care in general medical settings such as primary care and home health care. In addition, she conducts studies to understand mechanisms underlying racial/ethnic and socioeconomic disparities in health care, and to identify policies to eliminate such gaps. Dr. Bao maintains interests in methodological issues in health services research including modeling service utilization and costs, making causal inferences based on observational data, and decision analytical methods to assess stakeholder preferences. Her work has appeared in leading health services research and clinical journals such as *Health Services Research*, *Medical Care*, and *Archives of General Psychiatry*. One of her studies published in the journal *Health Services Research* received the John M. Eisenberg Article of the Year Award for excellent original research in health care policy in 2007. Prior to coming to Cornell, she held research and faculty positions at the University of California at Los Angeles and the University of North Carolina, Charlotte. Dr. Bao received her B.A. from Fudan University in Shanghai, China, her M.A. from the University of Alabama, and her Ph.D. from the RAND Graduate School in Santa Monica, California.

1. If you had not entered your current profession, what would you have liked to do?
I would have liked to become a journalist, that is, a reporter, writer, or editor.

2. Who was your most influential teacher, and why?
My high-school Chinese teacher who taught me integrity by living it herself.

3. What is the best piece of advice you have received, and from whom?
"Know where your heart is, focus on it, and don't get distracted." From several people.

4. How do you relax?
Making jewelries from beads with my daughter.

5. What is your worst habit?
Putting things off rather than dealing with them right away.

6. If you knew you had a week to live, how would you live those days?
Be a stay-home wife and mom.

NEWS AND ANNOUNCEMENTS

JOB OPPORTUNITIES

Positions: Full Time Research Fellows at the Sun Yat-Sen Center for Migrant Health Policy, Sun Yat-Sen University

About CMHP

Sun Yat-sen Center for Migrant Health Policy (CMHP) is a multidisciplinary research institution at Sun Yat-sen University, Guangdong, China. Funded by the China Medical Board (CMB), CMHP aims to take the role as a leading hub for research, communication and policy advocacy on issues relating to health and migration of China. More information on the mission, research focuses and organization of CMHP can be found at: http://cmhp.sysu.edu.cn/index_en.html.

Who are we looking for?

Title: Full time research fellows.

Qualifications:

Doctoral degree in public health, epidemiology, health economics, social medicine or public policy is required. Experience in research related to health and migration is highly desirable. Outstanding communication and writing skills are essential. The successful candidate must be highly organized, detail-oriented, and with team-work spirit to work with other members of the team.

"CARE" is what we expect the successful candidates to have:
C- CONCERNED with health and migration in China;
A- Think ACTIVELY and CREACTIVELY;
R- RESPECT the culture differences;
E- ENTHUSIASTIC about multidisciplinary endeavors.

Salary:

Pay, including basic salary and subsidies, will be in the range of RMB Yuan 150,000 - 500,000 annually (approximately US$23,000-$75,000) depending on professional experience and qualifications.

Contact us:

If you are interested in this position, please send us an application letter with current C.V./resume, representative publications in the past five years, research proposal and at least two letters of recommendation by post mail or email to the following address (Please do not hesitate to contact us if you have any questions).

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CMHP is open to all qualified applicants solely on the basis of their job-related experience, knowledge, skills, and ability. Qualified applicants are considered for the position for which they apply and for advancement without regard to race, color, religion, gender, sexual orientation, national origin, age, marital status, or the presence of a medical condition or disability.