The China Health Policy and Management Society
中国卫生政策与管理协会(海外)

China Health Review
中国卫生评论

Volume 3 Issue 3, October 2012

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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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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 and submissions should be addressed to Dr. Zhuo (Adam) Chen (CHR@chpams.org).

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China Health Review

Volume 3 Issue 3, October 2012

EDITORIAL INTRODUCTION

The October 2012 issue of China Health Review focuses on healthcare reforms.

The *Interview* section features two conversations centered on healthcare reform in China and the United States. **Professor LI Ling** from Peking University recounted her path from physics to macroeconomics and to health economics, while moving around from Wuhan to Pittsburg, to Towson, Maryland, and finally back to Beijing! Our interviewer, Dr. Rui Li, was fascinated by Professor LI's involvement in and thoughts on China's healthcare reform. **Professor Yuanli Liu** of Harvard University shared with Dr. Lingling Zhang his views on the healthcare reforms in China and the United States. He also provided updated information on the 2nd China-US Health Summit.

In the *Perspective* section, **Professor Yuanli Liu** delves into an in-depth review comparing the healthcare reforms in China and the United States. **Professor XIONG Maoyou** summarized a proposal to address issues facing China's health system from a practitioner's perspective.

Research Twitter provides summaries of ten recent publications related to China's health, including tobacco crop substitution, anaemia reduction, lung cancer, universal health insurance, audits to reduce caesareans, body mass index and health-related quality of life, alcohol drinking and overall and cause-specific mortality, and inequalities in income and health.

Policy Practice and Updates includes seven updates covering topics including medicine procurement system, electronic health record, human rights action plan, New Rural Cooperative Medical Insurance, and the recently established Health Policy Award by Minister CHEN Zhu.

In *About CHPAMS*, we introduce to you **Dr. Lu Shi**. You will also find recent career updates from **Drs. Lu Shi** and **Xuesong Han**, a report by **Jing Li**, **Dr. Xin Xu**, and **Yan Ding** on CHPAMS's participation at the Westlake Youth Forum in August 2012.

News and Announcements section features a job opportunity with Sichuan University and the announcement of the 2nd China-US Health Summit in Beijing later this month.

Enjoy Reading!

2012 年 10 月期《中国卫生评论》是关于中国医疗卫生改革的主题专刊。

访谈部分包括两篇关于中国医疗卫生改革问题的谈话。北京大学**李玲教授**回顾了她如何从物理学转到宏观经济学和卫生经济学，即从武汉到匹兹堡，再到马里兰州，并最终回到了北京的人生经历！**李蕊博士**对李玲教授关于中国的医疗卫生改革的参与和见解很感兴趣。哈佛大学**刘远立教授**分享了他对中国和美国的医疗卫生改革的见解；另外，他还提供了第二届哈佛中美健康峰会的最新信息。

在**观点**栏目中，**刘远立教授**对中美两国的医疗卫生改革的进程进行了深入的剖析和比较。**熊茂友教授**从政策实践的角度，总结了中国医疗卫生改革面临的问题以及相关建议。

研究动态列出 10 篇最新的有关中国卫生的文章，包括烟草替代作物、减少贫血、肺癌、全民医保、审计以减少剖腹产、身体质量指数（BMI）和健康有关的生活质量问题、饮酒及其全因和特因死亡率、收入和健康的不平等问题。

政策与新闻提供了有关药品采购系统、电子健康记录、人权行动计划、新型农村合作医疗保险、以及最近**陈竺部长**捐资成立的卫生政策奖相关信息。

CHPAMS **之声**栏目中有史律博士的介绍，**史律博士**和**韩雪松博士**的近期工作变化，以及**李婧**、**徐昕博士**、和**丁燕**撰写的 CHPAMS 参与 2012 年八月西湖青年论坛的报告。

快讯栏目中请注意四川大学的招聘广告和即将在北京召开的第二届哈佛中美健康峰会的信息。

阅读愉快！

INTERVIEW

FROM PHYSICS TO HEALTH ECONOMICS: PROFESSOR LI LING, PEKING UNIVERSITY
从物理学到卫生经济学：李玲教授访谈*

By *Rui Li*, PhD, BM, MM, CHPAMS member
访谈者：李蕊，博士，医学学士，医学硕士，中国卫生政策与管理学会成员

Dr. LI Ling is Professor of Economics and Deputy Director of the China Centre for Economic Research (CCER), housed within the National School of Development, Peking University. Professor Li has an M.A. and a Ph.D. in Economics from the University of Pittsburgh. She also has an M.A. in Economics and a B.S. in Physics from Wuhan University. She serves an advisor to the Ministry of Health of China and an expert consultant on China's healthcare reform for the World Bank. From 2000 to 2003, she was a tenured Associate Professor at the Department of Economics, Towson University. She has also been a faculty member of the Department of Management and Marketing at Hong Kong Polytechnic University and a teaching fellow of the Department of Economics at University of Pittsburgh. Professor Li's current research interests and teaching fields focus on Health Economics, Health Services Management, Economics of Aging, Economic Growth Theory, and Public Finance.

Dr. LI Ling

李玲教授简介：李玲博士现任北京大学国家发展研究院中国经济研究中心教授、副主任。曾任美国 Towson 大学经济学院经济系副教授（终身职），2003 年至今担任世界银行中国医疗卫生改革专家顾问，2005 年至今担任中国卫生部政策与管理专家委员，2007 年起担任国务院城镇居民基本医疗保险试点评估专家组成员。2000-2003 年曾担任香港理工大学部门咨询委员会非正式召集人和香港理工大学医疗管理学硕士项目负责人。李玲教授先后于 1982 年和 1987 年获武汉大学物理学学士学位、经济学硕士学位；接着求学于美国匹兹堡大学，并于 1990 年获得经济学硕士学位、1994 年获得经济学博士学位。她曾获得美国 Towson 大学 1995-2000 共六个年度的优异表现奖，曾获美国匹兹堡大学 1994 年"McKay 博士前教育奖学金"和该校教学优秀资格认证。李玲教授主要教学与科研领域是卫生经济学，卫生服务管理，医疗计划和评估，和商业研究方法。她曾在 Towson 大学和匹兹堡大学讲授管理经济学、微观经济学、老龄经济学等。

1. Career Path
工作经历

Rui: Professor Li, I'm really glad to have this opportunity to talk with you. I heard that you graduated from Wuhan University, received your doctoral degree from the University of Pittsburg, and then returned to China. Would you please tell us more about yourself?

李蕊：李教授，很高兴能对您进行这次访谈。我听说您毕业于武汉大学，在美国匹兹堡大学获得博士学位，然后回国发展。您能更多给我们介绍一下您的经历吗？

Professor Li: My career path has been very simple, just moving around from one university to another. In 1978, I was admitted to Department of Physics at Wuhan University as an undergraduate, and became a faculty member at the school after graduation. Two years later, I enrolled into the graduate program at Department of Physics, and after another two years transferred to Department of Economics. In 1987, I went abroad to study at University of Pittsburgh and received my Ph.D. degree in economics. I was a faculty member at Towson

* The English version was translated from the original transcript in Chinese. In case any ambiguity arises, please refer to the Chinese version.

University in Mary for 10 years before I came back to China to work at the National School of Development, which was called the China Center for Economic Research then.

I grew up during the Culture Revolution and didn't receive the typical schooling that kids go through nowadays. However, people from that time had early exposure to the everyday life and had many other experiences like learning from workers, farmers, and soldiers, visiting factories and military bases. I think the experience benefited me in terms of research design and survey. I was fortunate that I did not stay too long in the countryside like a lot of other people, and I went to college directly after graduating from high school. I was more interested in social sciences but when I entered college, it was the "golden time of science", so I followed the general trend and chose physics. I was able to build a very solid mathematics foundation, which benefited me in my later years. I often share with my students that the oft-spoken theoretical utility optimization doesn't necessarily lead to optimization in the real world. So when choosing a career, it is better to have a broader perspective, you will reap the benefits later. My undergraduate and graduate studies in physics built a very solid scientific foundation for me; with a firm grasp on systematic thinking and scientific methods, other topics became easy. Later when I transferred to economics, it was not difficult at all.

李玲：我的经历很简单，从一个校门到另一个校门。我 78 年进入武汉大学物理系读本科，毕业后留校，两年后考上物理系研究生，物理系两年后又转入经济系读研究生，87 年出国，在匹兹堡大学学习，94 年获得博士学位，在马里兰大学系统的 Towson 州立大学（后改名为 Towson 大学）, 差不多工作了有 10 年。2003 年回国，在当时的中国经济研究中心工作，也就是现在的国家发展研究院。然后一直在这里。

我们所受的教育在文革期间，学校里的时间不是很多，学工学农学军，很多机会下工厂，去部队，那时侯文化课的教育和现在不一样，但是使我们比较早的和社会联系。我觉得那段经历对我非常有益，后来做研究，做调研，自然而然就知道怎么去做，怎么去设计。我又很幸运，没有象很多人一样去农村呆很长时间，78 年高中毕业，直接就考上大学。本来我是喜欢文科，如果现在的话，从个人兴趣出发，我可能就选文科了。但是当时的大潮是"科学救国"，"科学的春天"，最热的就是物理，数学，也就是科学吧，所以我选择了物理，也就是随大流，但是我觉得对我后面受益无穷。我常常愿意跟我的学生分享：其实有时经济学上常讲的最优化效用并不一定是真正的最优化。如果你把视野放大一些，在带来社会效益的同时，反而自己受益更大。因为我本科和研究生都读了物理，奠定了很好的数理的基础，实际上就是思想观和方法论。这个基础奠定了，后来学什么都很简单。我后来转到经济系学习，其实都是很容易的，一点都不难。

Rui: Majoring in physics, when and how did you grow interested in health economics?

李蕊：您以前是学物理的，请问您什么时候开始对卫生经济学感兴趣的呢？

Prof. Li: There were a lot of coincidences. When I studied in Wuhan University, our beloved Chancellor, Mr. LIU Daoyu, was a strong advocate of academic freedom. Thanks to him, we had the chance to attend seminars and presentations from a variety of disciplines, including Western social science. Having studied physics and social science, I felt that what China needed the most was social management, especially the effective allocation of resources for the entire society. So I transferred from Department of Physics to the Department of Economics. Later at University of Pittsburgh, I studied macroeconomics and grew interested in the elderly population. This population's consumption and expenditures have significant impact on national economy. For the elderly, they have limited need for things such as food and clothing, but almost unlimited demand for healthcare. Since then I began to pay attention to health economics, and found this discipline very interesting: it touches on almost all the difficult questions in modern economics, such as asymmetrical information, risk aversion, adverse

selection, moral hazard, and many others. Towson University had a large School of Public Health Management and I had the chance to teach health economics there for 10 year, starting in 1994. That same year, Bill Clinton was running for President of the United States and he was campaigning for universal healthcare coverage. At that time, few scholars focused on health economics, including those in the United States. Health economics is still an evolving field, receiving more and more attention.

李玲： 这也是很多巧合。我当时上大学的时候我们武汉大学的校长是刘道玉，他是一位非常优秀的校长，可以说是现代的蔡元培。记得他那个时候非常提倡学生的自由，那个时候武汉大学学生的风气是最自由的了，有机会听各种各样的讲座，看各种各样的书，比如西方社会科学。我们物理学是科学救国，我学了物理又学了社会科学，感到中国最缺的其实不是科学，而是社会管理，就是怎样让整个社会的资源得到最有效的配置，所以这就是我为什么就转到了经济学。我的论文是有关宏观经济的增长，学习宏观经济增长的理论的时候，发现老年人这个群体，它的消费和支出对整个经济的影响非常大。它的消费支出是由政府的养老保障，还是个人支出，这个决策对于整个宏观经济的影响很大。所以我就开始关注老年经济学，关注以后发现老年经济的最大一块就在卫生这一块。因为他们对吃和穿的需求都有限，可是他们对医疗服务的需求可以说是无限的。那个时候就开始关注卫生经济学。恰好我原来教书的学校有很大的医疗管理的学院，正好需要老师教卫生经济学，所以我就去给他们教卫生经济学。在教的过程中开始研究卫生经济学，后来越研究越觉得卫生有意思，因为卫生经济学这个学科，可以说集合了我们现代经济学所有的难点问题，比如信息不对称，比如风险规避，逆向选择，道德风险，很多很多问题，都包含在里面。卫生这个领域，很有挑战性, 很有意义。我是从 94 年教卫生经济学开始接触这门学科。我转过去教书的那一年正好是克林顿的总统竞选，他提出的口号是全民保险。那时候医改在美国是一个很热的话题，但当时中国还没有医改这个词。[我做这方面的研究，]一方面是学术上的兴趣，另一方面是整个大环境的态势。那个时候真正做卫生经济学的人还很少，包括在美国。英国比较早一些。美国卫生经济学开始热实际上在 90 年代，也就是 94 年左右，克林顿竞选的时候。卫生经济学还是一个正在发展的领域，很多经济学家关注的还是不够,但是这些年越来越多的人开始关注它。

Rui: When did you decide to go back to China and work for the China Center for Economic Research (currently National School of Development)?

李蕊：您是什么时候决定回国在中国经济研究中心工作？

Prof. Li: I moved back to China in 2003. At that time I had already received my tenure in Towson University and there didn't seem to be many challenges remaining. Perhaps life in the U.S. had become too comfortable. Our generation grew up with the idealistic motto of "striving for the country and the people". If I stayed in the United States, I could definitely see what life is like for the next 30 years, which would be dull. I wanted to make a difference, so I accepted Professor Justin (Yifu) Lin's invitation and joined the China Center for Economic Research.

李玲：我是 03 年回国的。当时我的终身教职已经拿到了。在美国就是一步步奋斗，上学，找工作，拿终身教职。拿到终身教职以后，好象没什么奋斗目标了。而且可能在美国生活太舒服了。我们这一代人当年在国内受的是理想主义的教育，总有"为国家，为人民奋斗"的比较天真的想法。综合考虑吧。当时我想我还可以工作 30 年。未来的 30 年如果在美国的话，每一天我都知道我在干什么，太没劲了。所以我想做一些不一样的事, 决定回来。林（毅夫）老师邀请我回国，我也想回来，就回来了。

2. Involvement in China's Health Care Reform

参与中国医改设计

Rui: Can you tell us how you were involved in the debate of health care reform, the central part of your proposal, and how did you feel about your proposal when there were at least 8 competing proposals being discussed?

李蕊：请您给我们讲一讲您参与医疗体制改革的情况好吗？

Prof. Li: I have always been lucky in that I am always at the right place at the right time. In 2003, I returned to Beijing when SARS outbreak happened. The impact of SARS on China was profound. Government began to realize that economic development alone was not enough for the country, because a pandemic outbreak could cause economic stagnation and even contraction. I feel that the government did some soul-searching and proposed the concept of balanced development, known as the "scientific concept of development", as well as the "people-oriented" and "harmonious society". Since then, health reform in China had been proposed partly to meet people's demand for accessible and affordable healthcare. At that time, many scholars believed that privatization, i.e., selling the public hospitals, should be the future of health reform. However, even in the United States, the government had a clear role and responsibilities in providing healthcare to its people, and healthcare expenditure is a major part of U.S. federal budget. Based on my research and knowledge of international healthcare systems, I wrote a series of articles detailing how other countries have dealt with healthcare, and how the systems have been evolving, trying to help people understand why the health sector is special, and government must be involved. The articles were well received. In 2006, I participated in a training session for China's Politburo. It was after that training that the government established its leading role in China's health care reform, which aimed to provide basic health services as a form of public services to all citizens.

李玲：我就是属于运气特别好的人，总是能赶上热点。2003 我回国的时候，刚好赶上非典，我觉得 SARS 对中国社会的影响是非常深刻的。因为非典，中国政府认识到仅仅发展经济是不行的，一场传染病，就可以使经济停滞，甚至是倒退。所以非典以后，我觉得我们整个政府是深刻反思的了，所以在那以后提出了科学发展观，以人为本，和谐社会，从光搞经济扭转到平衡发展，提出了科学发展观的新的理念，当时就开始了医疗卫生领域的改革。医改一方面是迎合百姓的呼唤，当时看病贵，看病难的问题已经成为人们最关注的问题，已经开始了关于医疗卫生改革的讨论。但是当时我回来的时候，我觉得这个讨论和国际非常不能接轨，因为卫生这个领域，即使在美国，政府承担的责任都是非常明确的。美国财政的大头也是在卫生上。当时讨论的时候，很多学者的观点还是私有化，就是把公立医院卖掉，这就是改革了。我当时回来，面对的就是这样一种情形。我根据自己在国外这么多年的研究以及自己对国外体系的了解，就写了很多文章，想告诉大家，医疗卫生到底特殊在那里，政府是不能不承担责任的，以及其他国家都是怎样的一种体系，体系是怎样演变的。应该说还是收到了比较好的效果。06 年我参加政治局的集体学习的讲课。就是那次集体学习，中央高层就明确提出医改的目标是建立覆盖城乡居民的基本医疗卫生制度，政府起主导作用，医疗卫生要回归公益性。

Rui: I heard that there were 9 proposals on the table.

李蕊：我听说当时有 9 种方案。

Prof. Li: Yes, there were 9 proposals submitted by domestic and international researchers including Peking University, Tsinghua University, Renmin University, World Health Organization (WHO), the World Bank, Mckinsey & Company, and Fudan University. The final scheme was a synthesis of the 9 proposals. However, the main framework was based on our proposal.

李玲：是的，当时有北大，清华，人大，世界卫生组织，世界银行，麦肯锡，还有复旦，一共有 9 个。我们代表北大方案。后来方案出来以后，当然是在各个版本方案基础上的一个综合。但是主要的框架，思路还是我们的。应该说我们这个方案很多部分是被政府采纳了的。

Rui: Rural China has recently seen much improvement in healthcare. Could you please tell us how you see the current situation regarding this part of the healthcare reform? Are there any issues that need further efforts?

李蕊：农村医疗体制改革是您的提案的重要部分，请问您对这部分的看法是什么？

Prof. Li: We believed that the government should take responsibility in two aspects of healthcare reform in rural areas: providing health insurance and increasing level of coverage for the New Rural Cooperation Medical Insurance and rebuilding rural primary care system.

Rural health care system in China is the weakest spot. During the Cultural Revolution, Chairman Mao emphasized the importance of rural health care systems, resulting in an influx of good doctors into rural areas and allowed the establishment of the three-level health system: "barefoot doctor-township hospital-county hospital", which greatly improved rural quality of healthcare. After the Cultural Revolution, the collective economy was replaced by the Household Responsibility System, and barefoot doctors, a system dependent on the old economics model, diminished as well. In addition, the "barefoot doctor" was considered as a product of the Cultural Revolution and banned by legislation in the 1980s. These changes pretty much destroyed the cooperative rural health care system. Before 2003 there was no health care protection for farmers at all, leaving rural residents in a deep poverty trap-illness begets poverty and poverty begets illness. In recent years, 18 ministries and commissions worked together to jumpstart the health care reform and presented the draft proposal in April 2009. From 2009 to 2011, the main objective was implementing reform at the grass-root level, in accordance with the slogan "Ensuring Grassroots Capacity, Strengthening Basics, and Establishing Infrastructure". Now there has been a dramatic change in the healthcare system in rural area. Farmers started to have medical insurance, even though the covered services were still limited. Nowadays, the most beautiful building in the rural area is usually the rural township community hospital. I just finished a field trip in seven counties in Jilin. A farmer told me that "[I]t is great! Now I can afford to see a doctor."

In rural areas, the most important task of health care reform is to rebuild the primary health care system, not just expanding insurance coverage or improving community hospital's facilities. Currently the primary healthcare system is funded with 120 CNY from each level of government and about 30 CNY out of pocket costs from rural residents. The funding level is still low, but it did allow the re-establishment of the three-level health services network: village doctors, township-village hospitals, and county hospitals. The township-village hospitals used to survive by selling medicines. After the reform, they become public service units and their budget is fully provided by the government, just like teachers and civil servants. To maintain quality and efficiency, the personnel system has also been reformed with a more competitive human resources policy being currently used. Employees for rural health care providers must compete for positions based on their qualification and performance evaluation. The new salary and incentive system is also based on performance evaluation. Furthermore, the introduction of digital recording and evaluation system guarantees the objectivity and impartiality of the personnel system. As a result,

dramatic changes have occurred in the health care system in rural areas of China. I recommend you to watch a TV series called "Sheng Si Yi Tuo (生死依托)". It reflects very well the reality of the ongoing healthcare reform in China. Previously rural residents often became poor due to their illness. Now things have changed: their agriculture taxes exempted; free nine year education provided, and the health insurance coverage provided after the reform.

Based on my experience during the past several years participating in China's healthcare reform, I think it's fair to give Chinese people and Chinese system a high score. Our system has many problems, but also many advantages. First of all, the Central Government has the willingness and capability to push for reform. The government solicited proposals globally; the process was open, transparent, and responsive to public comments. In addition, comparing with the U.S. 2010 health care reform, there is no room for pilot tests once the reform proposal became legislation. In contrast, any location in China can be a field experiment, with each pilot site implementing the reform in accordance with their capacity and resources. All these experience could be quickly summarized and developed into a model, then promoted nationwide. For example, the Anhui Model had been very successful and many places adopted or are planning to adopt it. The former Vice Governor of Anhui Province was in charge of the Anhui healthcare reform and later promoted to head the Office of National Healthcare Reform. The reform in China is a combination of top-down and bottom-up approaches and it is a continuous process with a lot of flexibility and strong momentum.

李玲：我们当时就是说政府应该承担责任，在农村两条腿走路。农村当时已经有新农合，要加大新农合的覆盖面和覆盖水平。第二个就是要把农村基层医疗卫生体系重新构建起来。

我们国家医疗卫生体系最薄弱的就是农村。应该说在文革期间毛泽东提出的把医疗卫生的重点放到农村去，是极大地改善了那时侯农村医疗卫生的水平。好的医生从城市到农村，在加上农村自己培养的以及大城市，大医院帮助他们培养的赤脚医生，使得农村建立了所谓的三级医疗网络，也就是赤脚医生，乡镇医院，县级医院的一个完善的医疗保障体系。改革开放以后，也就是实行家庭承包制以后，把赤脚医生，也就是基层服务的网络破坏了。原因就是赤脚医生依托的是当时的集体经济，集体经济跨了以后，赤脚医生也就跨掉了。而且当时反思文革，把赤脚医生也当成是文革的产物，所以 80 年代国家出台文件，说不允许再用赤脚医生。从这以后，农村过去的合作医疗制度就跨掉了。在 03 年以前农民基本上完全没有保障，都是自费，医疗费用又在不断的增加。当时农村的医疗服务问题应该说是很严重的问题，老百姓看不起病，因病致贫，因病返贫普遍存在。所以我们的方案集中在服务体系的再构造和筹资方面。前面谈到的 06 年提出医改，国家成立了由 18 个部委组成的医改领导小组，最后在 09 年 4 月份出台了医改方案。在 2020 年我们要建立覆盖城乡居民的医疗卫生制度。它近期的目标，就是头 3 年，09，10，11 年的主要任务是进行基层医改。口号是"保基层，强基本，建机制"。这三年的成效就是农村医疗卫生发生了根本的变化。农民从基本上自付看病，看不起病，小病就拖着，大病就扛着，到现在农民已经有了一个低水平的保障。最近我去了吉林省的 7 个县，调研基层医改，其中到延边，算是边疆了，现在当地农村最漂亮的建筑就是乡镇卫生院和乡镇卫生室。我在乡镇卫生院碰到一个农民，他感慨地说，现在"老好了"，就是"很好"。他现在觉得得病就是一种享受了。以前得病扛着，现在敢来看病，而且医院条件这么好，又便宜，得了病是一种享受了。

在农村医改最重要的是体系的重建。它不是一个单纯的扩保险，把乡镇卫生院硬件盖起来，而是它从体制机制上重新构建了农村的基层医疗服务制度。这个制度里面就包括了筹资体系，它现在是一个政府投入的筹资体系，农民交的比较少。现在大概各级政府出 120 元左右，农民交大概 30 元左右。当然保障水平还比较低。到今年年底达到 300 块钱。但是它同时把农村的三级卫生服务网络又重建起来。这两年建的重点主要是建乡镇卫生院。医改之前，乡镇卫生院的医生主要是靠卖药挣钱。它挂号费很少，又没有其他手段，主要是靠卖药。卖药以后拿提成，拿提成的部分来使医院运作。所以过度用药，滥用药的问题非常厉害。医改以后，全国乡镇卫生院都成为由政府主办的事业单位。既然是政府主办的事业型单位，政府就要负责

它的财政的投入，它的房子的建设，人员配制和工资等等。所以现在乡镇卫生院的人员享受的是教师，国家公务员的待遇，保证他的收入，以及医疗，养老之类的。但一提到政府要包起来，我们害怕的是又回到以前吃大锅饭的体制，干好干坏一个样。所以基层医改又进行了人事制度的改革。不是过去那样你只要进入编制，就得养你终身，干好干坏一个样。现在在乡镇卫生院采取的是竞争性人事制度，就是让乡镇卫生院的医生全体竞争上岗。要有资历，就是要符合条件才能进入乡镇卫生院，然后进来以后它不是一个终身饭碗，它是定编，定岗，不定人的。还有分配制度，也不是干好干坏一个样，它由各种考核指标，比如服务态度，水平，做了多少公共卫生，比较全面的综合考核，来决定他能得到多少收入。而且现在国内很多乡镇卫生院，甚至到村这一级都用了信息化手段来考核。中国是个人情社会，如果用过去的方法来考核的话，可能就变成你好我好大家好，很难真正考核。它现在是完全数字化了，做了多少，都很清楚。现在只要能够用到信息化考核的地方，改革效果就非常好。所以中国医改在基层确确实实正在发生非常大的变化。你们在国外，我建议你们去看一部现在刚刚开始播的电视剧，叫"生死依托"，比较真实的反映现在农村正在进行的医改。而且我们到各地调研，农民说最让他们得到实惠的是免农业税，义务教育，和医改。特别是医改，解决了他们的后顾之忧。以前的话，农民挣的那点钱是完全经不起一场病的折腾。可能是奋斗多少年，一场病就回到解放前。现在，因病致贫，因病返贫的现象正在缓解。因为一场病让家庭陷入绝望的情况已经不多了。因为新农合用各种办法来补偿他。很多地方一次补偿不够还有二次补偿，还有贫困补偿，所以基本上能够解决他的生活和大病后医疗费用的问题。

我参加医改这么多年来，我觉得还是要给我们中国人，中国制度以很高的评价 。我们的制度也有很多的优越性。当然我们有很多问题，这个一点也不回避，但是在推行医改过程中也看到我们的制度有很多的优越性。一个是高层强力推，第一次医改有了顶层设计，而且是向全球开放，全球征求方案。没有任何一个国家做国家公共政策选择像中国这样开放。我觉得这是中国在尝试一种新的民主方式。民主一方面是选人，一方面是选事。医疗卫生改革涉及每个人的利益，这次医改方案是对全民征求意见，08 年 10 月，方案放在中国发改委的网站上，全民都可以来提意见。中国政府在这次医改是尽可能的用公开，透明的方法来做决策，而且还一直顺应民意，因为这是民众最关注的事。跟美国医改相比较，中国医改还有一个好处，你看奥巴马这次医改，它一通过就成了法律，基层是没有空间去试点的。你一试点就违法了，所以它很难执行。中国的医改呢，我们在整体的框架，大的目标定下来以后，允许在各地试点。所以说医改在中国可以说是轰轰烈烈的社会实践，每个地方都不一样。每个县，每个城市，每个省都不一样。都是按他们的理解，结合当地的条件，能力，来推进医改，非常有意思。中国医改实际上是一个全世界最大的社会实验场，它让大家试，非常公开，但是试了以后，它又能够很快的总结经验。在各地试点情况下很快就形成模式。比如现在在基层推行的医改就是安徽的模式，因为安徽做得最好，所以它的经验可以很快的得到总结，提炼，推广。原来在安徽管医改的常务副省长就调去管国家的医改了，他现在是国家医改办的主任。我觉得这种从上到下，从下到上不断的上下联动，进行有机的结合，这是我们中国体制的最大一个优势，就是它的弹性。涉及 13 亿人的医改的战车，这么大的摩擦力，要往前推，是需要巨大启动力的。还要推到正确的方向，平稳的前进，不得不承认中国的体制还是有很大的优势的。

3. Health Care Reform in China: Next Steps
中国医改展望

Rui: Your healthcare reform plan, or a very close version of it, has been adopted by the Ministry of Health. What is now on your research agenda and what is your 5-year, 10-year goal in moving healthcare reform forward?

李蕊：您现在的研究方向是什么？可以问一下您将来 5 年，10 年的研究方向和您在医改方面的目标吗？

Prof. Li: We are researching and evaluating the current healthcare reform, as well as some theoretical research. During the early stage of the reform, we conducted surveys on the implementation and coordination of the New Rural Cooperative Medical System (NCMS). The next step will be to reform urban public hospitals. It is still not clear in which direction the reform should go. The healthcare reform has been successful at the grass-root level. However, only 20%

of the total health care services are provided at the grass-root level. All the hospitals at the county level and above, which provide 80% of the total health care services, have remained in the old system. We did pilot studies in 17 cities in the past three years, but there was not a clear model for health reform in urban public hospitals. It has to go through system reconstruction, including its financing system, payment system, and personnel system. In addition, the reform of personnel system plays a fundamental role, and the appropriate incentive system has to be established.

The reform of public hospitals should still be government-led, rather than completely market-oriented. However, in China the private sector nowadays is very strong. There is intensive lobbying from interest groups. I think we should learn from the U.S. Veterans Affairs system, to move away from for-profit and come back to public services—to provide the best quality of care to the public with the lowest cost. To achieve this goal, we need to reconstruct the system of public hospitals; and I think the experience of three years' primary health system reconstruction in rural areas can also serve as an example for the reform in public hospitals. The main difficulty is that the incentive system of public hospitals is much more complicated, for urban medical faculties are more professional and the classification of specialists is more complex. I think the U.S. Veterans Affairs system is the example we can learn from.

The reform in urban public hospitals will have a very long way to go, because it's a major issue of resource rebalancing. After we complete the reform in urban public hospitals, I think the overall healthcare system reconstruction project will be completed. And the next step, as the ultimate goal of healthcare, is "health", which has to be realized by prevention instead of medication. Information system will play a major role in promoting health for all Chinese people.

李玲：我们现在做医改研究，对医改进行评估，也进行一些理论方面的研究。医改前期主要是在基层，我们对新农合的实施，统筹在进行一些调研。现在做得比较多的还是下一步的公立医院改革。比如说，中国的公立医院到底何去何从。虽然我们三年医改在基层取得很大的成效，但是县级以上的医院基本上还没动。过去三年，我们对 17 个城市进行试点，目前公立医院的改革还没有一个明确的模式。但是下一步我们必须要做的是公立医院的改革。基层医改虽然农民得到不少实惠，但是基层它毕竟是低水平的。而且全部基层占的整个卫生服务的总量不到 20%。占 80% 的县级以上医院还是在按旧的体制运行。所以这就是为什么城市老百姓对医改没有多少感觉，因为城里医院还没有改。这也是我们下一步要研究的城市公立医院的改革。比如说整个体系如何来再造，它的筹资体系，它的支付方式，它的人员如何定位。中国公立医院改革最核心的是医务人员。这也是我们现在正在做的，如何建立一个正确的医务人员激励机制。

13 亿人的医疗卫生靠看病，吃药是解决不了的，要靠预防。而且这个预防也不是过去传统的方式，应该运用信息化手段，为全国人民建立一个从出生到死亡的终身健康维护的体系。

—李玲教授，北京大学

现在的公立医院改革方向应该还是以政府为主导，不是把它完全市场化。 但是现在中国资本的力量还是很强大的。现在公立医院可是最后一块没有被分掉的肥肉，各方利益的博弈很厉害。中国公立医院的改革很大程度上应该学习美国的退伍军人医疗系统， 应该建立一个信息化的服务网络，回归它的公益性，回归到用最低的成本为老百姓服务。不能象我们公立医院现在是要挣钱的，要利润最大化。怎么能保证它回到这个目标？需要进行体制的再构。三年基层医改的体系再构我觉得是可以复制到城市医改的。主要的难点在于医务人员的激励体制再构要比农村复杂得多。城市医务人员水平高，专科的分类更复杂。我觉得在这方面美国的退伍军人医疗系统很值得我们学习。

中国公立医院的改革还有很长很长的路要走。它不是一蹴而就的，非常难，是一个重大利益的再调整。回到你的问题，我觉得公立医院改革完了之后，我们整个体系的再构造就完成了。下一步就是回归到医疗服务的终极目标－－健康。13 亿人的医疗卫生靠看病，吃药是解决不了的，要靠预防。而且这个预防也不是过去传统的方式，应该运用信息化手段，为全国人民建立一个从出生到死亡的终身健康维护的体系。

4. Professor Li's Team and Words to CHPAMS members
团队和对青年学者的建议

Rui: Can you tell us about your group? Do you have plan for new recruitment? Are there any collaboration opportunities for other health economists and policy researchers to work with your group?

李蕊：请您简单介绍一下您的团队？请问有那些合作的机会？

Prof. Li: We have an excellent team, including Dr. CHEN Qiulin and JIANG Yu, with whom you're quite familiar. And most of them are my students and many of them have graduated. They are excellent in learning by doing, and they will play major roles in future healthcare reforms in both China and elsewhere. We also have two graduate students who are now studying at Harvard. One is working with Prof. William Hsiao in the School of Public Health and the other one is in the Department of Economics working with Prof. David Cutler.

If anyone would like to know more about our team and our work, please e-mail me. We love collaboration opportunities--we have a large amount of data from the three years' reform, and would like to evaluate the effectiveness of China's healthcare reform and get more high quality scientific papers published as well.

李玲：我的团队非常厉害，象你熟悉的陈秋霖博士，江宇，还有很多。主要是我的学生们。他们边做边学的能力非常强。他们现在对卫生经济学的掌握和对中国医改的掌握绝对都是专家级的。很多学生都毕业了，还有很多正在做。我觉得他们都是将来中国医改，世界医改的生力军。除了秋霖和江宇，还有两个学生现在在哈佛，一个在公共卫生学院，和萧（庆纶）老师在做，一个和 David Cutler 在做。我还有一些学生在政府部门，都是顶梁柱。我们的这个平台是开放的。任何人都可以加入，非常欢迎。如果感兴趣，可以直接和我联系。

我们也很想和大家合作。三年医改，我们积累了大量数据，我们也希望通过合作，把中国医改的经验除了描述性以外，出一些比较高质量的学术文章。既对中国医改进行评估，也为下一步的医改提供依据.

Rui: What advice do you have for young health economists in China and abroad? Do you have any words for members of the China Health Policy and Management Society (CHPAMS) and readers of the China Health Review?

李蕊：您对我们年资较浅的卫生经济学者有什么忠告？您对我们中国卫生政策与管理学会的成员和我们《中国卫生评论》的读者有什么建议吗？

Prof. Li: I hope you all pay more attention to what is going on in China's healthcare reform. I pay close attention to the U.S. healthcare reform, which seems to reach an ending point for this round. In fact, reform is always a political issue rather than a technicality. On the other hand, China's healthcare reform is ongoing; it has strong support from the leadership, it has generated grass-root know-how. Its innovative approaches are worthwhile for us to examine and study. It also provides new ideas and directions for theoretical research and academic efforts.

Thank you for organizing CHPAMS to attend to China's healthcare reform. I hope you will keep an eye on what is happening in China, build collaboration, and collectively push China's healthcare reform forward to benefit the Chinese people.

李玲：你们应该更多的关注国内的医改。我很关注美国的医改。现在美国医改这一轮又要完了。其实医改的背后都是政治问题，不是技术问题。你们应该更多的关注中国医改，因为中国医改还有戏，政治上推得动，基层有很多经验，创举值得我们去研究，去学习，它本身也为我们进行理论研究，学术研究，提供新的思路。

对于中国卫生政策与管理学会（海外），首先感谢你们能够形成一个组织来关注医改。希望你们未来更多关注国内，加强交流合作，共同推进祖国的医改，为老百姓造福。

INTERVIEW

PROF. YUANLI LIU, FOUNDING DIRECTOR, HARVARD SCHOOL OF PUBLIC HEALTH CHINA INITIATIVE

By *Lingling Zhang*, ScD, Harvard School of Public Health
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Dr. Yuanli Liu, serving on the faculty of the Department of Global Health and Population at Harvard School of Public Health, is founding director of the Harvard School of Public Health China Initiative since 2005. The China Initiative aims at helping advance health and social development in China by carrying out series of applied research studies targeting China's major unresolved public health and health system issues, regular policy dialogues to help drawing road maps for China's social sector reforms and development, and senior health executive education programs to help produce a critical mass of open-minded and well informed health sector leaders. He is also Adjunct Professor of Health Policy and Management at Tsinghua University and director of the Health and Development Institute at Tsinghua School of Public Policy and Management in Beijing. Professor Liu has been teaching and conducting research in the areas of health policy and health system analysis since 1994 at Harvard, and has carried out extensive research and policy consultation work in many African and Asian countries. In particular, he has been closely involved in helping inform China's policy making process for series of reforms and strategic developments in its health sector since 1993, including a 8-year survey and intervention study (1993-2001) on improving access to healthcare in China's poor rural areas and the most recent work on Healthy Beijing 2020 – developing China's first 10-year strategic plan for effectively combating diseases and improving population health. He serves on the Expert Committee of Health Policy and Management and the Expert Committee on Healthy China 2020, both of which are established by the Chinese Ministry of Health to help develop strategies for China to deal with major infectious as well as non-communicable diseases. Dr. Liu also served on the United Nations Millennium Development Taskforce on HIV/AIDS, Malaria, TB, and Access to Basic Medicines. He consulted for many international agencies including the World Bank, Asian Development Bank, UNDP, UNICEF, WHO as well as global corporations.

Dr. Liu received his MD and MPH from Tongji Medical University in 1987, MS in health policy and management from Harvard University in 1988, and PhD in health services research, policy and administration from University of Minnesota in 1995.

刘远立教授简介： 哈佛大学公共卫生学院中国项目部主任，博士生导师，清华大学公共管理学院卫生与发展研究中心主任。刘远立于 1987 年获得同济医科大学医学硕士学位，1988 年获得哈佛大学科学硕士学位，1995 年获得明尼苏达大学哲学博士学位。1994 年起任职于美国哈佛大学公共卫生学院，从事国际卫生政策与管理的科研和教学工作长达 16 年，是"卫生体系学"创始人之一，并从 2000 年至今在哈佛大学担任该学科的博士生导师。2005 年被任命为哈佛大学公共卫生学院中国项目部主任，负责领导哈佛大学与中国在医疗卫生领域的学术交流与合作，其中包括：1.与中国卫生部合作举办"中国卫生发展与改革高级国际研修班"（300 多名毕业生分别来自中央和各省、市负责卫生与社会发展的厅局长和大型医院院长）， 2. 开展重大卫生政策与管理问题的应用性研究，3.与中央党校合作举办"中国社会发展论坛"。2006 年又被清华大学公共管理学院聘为卫生与发展研究中心主任，负责领导中心围绕健康发展和卫生政策领域开展学术研究、政策咨询和教育培训等活动。

刘远立教授的专业研究领域主要着眼于运用经济学等工具探寻发展中国家卫生体系的效率和公平问题之解决办

法，在非洲和亚洲 10 多个国家开展过有关公共卫生（如：艾滋病防治）与卫生体系改革的学术研究。 他参与了中国卫生改革与发展的一系列重大问题的研究和政策咨询，通过多年开展干预性研究、组织干部培训、举办或参与各种高层次论坛等活动，在建立中国农村新型合作医疗制度、城市医疗救助制度，医药价格体系改革、医疗服务领域政府与市场相对作用的界定、医药卫生体系的绩效评价、医疗服务集团化建设、农村卫生服务体系县乡村一体化管理、跨区域的协同医疗服务体系建设、移动医疗与数字医疗体系建设等方面开展了一系列研究和咨询工作，产生了重要影响。作为世界银行的顾问，刘远立教授帮助建立和加强了"中国卫生经济培训与研究网络"。他出版过 6 本中英文学术专著，在国际和国内学术期刊上发表过 100 多篇论文。 刘远立教授曾经并继续担任联合国"千年发展目标"顾问委员会委员，世界银行、亚洲开发银行、世界卫生组织、联合国儿童基金会、联合国计划开发署、美国中华医学基金会等国际组织以及世界 500 强企业的战略顾问。 此外，刘远立教授还是中华人民共和国卫生部卫生政策与管理专家委员会委员、"健康中国 2020"战略规划专家组成员、中国医药卫生体制改革研究（"清华方案"）课题组组长、"健康北京 2020" 战略规划课题组组长。

Lingling：The Inaugural Harvard America-China Health Summit organized by China Initiative in September 2011 was a great success. As the leader of this historical event, what is your vision on the dialogue between China and the United States?

张玲玲：2011 年 9 月，由哈佛大学公共卫生学院中国项目部举办的首届哈佛中美健康峰会取得了巨大成功。作为这一历史事件的领导者，您对中美之间的对话有何见解和展望？

Professor Liu: Both China and the United States, despite cultural and socioeconomic differences, share a common goal – to create effective, equitable and efficient health systems that increase access, combat disease, and improve people's health. Recent initiatives in both countries demonstrate these parallel goals: between 2009 and 2010 we saw China announcing its ambitious Health Reform Plan and the United States passing the Patient Protection and Affordable Care Act (PPACA). In the years since implementation of these policies, many questions, challenges and ideas have arisen; we aim to explore these in depth by organizing regular dialogues between health policymakers, experts and healthcare frontline leaders. I believe bringing together health sector leaders from our two great countries and beyond to share experiences and perspectives would help inform future evidence-based policy making. That's why we are organizing the second Summit, which will be held in Beijing on October 31, 2012.

刘教授：尽管中美两国之间存在文化和社会经济的差异，但也有着共同的目标——创建一个公平和高效的医疗卫生体系，从而提高卫生服务的可及性、有效地控制疾病并改善人民的健康。近期，中美两国同时颁布的医疗卫生体系改革表明了这一共同目标：2009-2010 年，中国政府推出了意义深远的《深化医药卫生体制改革实施方案》，而美国通过了《保护患者与医疗可负担法案》（PPACA）。自从上述政策颁布以来，出现了很多问题、质疑和意见；我们的目标是通过定期举办医疗卫生政策决策者、专家和一线领导者之间的对话，对上述问题、质疑和意见进行深入探讨。我相信中美两国的有识之士通过峰会的形式，齐聚一堂讨论并分享各自的经验教训，对于中美两国和其他正在积极推进医疗卫生改革与发展的各国的精英来说是十分重要的。这也是我们筹办第二次峰会的原因，该峰会将于 2012 年 10 月 31 日在北京举行。

Lingling：In your report, you highlighted the common features and different characteristics of healthcare reforms in both countries, if each reform can only achieve one greatest accomplishment, what would you expect most?

张玲玲：在您的报告中，您强调了中美两国医疗改革的异同。假如中美各自的改革只能达到一项最重要的成就，您最期待的是什么？

Professor Liu: While improving health should be the ultimate goal of any health system and thus health system reform efforts, more immediate goals of healthcare reforms around the world can

be summarized in three 'A's: Availability, Affordability and Appropriateness of healthcare services. Affordability is the key, not only because without it people would suffer impoverishing effects of out-of-pocket medical expenditures, but also because making healthcare more affordable would help increase people's utilization of the healthcare services they need.

刘教授：提高人民健康水平是任何医疗卫生系统的终极目标和卫生改革努力的方向，全球医疗卫生改革的近期目标可以概括为三个 A：医疗保健服务的可用性，可负担性和适当性（Availability, Affordability, Appropriateness）。其中可负担性是重中之重，不仅仅因为穷人会因为自付医疗费用而愈发贫穷，还因为将医疗保健平价化有助于人们更充分利用他们所需要的医疗服务。

It is worth noting that both U.S. and China included in their reform packages following common measures: strengthening primary care and prevention services, adoption of electronic health records, and provider payment reforms.

—Prof. Yuanli Liu， Harvard

Lingling：What is the biggest obstacle in each country's health sector reform? What experience or lessons they can share with each other?

张玲玲：中美两国卫生部门改革的最大障碍是什么？有什么相互借鉴的经验或教训？

Professor Liu: I would say the biggest obstacle is resistance from the powerful interest groups. Any reform is about changing the status quo. Those economic and political groups, whose interests would be adversely affected by the reforms, cannot be expected to stay idle. For example, China's "public hospital reforms" have not yet made any significant progress because public hospitals are not enthusiastic participants. The reform implementation process in the U.S. has been resisted by at least a third of the states, because the governors of those states are Republican, which is the opposition party running against President Obama. It is worth noting that both U.S. and China included in their reform packages following common measures: strengthening primary care and prevention services, adoption of electronic health records, and provider payment reforms. The U.S. has had rich experiences in the areas of provider payment reforms such as DRGs and bundled payment in the context of developing "Accountable Care Organizations". China's unique heritage of traditional Chinese medicine offers alternative ways of helping manage chronic diseases that are confronting both countries.

刘教授：我认为最大的障碍是来自利益集团的巨大阻力。任何改革都是改变社会现状。某些既得利益团体的政治或经济利益将受到改革的不利影响，因此必然会阻挠改革进程。例如，中国的公立医院改革尚未取得任何重大的进展，因为公立医院没有积极参与。美国医疗改革的实施过程中，一直被至少三分之一的州抵制，因为这些州的州长是共和党人，是奥巴马总统的反对党。值得一提的是，中美两国的一揽子改革方案都遵循某些共同措施：加强初级保健和疾病预防服务，完善电子健康记录系统和供应商支付的改革。美国在供应商支付方面有丰富经验，比如诊断相关分组和捆绑支付发展"问责医疗组织"。中国独特的传统医学为中美两国面对的愈演愈烈的慢性疾病提供了替代疗法。

Lingling：We know that you have had contacts with high-level health officials in both countries. So could you say something about the role of government playing in each country's health reform?

张玲玲：据我们了解，您与两国高级别卫生官员都有所交流。可以介绍一下两国政府在各自的医疗改革中所扮演的角色吗？

Professor Liu: As the public policy maker and major implementer, government's role in any health reform is of course essential. But due to different political systems of the two countries, the ways in which the government plays its role are different in China vs U.S. In the United States, a new

legislation needs to be passed by the Congress in order for the reform process to be started. China does not need a new law, and the reforms were announced as the State Council "Decisions". It is also interesting to compare different roles of the central vs local governments. For example, while health insurance for the poor is financed by the Federal and state governments in the United States, Chinese central government plays almost no role in financing healthcare for the poor, which is the local government's responsibility. I like to point out that despite of the government's vital role in healthcare reforms, participation of many other stake-holders, especially healthcare providers, are necessary for the reforms to be successful.

刘教授：作为公共卫生政策的决策者和主要实施者，政府在任何医疗改革中扮演必不可少的角色。但由于两国政治制度的不同，两国政府发挥作用的方式也不尽相同。在美国要启动改革的进程，必须由国会通过新的立法；而中国不需要颁布新的法律，改革是作为国务院的"决策"开展的。而且，两国中央与地方政府的角色差异也很有趣。例如，在美国，穷人的医疗保险的资金主要由联邦和州政府共同支付，而在中国中央政府对贫困人口的医疗保险几乎没有责任，反而是地方政府的职责。我想指出的是，尽管政府在医疗改革中发挥重大作用，但其他利益相关者，特别是医疗服务提供者的参与是改革成功的必要条件。

Lingling：No health system is perfect. In which aspects you think China surpasses the United States, and vice versa?

张玲玲：任何卫生系统都不是完美的。您认为在哪些方面中国优于美国，反之亦然？

Professor Liu: China already managed to provide basic insurance coverage to over 95% of its population, while U.S. still has 15% of the population uninsured. This "nominal coverage" aside, China's incidence rate of catastrophic medical spending (a measure of individual affordability) is much higher than that of the U.S. Arguably, the U.S. health system is the world's least efficient system, with 18% of the GDP spent on health and medical waste being estimated to be as high as $750 billion in 2009. In terms of social affordability, China, with its total health spending only taking up 5.1% of its GDP, is in a much better situation than the U.S.

刘教授：中国的基础医疗保险的覆盖面超过总人口的 95%，而美国仍然有 15%的人口没有医疗保险。然而这个"名义覆盖率"的另一面是中国的高危疾病的医疗支出（衡量个人承受能力）远远高于美国。某种程度上可以说，美国卫生系统是世界上效率最低的卫生系统，美国将其国内生产总值的 18%用在健康和医疗支出，2009 年的医保估计值为 7500 亿美元。考虑社会承受能力，中国的卫生总支出只占国内生产总值的 5.1%，是另一项优于美国的方面。

Lingling：Serving as the Director of China Initiative, what was your motivation to initiate this work? What are the major achievements you are mostly proud of?

张玲玲：作为中国项目部的主任，启动该项目的动机是什么？到目前为止，最引以为豪的成果是什么？

Professor Liu: I felt fortunate to be the "right person at the right time". China Initiative at Harvard School of Public Health was established in the aftermath of SARS in 2005, and I have been serving as the founding director ever since. The mission of this initiative is to advance China's health and social development by carrying out high-impact programs in education, research, and policy. With this multifaceted and integrated approach we aim to create sustainable and cost-effective changes within China's healthcare system as well as creating lasting relationships between Chinese and international healthcare leaders. I am most proud of our educational programs, mainly because we have trained more than 400 policymakers and senior health executives who are now playing important roles at the national and regional levels to improve health of the 1.3 billion Chinese people. Furthermore, every year during winter break since 2006 I had been conducting a field study course on China's health system reforms for Harvard students and fellows, whose experiences in China help them play a more effective role in global health.

刘教授：我感到很幸运，可以"在合适的时间成为合适的人"。哈佛大学公共卫生学院中国项目成立于 2005 年、SARS 事件之后，我一直作为其创始主任。这一举措的使命是通过开展具有高影响力的教育、研究和政策项目，推动中国的卫生和社会事业的发展。通过多层次的综合措施，我们的目标是为中国的医疗保健制度带来可持续的、具有成本效益的发展，以及促进中国与国际医疗卫生部门领导人之间建立长久的合作关系。我最自豪的是我们的教育项目，主要是因为我们已经培训了超过 400 名政策制定者和高级卫生行政人员，在国家和区域层面为改善 13 亿中国人民健康发挥着重要作用。此外，自 2006 年以来每年寒假，我一直带领哈佛的学生和研究人员对中国卫生系统改革进行实地研究。他们在中国的经历将有助于他们未来全球卫生事业发展。

Lingling： I learned that the Second China-U.S. Health Summit will be held in Beijing at the end of October this year. Would you like to share some information regarding this summit with us?

张玲玲：第二届中美健康峰会将于今年十月底在北京举行。关于此次峰会，您有什么想与我们分享的吗？

Professor Liu: Minister CHEN Zhu and Assistant Secretary Sherry Glied, along with more than 700 Policy makers, academic experts, and business leaders from China and elsewhere attended the inaugural Harvard America-China Health Summit in September, 2011 in Boston. After the first Summit, Minister CHEN Zhu suggested that the second Summit be held in China.

The second Summit will take place on October 31, 2012 at the National Convention Center in Beijing (www.hci-bj.org). This summit will be held at a critical juncture of development for both U.S. and China. While the U.S. presidential election is under way and healthcare reforms are again debated and even legally challenged and upheld, China, also with leadership change in the fall, has just begun implementing the 12th 5-Year plan after 3 years of experiences with its Healthcare Reform Plan.

Based on the need assessment, the 2012 Beijing Summit is themed: "Healthcare Reforms: The Roles of Government, Market, and Professionalism". In addition to senior policy makers from China, such as Minister Chen Zhu and Dr. Sun Zhigang, China's national coordinator of healthcare reform, and from other countries, this Summit is expected to have about 800 registered participants, including healthcare experts, senior health executives, NGO and health industry leaders. The Beijing Summit is co-hosted by Harvard School of Public Health, Peking Union Medical College, and Tsinghua School of Public Policy and Management. We are grateful for the enthusiastic support of the Chinese Ministry of Health and the U.S. Department of Health and Human Services. We are excited by the impressive set of confirmed speakers and are confident that you will find the presentations and discussions informative and engaging. We sincerely welcome your participation in this Summit to create the most memorable event possible with a long-lasting impact.

刘教授：2011 年 9 月，陈竺部长和美国卫生与公共服务部副部长 Sherry Glied、以及 700 多位来自中国和世界各地的政策、学术专家和商界领袖参加于波士顿举办的首届哈佛中美健康峰会。第一次峰会后，陈竺部长建议第二次峰会在中国举办。

因此，第二次峰会将于 2012 年 10 月 31 日在北京国家会议中心（www.hci-bj.org）举办。本次峰会正值中美两国发展的关键时期。美国总统选举正在进行，医疗改革草案再次进行辩论，经过了法律评估并取得了成果；中国正值秋季最高领导层换届，医改政策实施三年，"十二五计划"刚刚开展。

2012 年的北京峰会的拟定的主题是："卫生改革：如何有效发挥政府监管、市场竞争、职业精神的作用"。除了部长陈竺、孙志刚博士等中国医疗改革的高级决策者和其他国家的官员，本届峰会预计将有 800 位注册与会者，其中包括医疗专家，高级卫生行政人员，非政府组织和保健品行业的领导者。本届北京峰会是由哈佛大学公共卫生学院，北京协和医学院和清华大学公共政策与管理学院共同主办。我们非常感谢中美

两国卫生部的大力支持。我们很高兴邀请到一些确定参会的重量级发言人，并且我们确信演讲和讨论内容丰富、引人入胜。我们真诚地欢迎你们的参与，并期待为本届峰会留下难忘的回忆和深远的影响。

Lingling：Do you have any words for CHPAMS (China Health Policy and Management Society)?

张玲玲：您对中国卫生政策与管理学会（海外）有什么寄语吗？

Professor Liu: I am a big fan of CHPAMS. I hope you guys can keep up the good work by serving as a bridge and network for sharing relevant and important information and ideas, and for fostering productive relationships among current and future generations of leaders in health policy and management research and practice.

刘教授：我是中国卫生政策与管理学会（海外）的坚定支持者。我希望你们能保持良好的工作，发挥桥梁和纽带作用，共享相关的、重要的信息和观点，并为促进当前和未来的几代领军人物在卫生政策与管理研究和实践方面的协作不懈努力。

PERSPECTIVE

INCREASING THE AFFORDABILITY OF HEALTHCARE: COMPARING REFORMS IN CHINA AND THE UNITED STATES

提高医疗服务的可负担性：中美医改比较

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ABSTRACT: *This article discusses the conceptual and measurement aspects of health care affordability. It points out that China's health care reforms need to tackle individual affordability while societal affordability is a critical issue in healthcare reform for the United States. The paper further compares and discusses the approaches adopted by the two countries to ensure healthcare affordability including, expanding insurance coverage and enhancing benefits design, as well as controlling medical costs. The author stated that the United States and China can benefit by learning from each other's experiences gathered through a systematic monitoring and evaluation of what works and what does not.*

2009 年 3 月 17 日，中国颁布了《深化医药卫生体制改革》的宏伟规划。[†] 一年后，美国的医改方案《患者保护和可负担医疗法案》于 2010 年 3 月 23 日成为了法律。[‡] 为什么世界上最大的发展中国家与最大的工业化国家会同时实施医疗体制改革呢？它们二者的医改是否有一系列相似或不同的目标？为实现其目标，它们是否采取了一系列相似或不同的策略？中美两国是否能够互为借鉴与相互学习？本文旨在回答这其中的一些问题。

首先应该指出的是，任何一个国家的医药卫生体制改革都力图实现多重目标，包括：扩大医疗服务的可获得性、提高医疗服务的可负担性、改善医疗服务的效率与质量，以及实现促进人群健康水平这个最终目标。[§] 由于可负担性毫无疑问是中美当前的医改所要实现的最重要的目标之一， 本文将集中讨论医疗可负担性问题。

首先，我们将讨论医疗可负担性的概念及其测量问题。我们会从两个层面来测量中美医疗可负担性的变化：个人可负担性（微观层面）和社会可负担性（宏观层面）。然后，本文将比较和讨论中美两国提高医疗可负担性所采取的路径。最后，本文将探讨通过这一比较分析所得出的主要经验教训。

（一）定义可负担性的路径

尽管由于资源稀缺、医疗费用快速上涨、经济风险保护需求等原因，人们对医疗可负担性的关注日益增加，但可负担性这个概念是模糊的。从字面意思讲，如果一个人能够承受一件产品或一项服务的花费，那么这件产品或这项服务就是人们可负担的。但是，我们又如何定义花费是否是“可承受”的呢？毫无疑问，医疗可负担性应该并且可以从微观层面（个人可负担性）和宏观层面（社会可负担性）来测量，因为这两个视角都与政策高度相关。尽管已经有大量的个人可负担性方面的研究存在，但关于社会可负担性测量问题方面的研究还相对缺失。因此，在本文中，我开发出一个测量医疗可负担性的简单模型。在我的模型中，医疗可负担性 A 被定义成 A’的反函数，即：

(1) $A = 1/A'$

其中，A’被定义为卫生费用 H 和收入 I 的函数

(2) $A' = (H/I) \le T$

其中，T 是一个阈值， 超过这个阈值的医疗被认为是不可负担的。因此，A’的值越小表示可负担性越高。

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[*] Corresponding author. Dr. Yuanli Liu, Professor, Harvard School of Public Health. The English version of this article appears in a report by the Center for Strategic and International Studies.
[†] http://www.gov.cn/jrzg/2009-04/06/content_1278721.htm (accessed on September 17, 2010)
[‡] http://www.healthreform.gov/ (accessed on September 17, 2010)
[§] Frenk J. The World Health Report 2000: expanding the horizon of health system performance. Health Policy and Planning. 2010 September;25(5):343-5.

根据世界卫生组织的定义，[*] 个人可负担性可以通过医疗支出占家庭可支配收入的比例来测量。如果一个家庭不得不将 40%或更多的维持生存的最低收入用于医疗，那么这个家庭就被认为是承受着灾难性医疗支出。除了把灾难性支出的发生率作为个人可负担性的重要指标以外，我们还可以用其它的指标如个人自费占卫生总费用的比例来测量个人可负担性。

同样，测量社会可负担性的指标包括医疗费用占 GDP 的比重、政府卫生支出占财政预算的比重等。最近 Chernew，Hirth 和 Cutler 指出，社会可负担性应该通过衡量卫生费用的持续增长对非医疗产品和服务消费的影响来测量。[†] 他们认为，只要卫生费用的增长没有导致推动经济持续增长的基本投资减少，那么医疗就被认为是社会（集体）可负担的。因此，我们可以运用个人可负担性（微观层面）与社会可负担性（宏观层面）的这类指标，对中美的情况进行分析和对比。

（二）近年来中美医疗可负担性的变化

图表 1 提供了中美两国医疗可负担性的基本比较。通过指标对比，我们可以清晰地发现，尽管中美两国的人均国内生产总值相差高达 9 倍，但两国都经历着卫生费用的快速增长，中国的卫生费用增长比例甚至比美国更高。值得注意的是，2003 至 2008 年间，中国在医疗保险覆盖方面进步非常显著。截至 2008 年，从受保人群的百分比来看，中国甚至比美国做得还稍微好一些。但是，中国医保覆盖下配套福利很有限，2008 年有 45%的卫生总费用仍然来自于个人卫生支出。相比之下，美国只有 11.8%。不仅如此，2003 年，中国灾难性医疗支出的发生率高达 14%，而在美国只有 0.5%（这是唯一能从美国找到的对比数据）。 很明显，中国医改需要把个人可负担性当作一个主要问题来解决。相比之下，对中国来说，社会可负担性这个问题比美国要小得多。

表 1 中美人均国内生产总值、卫生费用及个人可负担性指标对比

国家	2003	2007-2008
中国		
GDP($PPP)	3393.00	5515.00
人均国内生产总值增长比例(PPP)	46.12	62.54
人均卫生支出 ($PPP)	163.93	266.00
人均卫生支出增长比例(PPP)	62.69	62.26
受保人群比例	29.70	87.10
个人支付占总费用的比例	55.90	45.20
家庭发生灾难性支出的比例	14.7	14.8
美国		
GDP($PPP)	42746.21	47757.40
人均国内生产总值增长比例(PPP)	15.14	11.72
人均卫生支出 ($PPP)	6778.49	7722.09
人均卫生支出增长比例(PPP)	34.24	13.92
受保人群比例	83.40	86.60
个人支付占总费用的比例	12.95	11.88
家庭发生灾难性支出的比例	0.5	N.A·

注：表中所列的 2003 年与 2008 年的增长比重分别指代 1998—2003 年与 2003—2008 年期间的增长比重。

来源：中国数据，参见中国卫生部，http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohwsbwstjxxzx/s8208/200904/40250.htm. 美国数据，参见 David K et al. 2010. Starting on the path to a high performance system: analysis of the payment and system reform provisions in the Patient Protection and Affordable Care Act of 2010.(New York: Commonwealth Fund, September 2010.)

[*] Xu K et al. 2003. Household catastrophic health expenditure: a multicountry analysis. Lancet 362: 111-117.
[†] Chernew ME, Hirth RA, Cutler DM. 2009. Increased Spending on Health Care: Long-Term Implications for the Nation. Health Affairs 28(5): *1253-1255*.

如表 2 显示，中国的卫生总费用占国内生产总值的比重从 1998 年至 2008 年十年间都稳定地保持在 5%以下，而美国的这个比重却在持续地升高，而且是世界最高的。2008 年，中国政府的卫生支出占政府财政总预算的 4.3%，而则美国把 25.2%的政府预算经费花在了医疗上。

不仅如此，2003 至 2008 年间，与高达 62.5%的非卫生支出的增长比例比较，中国只有 4.8%的新增人均收入用于医疗。相比之下，美国同期将 18.8%的新增人均收入用于医疗，而非医疗支出的增长比例只有 11.3%。因此，美国医改的根本关注之一是提高社会可负担性。

表 2 中美医疗社会可负担性指标

中美比较	1998	2003	2008
中国			
卫生费用占 GDP 比例	4.40	4.90	4.83
中央政府卫生支出占财政支出的比例	5.46	4.53	4.36
用于医疗的新增人均 GDP 的比例		5.90	4.81
非医疗支出的增长比例		45.37	62.55
美国			
卫生费用占 GDP 比例	13.50	15.60	16.20
中央政府卫生支出占财政支出的比例	21.60	24.20	25.20
用于医疗的新增人均 GDP 的比例		30.76	18.83
非医疗支出的增长比例		12.14	11.31

来源：中国，卫生部，http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohwsbwstjxxzx/s8208/200904/40250.htm。 美国，医疗保险与医疗救助服务中心, https://www.cms.gov/NationalHealthExpendData/.

(三) 中美医改：相同特点与不同特征

中国医疗行业的特征是：在医疗提供体系上高度社会化，而由于一半的卫生费用仍来自于个人自费，在医疗筹资方面社会化的程度则较低。目前，中国 95%的医院病床由不同层级的政府所有和经营，而政府的财政拨款占医院经常性费用的比例却低于 10%。因此，跟美国的医院一样（美国的医院大多数都是私立和非盈利的），中国的医院必须依赖于病人付费为主要的收入来源。但与美国商业保险为主导的筹资体系不同，中国有组织的卫生筹资体系越来越依赖于社会保险。中国的社会保险体系包括针对正式部门的城镇职工社会保险，保费是 8%的工资税（其中 2%来自职工，6%来自企业），针对非正式部门、老人、学生和失业人员（自愿登记、政府提供保费补贴）的城镇居民社会保险，以及针对农村居民的新型农村医疗合作制（三分之二以上保费的由中央和地方政府的基金支付）。

美国针对老年人主要社会保险项目是 Medicare. 中国对这类人群没有专门的保险计划。尽管中美两国都针对贫困人群开展了专门的保险项目，而这些项目的筹资和组织方式是不同的。在美国，Medicaid 越来越依靠联邦政府为经费支持，而中国对贫困人口的医疗救助项目主要由地方政府提供财支持。美国的 Medicaid 的福利设计与支付作为一个独立的系统运营。与此对比，中国政府主要通过替贫困人口提供保费，从而把他们纳入城镇和农村的基本社会保险体系内。

基本上来说，提高可负担性的路径有两种：一、提高第三方支付（包括扩大保险覆盖和提高福利）；二、控制费用。在接下来的部分，我们将比较中美两国医改措施中所采取的这两种路径。

1. 扩大保险覆盖

表 3 总结了中美医改方案中旨在扩大保险覆盖的主要规定。中国的策略集中在提升社会保险的作用，让商业保险在医疗筹资方面扮演补充性的角色。美国的策略则以扩大商业保险的筹资途径为目标。两国都试图通过医疗

保险增加两国人民的负担性。在中国，这一点是通过政府从一般性税收中拨款为个人筹资提供保费补贴实现的。在美国，保费补贴则通过免税间接提供。

表 3 中美两国扩大保险覆盖的策略

美国	中国
• 通过免税政策提供间接补贴 • 建立互换 • 设立新方案选择 • 提供长期保险的自愿选择 • 扩大 Medicaid 的获得途径 • 个人强制	• 对新农合增加保费补贴 • 建立新型城镇居民保险 • 扩大对穷人医疗救济 • 鼓励商业保险提供补充性的覆盖

在美国，尽管各州间存在着差异，但在州内获得社会保险和商业保险的途径基本上是一样的。而在中国，由于地区间和地区内在收入和基础设施上存在着巨大的差距，公共领域的筹资甚至在区与区之间、县与县之间都不同。比如，区县在社会保险项目下，其风险分担水平比市或省要低。换句话说，鉴于地方政府在筹资和管理方面起着主导作用，中国的社会保险计划是一个碎片化的计划，

美国模式强调医保方案的个人选择，新法案下的这一机制鼓励通过新的标准化的互换平台进行竞争。现存的中国模式强调提供统一的、由政府管理的基本医疗覆盖，但对医保方案的选择并没有给予高度关注。随着中国中产阶级的迅速崛起，对保险福利多元化的需求可能会在将来成为一个重要的问题。

2. 提高受保人群的福利

除了覆盖未受保人群，中美都面临着提高受保人群福利的挑战。中国医疗保险发展方面的近期研究表明，尽管在中国医保名义上的覆盖在迅速地扩大，但由于福利包十分有限，可负担性没有得到显著的提高。[*]在美国，受受保人群的主要问题包括：既存病、保费的快速增长和拒绝覆盖。[†]

提高受保人群的福利可以通过扩大福利包，或通过供方改革扩大特定服务的可获得性，如此以来由于等候的时间和其他花费可以减少，可负担性就能够间接地得到提高。表 4 比较了中美所采取的的策略。

表 4 中美提高保险福利的策略

美国	中国
• 监管关于既存病、最低保费医疗损失率方面的医保实践 • 提高 Medicare 的药品福利 • 确保预防服务和临床试验的覆盖 • 增加儿童健康保险计划的基金	• 要求新农合达到最低医疗损失率 • 提高基本医疗服务的可获得性 • 强化公共卫生 • 提供一套基本的免费医疗服务

一个有趣的发现是：不论是社会保险还是商业保险，中美两国都热切地关注对受保者的监管问题。2010 年《可负担医疗法案》中的一个主要条款就是用来规范最低保费/医疗损失比率的保险实践的，这一条款力图防止保方积累超额剩余价值从而保证惠及病人的保险费用保持在一个适当水平。 中国也采取了相似的规范制度，尽管这一制度目前只把目标锁定在新农合上。随着公共经费支持的增长，两国都力图在所覆盖的福利包内包含更多的服务。

[*] Wagstaff A, et al. 2009. China's health system and its reform: a review of recent studies. Health Economics. 18: S7-S23
[†] David K et al. 2010. Starting on the path to a high performance system: analysis of the payment and system reform provisions in the Patient Protection and Affordable Care Act of 2010. New York: Commonwealth Fund, September 2010.

在美国，Medicare 的药品福利得到了增加，Medicare 的保险计划要求覆盖特定的预防服务和临床实验。 在中国，人们也设想了相似的策略，包括提供一套免费的基本医疗服务，如接种乙肝疫苗。

除了监管保险行业以外，中美两国都力图强化医药卫生体系的提供方，尤其是在未受到政府足够关心的地区。比如，两国都采取了旨在促进基本医疗服务的政策，要么是提高支付刺激（以美国为例），要么是直接为社区卫生服务中心投资和培训全科医师（以中国为例）。由于获得必要的医疗服务的成本减少了，这些探索对提高病人的可负担性都起到了积极的作用，尽管作用比较间接。

3. 控制医疗费用快速增长

与许多其他进行医药卫生体制改革的国家一样，特别是经合组织成员国，中美两国必须找到抑制医疗费用快速增长的有效措施。这是美国医改的当务之急之一，因为日益增长的医疗费用正在破坏美国经济的竞争力。尽管对中国来说，这个问题没有那么紧迫，中国的经济发展还很强劲，社会可负担性还很其强大。但中国，作为一个发展中国家和一个快速老龄化的社会，会希望把更多可获得的资源投入到非卫生部门包括教育和社会保障等。表 5 比较了中美控制医疗费用增长所采取的策略。

表 5 中美医疗控费策略

美国	中国
• 打击骗保行为	• 基本药物制度
• 审核保费增长	• 公立医院改革
• 减少文书工作	• 支付制度改革
• 激励基本医疗提供者	• 强化预防和社区卫生
• 支付制度改革	

由于中美筹资模式不同，两国在医疗控费上的主要策略也不相同。在美国，控费主要聚焦在减少现存体系的浪费上，包括打击保骗保行为、审查保费增长、减少文书工作等。中国的控费努力集中在两个内在相互关联的“花费中心”上：药品支出和公立医院支出。中国 40%以上的卫生总费用花在药品上。开药和发药都是主要通过公立医院的药房。医疗定价仍由政府控制。由于许多医疗服务的定价都低于成本，政府许可的 15%至 20%的零售药品的加成就成为了中国医疗服务提供者的主要收入来源。因此，在当前的定价和按项目付费体系下，医疗服务提供者，尤其是公立医院有过度医疗和开大处方的强烈经济动机。[*] 通过要求公立社区卫生服务中心只提供政府基本药物目录上的药品和实行零差率，以及增加直接财政拨款，中国希望能够控制药品费用和公立医院的行为，从而控制医疗费用的增长。[†]

除了这些不同的路径和侧重点以外，中美两国都对支付方式的改革给予了极大关注。在这一领域， 美国通过把许多创新的方法，如诊断相关组（Diagnosis-related Groups），传向全世界和将重心转移到开发按绩效付费上，尤其是通过在卫生与人类服务部建立新的研究中心，树立了其领军地位。在支付方式改革方面，中国还刚起步，只是选定的城市和农村地区在进行项目试点。

中美医疗控费的另一个有趣的不同点是中国侧重侧重公共卫生和社区医疗服务。中国政府在 2009-2011 三年间对卫生领域另行投入的 1250 亿美元中大约有一半用于强化公共卫生、更新农村地区和城市社区的基层医疗服务设施，以及培训基层卫生的医生。2011 年 3 月，笔者受中国国家发改委邀请带领一个专家组对两个省的医改进展进行中期评估。 笔者发现在政府投入出现前所未有的增长的情况下，新建的医疗设施随处可见。然而，由于面临着人口和流行病的转型，中国意识到，除了对维持对传染病的有效控制，在非传染病的预防和控制方面也应该做得更好。此外，中国希望通过质量改进以及报销和双向转诊等规范机制，鼓励加大对社区医疗设施和中医的利用，从而能够减轻三级医院的拥挤不堪以及费用高昂的问题。

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[*] Yip W, Hsiao WC. 2008. Chinese health system at a crossroads. Health Affairs 27(2): 460-68.
[†] Yip W et al. 2010. Realignment of incentives for health-care providers in China. The Lancet 375 (9720): 1120 - 30

（四）讨论

基于中美相互学习、互为镜鉴的信念，本文比较了两国为了实现提高医疗可负担性这样一个共同的目标所实施的主要策略。这些策略已经在两国最近颁布的政策中已经清楚地阐明了。在这一对比中，我们得到了一些有趣的发现：

第一，尽管中美两国经济发展水平和社会政治制度不同，但两国有一系列共同的医改目标，包括提高医疗可负担性。为了提高医疗可负担性，两国都采取了一系列相似的策略，包括扩大医保覆盖、增加医保福利、控制医疗费用快速增长。

第二，尽管医疗可负担性对中美两国来说都是一个重大问题，同一问题的不同方面却成为了中美高层政策关心的不同焦点。中国在现阶段主要关注的是个人可负担性，因为尽管近年来基本的社会保障覆盖在迅速地扩大，但获得医疗服务的经济障碍和个人自费负担重的问题仍然存在。相比之下，美国由于医疗费用占 GDP 的比例已经很高而且还在增加，美国医改关注的是社会可负担性。

第三，由于各自的当务之急不同，中国是个人可负担性，美国是社会可负担性，我们可以发现两国在不同领域的策略中所付出的努力是不同的。 中国把更多精力投入到增加社会保险覆盖的宽度和深度，这样个人可负担性才能提高。与之相比，美国医改的许多政策都旨在通过抑制医疗费用增长曲线来提高社会可负担性。

最后，这一比较研究表明中美两国有一些可以相互学习的东西。比如，中国可以通过学习美国支付方式改革方面的经验而获益，而美国则可以学习中国强调把公共卫生和社区卫生作为一个整体的策略来控制费用、促进全民健康的经验。现在中美两国都进入了大力执行医改方案的阶段，两国可以学习彼此的实践经验，而这些实践经验则可以通过汇集系统的检测以及评估哪些医改措施有效、哪些医改措施无效来获得。

（注：此文原文为英文，由姚杏翻译成中文；刘远立校对。陶雯为数据分析提供了有力的协助。
英文原文见 http://csis.org/files/publication/111202_Freeman_ImplementingChinaHealthReform_Web.pdf。本文经刘远立教授授权转载。）

PERSPECTIVE

'1+N' method: a promising way to quality and affordable health care for China's 1.3 billion people

只有用“1+N”全民健康保险思路才能让中国13亿人看病不贵不难

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ABSTRACT*

Although recent healthcare reform has expanded health insurance coverage and increased the coverage for selected major diseases, healthcare is still a heavy financial burden for many patients. The advance payment total method commonly used by government health insurance sector in paying medical care providers cannot effectively control the waste and inefficiency in the use of health insurance funds. As a result, abuse of medical examination and surgery, shirking critically ill patients, arbitrary medical charges, indiscriminate drug prescription, artificially high drug prices, and fraudulent insurance claims still exist in some medical institutions.

Prof. XIONG Maoyou

To make healthcare accessible and affordable to China's 1.3 billion people, the author proposed that "1 + N" universal health insurance would be a solution where "1" represents one model—the "413" model, and "N" stands for a number of corresponding supporting measures.

The "413" model has been pilot launched in Jiu Jiang City among employees of some financially challenged state-owned enterprises and has been proven effective in improving health service quality and containing healthcare budget. This model includes "four fixed," "one freedom," and "three-party payment."

The four fixed are fixed visiting hospital for the patient, fixed per capita health care costs (based on age and covering clinic, hospital, and preventive care), fixed health care responsibility, and fixed number of patients for a given hospital. Based on this, the government health insurance sector assigns the total health care costs to contracted hospitals (or hospital groups) and the hospitals keep any left-over in costs but will not get reimbursed if costs overrun. The "one freedom" means the patients have the freedom of changing their hospital choice once a year when unsatisfied with current hospital. Under the "three party payment," the hospital pays the most part of the healthcare costs, the patient pays a small portion, and the government health care agencies pay the special costs caused by major infectious diseases or natural disasters.

This model requires a number of supporting measures. First, a close network of urban and rural community general hospital group must be established to effectively cover clinic, hospital, and preventive care with the fixed per capita health care costs. Second, to improve the efficiency and service quality of public hospitals, private general hospitals or hospital groups must be encouraged. Third, allow patients to choose voluntarily between the 413 model and other health care management models according to the ability to pay of the individuals and their employers. Fourth, hospitals should improve management in order to control cost and enhance service quality. Fifth, government health care funds should focus on the universal health insurance which encourages prevention and early treatment of diseases, especially for the impoverished people. Finally, government health care agencies should give the hospitals the right of using the per capita health insurance funds below the threshold. Government agencies should focus on the coordination of the funds for major diseases above the threshold.

In summary, the "1+N" method bases on the "413" health insurance model and calls for a number of supporting measures. It will be effective in improving the health service quality and making healthcare affordable to China's 1.3 billion people.

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* *The English abstract was summarized and translated by Dr. Lili Yan. In cases where different interpretations may arise, please refer to the original text in Chinese.*

中国三年新医改试点已经结束，虽然在扩大医保覆盖面，提高若干重大疾病医疗保障水平等方面取得了一定成效，但试点结果与预定目标仍有较大距离，看病贵、看病难依然是中国许多老百姓反映的热点，也是中国政府工作的重点和难点。笔者根据十余年医改理论研究和实践探索，认为：只有用“1+N”全民健康保险（简称健保）新思路才能真正让中国 13 亿人看病不贵不难。

一、中国全民医保面临的严峻挑战

从 1995-1998 年的国务院“两江”（即江西省九江市和江苏省镇江市）医改试点，到 2009 年的国家新医改方案出台，再到 2009-2011 年国家新医改试点，尽管政府的投资力度在不断加大，医保（含新农合，下同）报销比例也在逐步提高，可是由于医疗机构中的滥开药、滥检查、滥手术、乱收费、药价虚高和造假骗保等现象久禁不止，因而导致大量患者看病负担依然十分沉重；同时，由于基层公立医疗卫生机构中平均主义和“大锅饭”机制滋生，有更多的患者由基层推向大医院，因而导致不仅城市大医院的看病难没有明显改善，而且许多农村地区看病变得更加困难。

为了回避医保基金风险，政府医保部门一直在普遍采用一种被医院称之为“野蛮”的医保结算方式——总额预付。该方式可以确保医保基金总额不超支，却不能有效控制医保基金的浪费和流失，而且会导致医院推诿患者，尤其是推诿重症患者的现象，其结果只能让参保人的医保水平和质量大幅度缩水。这种只能“向上交差”（避免政府财政风险），却不能“对下负责”（让大量患者看病负担越来越重）的结果，并不是我国全民医保所需要的目标。中国全民医保并不只是人人持有一张医保卡，而是要人人看得起病，并能及时看得上病。因而控制医保基金的浪费和流失，提高全民医保的投资效率和服务质量迫在眉睫。

为了提高医保基金的使用效率，从 2011 年开始，国家人社部和卫生部准备对医疗保险和新农合实行门诊按人头付费、住院按病种付费。然而，该方法也会出现以下问题：

一是会导致大量的门诊病人向住院推诿。因为按人头付费（即按参保人在医院的“定点”人头数付费，而非按“就诊”的人头数付费，下同）会让医疗机构希望自己的门诊人次越少越好；而按病种付费则让医院希望自己的住院人次越多越好。这就会有更多的患者被医疗机构以种种理由从社区门诊推向大医院住院。而政府部门和经办机构也无法识别，更无法阻止这种推诿行为。如果将大量在社区门诊就能治愈的患者推向大医院住院，这会大大加重患者的看病负担，也会导致大量医保基金浪费和流失。也许政府为了控制这种推诿现象，会规定医疗机构的门诊人次必须达到一定数量或金额，这又会把按人头付费演变成总额预付，那么过度服务和造假骗保等现象又会在门诊医疗机构中重演。

二是按病种付费的缺陷也显而易见。按病种付费除了会促使医院提高病种等级、伪造就诊病例和推诿危重病人等弊端外，更明显的缺陷就是病种覆盖范围有限。因为人类有二万多种疾病，可是现在不少地方实行按病种付费的只有几个病种，多的也只有十几个，最多的也只有一百把个。那么其它绝大多数没有覆盖的疾病怎么办？据说卫生部准备搞几百甚至上千个病种。可是中国现已是市场经济，药品成本会随着物价的波动而改变，政府部门是否有能力将这么多病种限价标准也跟着市场变化及时调整？同时，不同地区的物价和医务人员工资水平也不同，也会导致不同地区病种成本的不同，那么不同地区的病种限价标准是否也要有所区别？如果不考虑上述因素，所制定的病种限价标准是不准确、不合理的；而如果考虑上述因素，其操作成本之高和难度之大可想而知。

中国目前还是个发展中国家，尤其是经济欠发达地区，政府财力十分有限，加之中国的新医改又是一种“撒胡椒面”式的政府投资方式，政府投入全民医保的资金更是有限，如果政府部门还找不到一种控制医保基金大量浪费和流失，提高医保工作效率和服务质量的有效方法，要想让中国 13 亿人看病不贵、不难，其难度不言而喻。

综上所述，医保基金浪费和流失严重，而政府部门至今仍未找到一种能遏制医保基金浪费和流失的有效方法，加之政府又是“撒胡椒面”式的医改投资方式，这三个方面的原因将会给中国全民医保带来巨大风险，这也正是中国全民医保目前和今后所面临的严峻挑战。所以，探索一种低成本、高质量的中国全民健保新思路不仅十分必要，而且非常紧迫。

二、事实早已证明按人头付费也能用于住院

中国国家人社部和卫生部只打算将按人头付费用于门诊，难道是按人头付费不能用于住院？事实证明并非如此。1998 年（即国务院“两江”模式试点结束的这一年）笔者提出的以按人头付费为核心措施的“四一三”健保模式，从 1999 年开始，先后被九江市科委、江西省社科规划办、江西省科技厅和国家科技部立项研究，并在九江市和九江县将按人头付费用于住院试点，试点取得了明显成效[1-2]。

2001 年，中国国家科技部的“四一三”模式试点是将医保按人头付费在九江市直单位用于住院（因当时门诊没有实现统筹，所以门诊无法采用按人头付费，预防保健按人头付费更是无从谈起）。试点结果：医保费用比上年下降了 53%（上年超支 690 万元，当年结余 514 万元），扭转了九江“两江”模式试点连续 6 年大量超支的局面（共超支 5309 万元），给政府减轻了巨大财政压力；因有效的遏制了过度医疗服务，也减轻了患者看病负担；尤其是政府还从结余的数百万元中拿出大部分资金用于大病患者的第二次报销，更减轻了大病患者的看病负担；患者的医疗质量也实现了零投诉，改变了九江“两江”模式试点 6 年来平均每年 114 人次，最多一年 361 人次医疗质量投诉的局面；医保定点医院也改变了多年来“丰产不丰收”的局面（医院虽有大量违规收入，而因医保基金大量超支，政府无力也不愿意给医院拨付费用），第一次实实在在拿到了属于自己的合理医保收入。有的医院还利用这一年医保增加的收入将门诊部装饰一新。因而 2002 年 5 月 23 日的《中国劳动保障报》报道：九江“终于在 2001 年底实现了医疗保险的‘三满意’：职工满意、医院满意、政府满意。”不过十分遗憾的是，因当时“四一三”模式中的按人头付费未得到国家有关部门认可，仅试点一年后经行政干预而被迫终止。

从 2004 年 7 月开始，九江市的困难企业职工住院医保，不得不再次借鉴 2001 年“四一三”模式试点中的按人头付费作法。当时因九江市政府和企业均无力为困难企业职工投资参保，不少困难企业职工因无医保而病无所医。九江市医保部门顶着重重压力，利用按人头付费低成本的特点，将医保筹资负担下降了 40%（仅用职工工资的 3%标准筹资，而全国困难企业普遍采用职工工资的 5%标准筹资），再加上 5 元大病保险，每月仅交 28.8 元保费，就可获最高 17.5 万元的住院医保待遇。因是“低收费、高保障”，在财政无一分钱投入，政府也未作任何宣传动员的情况下，有 33 家困难企业，一万多名职工自愿自费参保。运行 5 年，基金基本收支平衡，职工病有所医。该作法直到 2009 年企业改制，因困难企业不复存在而终止。

从 1999 年至今，九江市的九江县先后被九江市科委和科技部作为“四一三”模式试点的合作单位之一，将按人头付费在行政事业单位职工的住院医保中应用了十余年，运行一直平稳。这是因为与九江市相比，九江县的地方更小，受外界关注小，因而外界的干预也小。当然与当地政府的重视和支持密切相关。

还有武汉市商业职工医院的“保险医疗”，曾不仅将按人头付费用于住院，而且同时用于门诊，仅用职工工资的 5-6%标准筹资（全国普遍用职工工资的 8-10%标准筹资），就能让参保人享受门诊和住院，除高档检查需要患者少量交费外，其它检查和用药基本免费的医保待遇。因而该作法曾享誉国内外。后同样因与中国现有政府医保管理体制格格不入而发展受阻。

无论是九江市还是九江县，之所以能将“四一三”模式的按人头付费用于住院，是因为九江是经济欠发达地区，政府和企业的财力十分有限，控制医保基金的浪费和流失，提高医保基金的使用效率显得格外重要；同时九江又是一个老医改城市，已饱受过因医保基金超支给医保主管部门和经办机构带来的巨大压力，包括来自参保职工的压力，尤其是来自市政府的压力。当然还有一个十分重要的原因：当地的医保行政主管部门和经办机构具有崇高的自我牺牲精神，因为按人头付费用于住院就意味着要放弃医保统筹基金的审批权。为了让千千万万的患者病有所医，他们选择了放弃，精神实在可嘉。如果说，按人头付费不能用于住院，其障碍并非是操作技术，而是政事不分、管办不分的政府管理体制。所以，到目前为止，在中共中央 2009 年第 6 号文件（即国家新医改方案）第十二条要求的“完善支付制度，积极探索实行按人头付费、按病种付费、总额预付等方式”，其中后两种付费方式政府部门探索和推广十分积极，而唯有名列首位的按人头付费方式却因政府部门利益的影响而遭受冷遇。如果中国的医保实行了管办分离，这种障碍也就不复存在了。

三、“1+N”健保思路能让中国 13 亿人看病不贵不难

“1+N”就是“四一三”健保模式 + 多项相应配套措施。

什么是“四一三”健保模式？如果简明扼要解释就是：将按人头付费同时用于门诊、住院和预防保健 + 参保人有定期选择医院或医院集团定点的自由 + 参保人看病个人少量付费。比如：2012 年有 10 万参保人自愿选择某家医院集团健康保险定点，经办机构则将这 10 万人的防病与治病（含预防保健和门诊、住院）费用与责任交给这家医院集团，费用超支不补，节余也归这家医院集团，医院集团必须保障这 10 万人病有所防，病有所医。行政主管部门和经办机构的主要工作精力由控制费用转向监督医疗卫生服务质量。参保人如对医疗卫生服务质量不满意，有定期（一般每年一次）重新选择其它医院集团定点的自由，任何组织和个人不得以任何理由进行干涉。参保人看病时个人应少量付费（不得完全免费），特困人群可由政府实行医疗救助。需要说明的是，在初始阶段，参保人选择的可能只是一家普通综合性医院，但在“四一三”模式机制的作用下，在 3-5 年内，医院集团就会在全国广泛建立起来。

“四一三”模式的主要作用有三：

一是能让医药卫生事业变恶性循环为良性循环，变六败俱伤为六方共赢。因为医疗行业是个由供方点“菜”而由需方买单的特殊行业。因是别人买单，从自身利益出发，就有可能：医生乱点“菜”、医院乱买“菜”、药商乱卖“菜”、药厂乱做“菜”、政府乱管“菜”，最终导致患者不得不乱吃“菜”。这“六乱”必然导致整个医药市场经济规律混乱，受害的首先是患者，同时还有医生、医院、药商、药厂、政府。如果通过“四一三”模式机制作用，让医院自己点“菜”自己买单，那么就是良性循环：医生合理点“菜”、医院合理买“菜”、药商合理卖“菜”、药厂合理做“菜”、政府合理管“菜”，最终让患者合理吃“菜”。这六个“合理”就会让整个医药市场经济规律正常回归，受益的首先是患者，同时还有医生、医院、药商、药厂、政府。

二是能促使医院自觉做好预防保健工作，让参保人少生病、不生病。因为“四一三”模式是让医院自己买单，医院为了获得更多的健保利润，医院不仅会让参保人有病早治（以免患者的病小病拖大，短病拖长，花医院更多的钱），而且会让参保人无病早防（积极做好预防保健工作），从而提高参保人的健康水平，一方面减轻参保人看病负担，另一方面减少大医院看病排队人数。

三是让医保经办机构操作变得更加简单、容易、高效。因为如果将按人头付费同时用于门诊、住院和预防保健，自然不存在将病人从门诊向住院推诿；也不会像按病种付费那样，只能覆盖部分病种，而能覆盖所有病种和所有人群（包括职工、非国企职工、灵活就业人员及城乡居民）；也无需政府花大量人力、财力和物力去经常计算和调整各个病种的限价标准；更不会像总额预付那样拒收和推诿医保患者。因为按人头付费与总额预付的根本区别在于：前者从定点医院转出的患者，医疗费用仍由定点医院买单；而后者从定点医院转出的患者，医疗费用完全由别人（即其它定点医院或医保经办机构）买单，所以当后者的定点医院的总额控制指标超额时，会毫不犹豫以种种借口拒收和推诿患者。

不过，无论是九江市和九江县，还是其它地方的大量事实都说明，虽然“四一三”模式的作用是明显的，但是如果要让“四一三”模式充分发挥作用，并在全国更大范围内推广应用，还会受种种条件的限制，因而还需要有更多相应的配套措施。这些配套措施主要是：

（一）必须建立非垄断、有城乡社区网络的紧密型综合性医院集团。
也就是在一个城市或地区必须建立多家让社区与医院成为真正“一家人”的紧密型综合性医院集团，只有这样才能将按人头付费同时用于门诊、住院和预防保健。如大庆油田医院集团有 2 家三甲综合性医院、9 家成员医院（其中有多家专科医院）、14 家社区卫生服务中心、59 家社区服务站，覆盖大庆市 55 万服务人口（占大庆市总人口 1/3）的大型紧密型综合性医院集团。普通的县级医院能治愈 90%以上的疾病，这种医院集团，无疑小病、大病的治疗和预防应都能胜任。

大庆油田医院集团是全国社区卫生服务和双向转诊的先进典型，它能较理想的解决当地居民的看病难[3]，如果又通过在医院集团实行门诊、住院和预防保健（除重大公共卫生事件防控工作外）按人头付费，让医院集团自

己点“菜”自己买单，促使医院集团自觉控制滥开药、滥检查、药价虚高和造假骗保，就能大幅度提高健保基金的使用效率，提高城乡居民的健康保障水平。这样，大庆油田医院集团如还有相应配套措施，它所能解决的就不只是居民的看病难，还有居民的看病贵。

如果大庆油田医院集团的门诊、住院和预防保健都是自己点“菜”自己买单，医院集团还会去滥开药、滥检查吗？还会与患者合谋造假骗保吗？还会去买高价，甚至天价药吗？如果医院集团不买天价药和“换脸”药，天价药和“换脸”药还有销售市场吗？如果没有这种市场，药商和药厂就会老老实实卖药和做药。如果医院集团能合理买药和用药，药商和药厂也能合理卖药和做药，政府就没有必要去搞吃力不讨好的药品强制集中招标采购，药品“零差率”销售和财政补贴。
也许有人会问，又如何让大庆油田医院集团模式在全国大量复制呢？这当然还要借助“四一三”模式机制的作用。这主要体现在以下两个方面：

第一，因“四一三”模式能促使社区卫生机构的预防保健工作良性循环。大庆油田医院集团无法在全国复制的第一个原因，是因为医院集团的下属社区卫生机构的预防保健工作做得越多越好，那么医院集团就会赔得越惨，如果其它城市没有大庆油田管理局的财政支持能力和力度，那么医院集团不愿也无力去做好预防保健工作；而如采用“四一三”模式则相反，社区卫生机构的预防保健工作做得越多越好，医院集团的医保利润就会越大，全国其它城市即使没有政府财力支持，医院集团同样不仅愿意也有能力帮助其下属的社区卫生机构做好预防保健工作。

第二，因“四一三”模式能促使医疗卫生机构必须做强做大。大庆油田医院集团无法在全国复制的第二个原因是，全国其它地方医疗机构的产权所者不像大庆油田那样单一，而是多元化的，只要日子混得下去，都会以种种理由不进行资源整合。而如果采用“四一三”模式，让参保人有定期选择一家普通医院或一家医院集团定点的自由，参保人自然更愿意选择看病更方便的医院集团医保定点。在全民医保的情况下，医疗卫生机构要想生存和发展就不得不抱团做强做大。可以肯定，假如在大庆市采用“四一三”模式，大庆市政府一定会在 1-2 年内另建 1-2 家能与大庆油田医院集团抗衡的紧密型医院集团[4]。

（二）必须采用三个“不同”和一个“自选”的健保操作方法。
如何才能让参保人自愿与医院集团签约，这是保证“四一三”模式顺利实施的另一个关键措施。可采用以下方法：1、在同一城市或地区可采用“四一三”与非“四一三”两种不同的健保管理模式。2、两种不同的管理模式应有两种不同的筹资标准和保障水平。因“四一三”模式比非“四一三”模式的运行成本更低，如果是相同的筹资标准，那么前者比后者的保障水平要高得多；而如果是相同的保障水平，那么前者比后者的筹资标准要低得多；3、两种不同的管理模式应采用两种不同的基金收支渠道，也就是两种模式的基金必须分别核算和分开管理，不得互相挤占挪用；4、两种不同的管理模式必须由参保人自愿选择，政府和经办机构不得强制。以上作法简称为：三个“不同”（即管理模式不同、筹资标准和保障水平不同、基金收支渠道不同）和一个“自选”（即由参保人自愿选择管理模式）。

上述做法的目的是让参保人根据个人和所在单位的参保缴费能力自愿选择管理模式：如果缴费能力弱可选择“四一三”模式；如果缴费能力强可选择非“四一三”模式。比如，深圳市从 2005 年开始，在门诊中采用两种付费方式：一种是按人头付费，每月人均仅交 8 元保费就能享受到 80%的门诊报销待遇（因目前深圳缺少像大庆那样的医院集团，如果将按人头付费扩大到住院，会有一定的操作难度）；而另一种是其它付费方式，每月人均需交 100 元以上（是前者 10 倍以上），享受的医保待遇是：如无大病保险，门诊在用完个人账户后全由个人自费。参保人采用何种付费方式深圳市政府并不强制，完全由单位和个人自选。结果：到 2010 年，在全市 1100 万参保人中已有 840 万自愿选择了门诊按人头付费（占全市总参保人数的 76%），参保人自觉与自己选定的社区健康服务中心签约。选择按人头付费的基本上是中低收入人群，而选择非按人头付费的基本上是企业经理和老板等高收入人群。

（三）必须扶助更多能产生真正“鲶鱼效应”的民营综合性大医院，尤其是医院集团建立和发展。
如果不打破公立医院垄断局面，不改变公立医院的“大锅饭”机制，再好的管理模式也很难发挥作用，所以必须扶助更多能对公立医院形成强大竞争压力的大型民营综合性医院，尤其是医院集团。发展民营医院不只是为了补充，更重要的是为了制衡。通过强大的竞争压力促使公立医院自觉改革、真正改革，从而提高工作效率和

质量。考虑到民营医院发展处于起步阶段，政府应采取扶助政策。比如，让非营利性民营医院也享受公立医院的土地划拨政策待遇（土地不得改变用途）；鼓励公立医院的技术人才停薪留职到民营医院工作或在民营医院兼职；规定凡由民营医院出资培养的技术人才在一定年限内公立医院不得接收为员工；民营医院固定资产投资达到一定金额政府应给予奖励等。

（四）必须改变政府现有“撒胡椒面”式投资方式，应将政府投资集中用于全民健保。
“四一三”模式尽管能大幅度降低医疗卫生成本，从而大幅度降低参保和看病负担，可是依然会有许多普通百姓，尤其是贫困人群参不起保，需要政府投资帮助他们参保。更会有许多普通百姓和贫困人群在生病后，尤其是生大病后看不起病，更需要政府投资实施医疗救助。因而各级政府应将财政集中用于全民健保（即防病与治病保险）上，而不是到处去“撒胡椒面”（目前政府对新医改是从五个方面分散投资）。所有医疗卫生机构必须通过质优价廉的医疗卫生服务吸收健保基金生存和发展。

（五）必须加速医院管理“三个现代化”建设，实现成本与质量的有效控制。
必须尽快改变目前医院，尤其是公立医院普遍既不乐于也不善于成本与质量控制的现状。特别是医院集团管理层级更多，管理难度更大，因而必须加速医院管理“三个现代化”的建设：一是现代化企业管理制度的建立，二是现代化管理人才的培养和使用，三是现代化信息技术的利用。

除了上述配套措施外，“四一三”模式的应用还必须要有科学、合理的操作方法与程序，否则也会事与愿违。
综上所述，“1+N”是以九江的“四一三”健保模式为基础，以大庆油田的医院集团模式和深圳的三个“不同”一个“自选”模式为补充，以政府集中投资全民健保、“多元化”办医和“三个现代化”医院管理为必要条件的中国全民健保新思路。“1”和“N”两者是相互依存、互助共赢的关系。“四一三”模式离不开多项配套措施，否则“四一三”模式很难发挥作用。同样，多项相应配套措施也离不开“四一三”模式。因为：如果没有“四一三”模式，仅靠行政干预在中国很难建立起更多真正的医院集团；如果没有“四一三”模式，三个“不同”和一个“自选”根本没有存在基础；如果没有“四一三”模式，比公立医院更加强烈的医民营医院逐利欲望会使全民健保基金面临更大风险；如果没有“四一三”模式，即便政府对全民健保的投资力度再大也会成为“无底洞”；如果没有“四一三”模式，医院对成本与质量控制不会感兴趣……。所以，要让中国 13 亿人病有所医，需要建立中国全民健保制度，而中国全民健保制度又离不开具有相应配套措施的“四一三”模式为其保驾护航。因而，只有“1”种健保管理模式（“四一三”健保模式）+“N”项配套措施（非垄断的医院集团 + 三个“不同”一个“自选” + 政府集中投资全民健保 + “多元化”办医 + “三个现代化”医院管理 + 科学、合理操作方法……）= 中国 13 亿人看病不贵、不难。

注：本文是熊茂友为应邀参加 2011 年 12 月在湖北医药学院召开的《2011 年中国医疗保险高峰论坛》准备的发言稿；后被中国国家财政部财政科学研究所全文刊登在 2012 年第 3 期《财政研究简报》（内部刊物）上；现又在原有的基础上又作了进一步修改、补充。

附：“四一三”健保模式简介
该模式的基本作法是：
1、四定：定就诊医院、定医保费用、定医保责任、定医院定点人数规模。也就是根据参保人不同年龄段的费用标准和参保人所选择的医院的“定点”人头数，将医保费用和医保责任包干给各医院（或医院集团），费用超支不补，节余归医院（即实行按人头付费）。这样做的目的就是要让医院自己“点菜”自己“买单”，促使医院不该点的“菜”自觉不去乱点。

2、一自由：参保人如对医院的医疗服务质量不满意，可以有定期（一般一年一次）无条件重新选择其它医院定点的自由。这样做的目的是让医院必须注重医疗服务质量，该点的“菜”也必须得点。

3、三方付费：参保人就诊时由三方支付费用，由医院出大头、患者本人出小头、医保经办机构或政府支付特殊费用（特殊费用指大的传染病和自然灾害导致医院无力承受的费用）。这样做的目的是要让参保人在看得起病的同时也要有费用意识，让医院在有费用意识的同时又不至于因无力抗拒的外部原因将医院压垮。
以上归纳为“四定一自由三方付费”医保模式，简称为“四一三”医保模式。因作者主张将医疗保险上升为健康保险，所以将“四一三”医保模式后改为“四一三”健保模式。

“四一三”健保模式是笔者于 1998 年在客观总结“两江”医改试点经验与教训，汲取国内外多种医改模式优点的基础上，结合中国国情，提出的健康保险模式。该模式先后由当地省、市科技和社科部门立项研究，并于 2000 由国家科技部立项研究，于 2004 年通过了由科技部组织，有卫生部、劳社部、国家体改委等国家相关部门专家参加的国家软科学研究成果评审鉴定。该模式除在江西省九江市和九江县试点外，在浙江、江苏、重庆、广东、湖北等省（市）也有不少城市和农村有近似“四一三”模式的做法，均取得了不同程度的效果。目前只因操作不规范、措施不配套，所以作用并未得到充分发挥；如果操作能规范，措施能配套，效果必然会更好（互联网上还可搜索到更详细资料）。

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中英词汇对照 Glossary

总额预付 Advance payment total method
滥开药 Indiscriminate drug prescription
乱收费 Arbitrary medical charges
滥检查、滥手术 Abuse of medical examination and surgery
综合性医院 General hospital

PERSPECTIVE: COMMENT

Comment on “'1+N' method: a promising way to quality and affordable health care for China's 1.3 billion people”

只有用“1+N”全民健康保险思路才能让中国13亿人看病不贵不难: 评论

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Mr. Xiong's advocacy for "1+N" draws from the local experience of Jiujiang （九江） and Daqing （大庆）, which illustrate a key difference between the health care reform approach in the United States and the one in China. One important advantage of China's health reform, as more than one scholar have pointed out, lies in its nature as an administrative implementation rather than a nationwide legislative effort. This approach surely risks inconsistency, unpredictability and geographical disparity, yet the bright side is that the non-legislative approach opens a door for cities and counties to choose their own ways for implementing the reform. Part of the reason why the 2010 Patient Protection and Affordable Care Act in the United States has become so controversial and encountered so much resistance is its attempt to pass a federal law to address health care issues in all 50 states, while some states are more ready for such a health care overhaul than others. So far, the U.S. has witnessed important reform initiatives like the individual mandate in Massachusetts and San Francisco's universal health care (instead of universal coverage). Both the U.S. and China will benefit from a "bottom up" discussion when it comes to health care reform debate, a discussion that draws a sufficient variety of local experiences before any major reform initiative can be adopted at the national level.

根据在九江和大庆的实践经验，熊茂友先生提出的“1+N”医疗卫生改革主张，显示中美两国在各自医改进程中的一个重要区别。正如很多学者指出的那样，中国医改的重要优势之一，在于其本质是执行政府的行政决策，而不是全国范围内立法表决。尽管中国模式有诸如不一致性、不可预测性和地区差异等问题，但好的一面是，非立法性质的改革为地方和基层选择符合自身特点的改革方式打开了一扇门。2010 年美国《患者保护和可负担医疗法案》之所以遭遇重重阻挠和非议，在于政府试图通过一项解决全国 50 个州医疗问题的联邦法律，但各州之间对这一重大医改的准备程度各不相同。迄今为止，美国通过了的重要的医改方案均为地方性而非全国性，例如麻省和旧金山的“个人强制购买医保”以促进医疗保险普及。在医改讨论方面，在全国性的重大医改举措通过之前，丰富的“自下而上”的地方实践经验将使中美两国都受益匪浅。

RESEARCH TWITTER

Virginia C. Li, Qiongli Wang, Ning Xia, Songyuan Tang, and Caroline C. Wang. **"Tobacco Crop Substitution: Pilot Effort in China."** *American Journal of Public Health*, 2012, 102(9), 1660-3.

In China, approximately 20 million farmers produce the world's largest share of tobacco. Showing that income from crop substitution can exceed that from tobacco growth is essential to persuading farm families to stop planting tobacco, grown abundantly in Yunnan Province. In the Yuxi Municipality, collaborators from the Yuxi Bureau of Agriculture and the University of California at Los Angeles School of Public Health initiated a tobacco crop substitution project. At 3 sites, 458 farm families volunteered to participate in a new, for-profit cooperative model. This project successfully identified an approach engaging farmers in cooperatives to substitute food crops for tobacco, thereby increasing farmers' annual income between 21% and 110% per acre.

Grant Miller, Renfu Luo, Linxiu Zhang, Sean Sylvia, Yaojiang Shi, Patricia Foo, Qiran Zhao, Reynaldo Martorell, Alexis Medina, and Scott Rozelle. **"Effectiveness of provider incentives for anaemia reduction in rural China: a cluster randomised trial."** *BMJ*, 2012, 345: e4809.

This study tested the impact of provider performance pay for anaemia reduction in rural China. It was conducted among the 72 randomly selected rural primary schools across northwest China. Sample schools were randomly assigned to a control group, with no intervention, or one of three treatment arms: (a) an information arm, in which principals received information about anaemia; (b) a subsidy arm, in which principals received information and unconditional subsidies; and (c) an incentive arm, in which principals received information, subsidies, and financial incentives for reducing anaemia among students. It found that mean student haemoglobin concentration rose by 1.5 g/L (95% CI –1.1 to 4.1) in information schools, 0.8 g/L (–1.8 to 3.3) in subsidy schools, and 2.4 g/L (0 to 4.9) in incentive schools compared with the control group. This increase in haemoglobin corresponded to a reduction in prevalence of anaemia (Hb <115 g/L) of 24% in incentive schools. Interactions with pre-existing incentives for principals to achieve good academic performance led to substantially larger gains in the information and incentive arms. It concluded that financial incentives for health improvement were modestly effective and understanding interactions with other motives and pre-existing incentives was critical.

Francesco Barone-Adesi, Robert S Chapman, Debra T Silverman, Xinghzhou He, Wei Hu, Roel Vermeulen, Bofu Ning, Joseph F Fraumeni, Jr, Nathaniel Rothman, and Qing Lan. **"Risk of lung cancer associated with domestic use of coal in Xuanwei, China: retrospective cohort study."** *BMJ*, 2012, 345: e5414.

This retrospective cohort study estimated the risk of lung cancer associated with the use of different types of coal for household cooking and heating. It compared mortality from lung cancer between lifelong users of "smoky coal" (bituminous) and "smokeless coal" (anthracite). Participants were 27310 individuals using smoky coal and 9962 individuals using smokeless coal during their entire life. It found that lung cancer mortality was substantially higher among users of smoky coal than users of smokeless coal. The absolute risks of lung cancer death before 70 years of age for men and women using smoky coal were 18% and 20%, respectively, compared with less than 0.5% among smokeless coal users of both sexes. Lung cancer alone accounted for about 40% of all deaths before age 60 among individuals using smoky coal. Compared with smokeless coal, use of smoky coal was associated with an increased risk of lung cancer death. It concluded that in Xuanwei the domestic use of smoky coal is associated with a substantial increase in the absolute lifetime risk of developing lung cancer and is likely to represent one of the strongest effects of environmental pollution reported for cancer risk. Use of less carcinogenic types of coal could translate to a substantial reduction of lung cancer risk.

Ye Li, Qunhong Wu, Ling Xu, David Legge, Yanhua Hao, Lijun Gao, Ning Ning, and Gang Wan. **"Factors affecting catastrophic health expenditure and impoverishment from medical expenses in China: policy implications of universal health insurance."** *Bulletin of the World Health Organization*, 2012, 90: 664-71.

This study was to assess the degree to which the Chinese people are protected from catastrophic household expenditure and impoverishment from medical expenses and to explore the health system and structural factors influencing the first of these outcomes. Data were derived from the Fourth National Health Service Survey. An analysis of catastrophic health expenditure and impoverishment from medical expenses was undertaken with a sample of 55,556 households of different characteristics and located in rural and urban settings in different parts of the country. It found that the rate of catastrophic health expenditure was 13.0%; that of impoverishment was 7.5%. Rates of catastrophic health expenditure were higher among households having members who were hospitalized, elderly, or chronically ill, as well as in households in rural or poorer regions. A combination of adverse factors increased the risk of catastrophic health expenditure. Families enrolled in the urban employee or resident insurance schemes had lower rates of catastrophic health expenditure than those enrolled in the new rural corporative scheme. It concluded that policy-makers should focus on designing improved insurance plans by expanding the benefit package, redesigning cost sharing arrangements and provider payment methods and developing more effective expenditure control strategies.

Ma Runmei, Lao Terence T, Sun Yonghu, Xiao Hong, Tian Yuqin, Li Bailuan, Yang Minghui, Yang Weihong, Liang Kun, Liang Guohua, Li Hongyu, Geng Li, Ni Renmin, Qi Wenjin, Chen Zhuo, Du Mingyu, Zhu Bei, Xu Jing, Tao Yanping, Zhang Lan, Song Xianyan, Qu Zaiqing, Sun Qian, Yi Xiaoyun, Yu Jihui, and Zhang Dandan. **"Practice audits to reduce caesareans in a tertiary referral hospital in south-western China."** *Bulletin of the World Health Organization*, 2012, 90: 488-94.

This study was to assess the effectiveness of a three-stage intervention to reduce caesarean deliveries in a Chinese tertiary hospital. A retrospective study was conducted to assess whether educating staff, educating patients and auditing surgeon practices (introduced in 2005) had reduced caesarean delivery rates. It found that the caesarean delivery rate ranged from 53.5% to 56.1% in 2001–2004 and from 43.9% to 36.1% in 2005–2011. When 2001–2004 and 2005–2011 were treated as "before" and "after" periods to evaluate the intervention's impact on the mean caesarean section rate, a significant reduction was noted: from 54.8% to 40.3%. The overall drop in the caesarean section rate was significant and inversely correlated with the years. Although complicated pregnancies increased after 2004, the primary caesarean section rate decreased annually by 20% on average in 2005–2011, after practice audits were implemented. Multiple logistic regression showed a positive association between the caesarean delivery rate and the rate of admission to the NICU. It concluded that patient and staff education and practice audits reduced the Caesarean section rate in a tertiary referral hospital without an increase in admissions to the NICU.

Liutang Gong, Hongyi Li, and Dihai Wang. **"Health investment, physical capital accumulation, and economic growth."** *China Economic Review*, 2012, 23(4), 1104-19.

This paper analyzes the effect of health investment, and hence of health capital, on physical capital accumulation and long-run economic growth in an extended Ramsey model with an Arrow–Romer production function and a Grossman (1972) utility function. This paper concludes that economic growth is related to both the health growth rate and the health level. While growth in health capital always facilitates economic growth, the gross effect of health level on the rate of economic growth depends on how it affects physical capital accumulation. If the negative effect of health on economic growth through its influence on physical capital accumulation is not taken into consideration, then health level has a positive effect on the rate of economic growth by improving the efficiency of labor production. However, since health investment may crowd out

physical capital investment and thus influence physical capital accumulation, excessive investment in health may have a negative effect on economic growth. Empirical tests of these theoretical hypotheses using panel data from individual provinces of China produce results that are consistent with the theoretical conclusions.

Rui Wang, Mei-Jing Wu, Xiu-Qiang Ma, Yan-Fang Zhao, Xiao-Yan Yan, Qing-bin Gao, and Jia He. **"Body mass index and health-related quality of life in adults: a population based study in five cities of China."** *European Journal of Public Health*, 2012, 22(4): 497-502.

This paper investigates the relationship between obesity and health-related quality of life (HRQL) in a randomly selected Chinese sample. A total of 3600 residents aged 18–80 years were sampled in five cities of China using a randomized stratified multiple-stage sampling method to receive the interview. Among the 3207 participants (mean age 42 years) suitable for analysis, body mass index (BMI) differed by age and gender. In women, meaningful impairments were seen between obese and normal weight participants in four physical health scales but only in one of the four mental health scales; in men, impairments by obesity were not found in all of the eight scales, and better HRQL in two mental health scales were observed in obese participants; after adjusting related variables, several physical but not mental health scales were found impaired by obesity. It concludes that obesity impaired physical but not mental health, and the impairments varied between genders. Public health agencies and government should emphasize the impairments of obesity on physical health.

Ling Yang, Maigeng Zhou, Paul Sherliker, Yue Cai, Richard Peto, Lijun Wang, Iona Millwood, Margaret Smith, Yuehua Hu, Gonghuan Yang, and Zhengming Chen. **"Alcohol drinking and overall and cause-specific mortality in China: nationally representative prospective study of 220 000 men with 15 years of follow-up."** *International Journal of Epidemiology*, 2012, 41(4): 1101-13.

This nationally representative prospective cohort study included 220,000 men aged 40–79 years from 45 areas in China in 1990–91, and >40,000 deaths occurred during 15 years of follow-up.
It found that overall, 33% of the participants reported drinking alcohol regularly at baseline, consuming mainly distilled spirits, with an estimated mean amount consumed of 372 g/week (46.5 units per week). After excluding all men with prior disease at baseline and the first 3 years of follow-up, there was a 5% excess risk of overall mortality among regular drinkers. Compared with non-drinkers, the adjusted hazard ratios among men who drank <140, 140–279, 280–419, 420–699 and ≥700 g/week were 0.97, 1.00, 1.02, 1.12 and 1.27, respectively. The strength of the relationship appeared to be greater in smokers than in non-smokers. There was a strong positive association of alcohol drinking with mortality from stroke, oesophageal cancer, liver cirrhosis or accidental causes, a weak J-shaped association with mortality from ischaemic heart disease, stomach cancer and lung cancer and no apparent relationship with respiratory disease mortality. It concluded that among Chinese men aged 40–79 years, regular alcohol drinking was associated with a small but definite excess risk of overall mortality, especially among smokers.

Steef Baeten , Tom Van Ourti and Eddy van Doorslaer. **"Rising Inequalities in Income and Health in China: Who is Left Behind?"** Tinbergen Institute Discussion Paper 12-091/V.

During the last decades, China has experienced double-digit economic growth rates and rising inequality. This paper implements a new decomposition on the China Health and Nutrition Panel Survey (1991-2006) to examine the extent to which changes in level and distribution of incomes and in income mobility are related to health disparities between rich and poor. It finds that health disparities in China relate to rising income inequality and in particular to the adverse health and income experience of older (wo)men, but not to the growth rate of average incomes over the last decades. These findings suggest that replacement incomes and pensions at older ages may be one of the most important policy levers in combating health disparities between rich and poor Chinese.

Hong Liu and Zhong Zhao. **"Impact of China's Urban Resident Basic Medical Insurance on Health Care Utilization and Expenditure."** IZA Discussion Paper No. 6768.

In 2007, China launched a subsidized voluntary public health insurance program, the Urban Resident Basic Medical Insurance, for urban residents without formal employment, including children, the elderly, and other unemployed urban residents. This paper estimates the impact of that program on health care utilization and expenditure using 2006 and 2009 waves of the China Health and Nutrition Survey. It finds that the program has significantly increased the utilization of formal medical services. This result is robust to various specifications and multiple estimation strategies. However, there is no evidence that it has reduced out-of-pocket expenditure and some evidence suggesting that it has increased the total health care expenditure. It also finds that the program has improved medical care utilization more for the elderly, for the low- and middle-income families, and for the residents in the relatively poor western region.

POLICY AND PRACTICE UPDATES

深圳“新医改”启动：挑战药品招标采购
来源：21 世纪经济报道 2012-06-20
http://www.21cbh.com/HTML/2012-6-20/4NMDY5XzQ1NzM4Nw.html

全国公立医院改革试点城市、广东省按照新医改的进程，全国公立医院改革试点城市、广东省深圳市宣布年底以前全面取消药品加成；5 月出台的《深圳市公立医院医药分开改革实施方案》，更明确规定将正式启动医药分开改革，取消公立医院药品加成、建立允许患者使用外购药品制度、完善公立医院补偿机制。

与此同时，为了弥补药品零加成带来的医院减收，深圳市另辟蹊径，除了同样提高诊疗费以外，更把矛头指向药品集中招标采购制度，提出公立医院集团式采购、药品“厂院直销”等创新做法。

改革措施之一是实行集团式采购。即由深圳市公立医院管理部门制订全市公立医院采购药品目录，以广东省药品统一采购中标目录和中标价格为基础，对进入深圳公立医院的药品实施二次遴选；与中标药品供应商进行价格谈判，代表全市所有公立医院实施集团式采购，并实行统一配送，从而降低药品入库价格。

此次改革的另一个主要做法是实施“厂院直销”。由市公立医院管理部门选取试点单位，探索建立医院与药品生产企业之间的直销渠道，以此减少流通环节，降低采购价格；或者以不高于广东省同品规药品集中采购中标价格为前提，参照周边地区中标品种和中标价格进行采购。

Shen Zhen Initiates “New Medical Reform”: Challenging Current Medicine Procurement System

In May, City of Shen Zhen in Guangdong Province introduced the Reform Implementation Plan for Separation of Hospital Management and Medicine Procurement in Public Hospitals, formally initiating the reform, eliminating public hospital medicine markups by the end of 2012, allowing patients to use medicine outside the hospital system, and improving current public hospital reimbursement system.

In order to reduce hospital revenue shortfalls resulting from zero medicine markups, Shen Zhen will increase hospital fees and decrease medicine purchasing price through group procurement. Shen Zhen Public Hospital Management Office will compile a medicine list based on Guangdong Province Unified Procurement Bidding List and Price, and represent all public hospitals in the city to negotiate with medicine suppliers to reach lowest possible price. The management office will also attempt to establish a direct link between pilot hospitals and medicine suppliers, eliminating all middle men and further reducing costs of medicine.

中国2020年拟实现人人享有基本医疗卫生服务
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http://www.chinanews.com/jk/2012/06-15/3966654.shtml

据卫生部网站消息，日前，卫生部、国家中医药管理局联合印发《关于加强卫生信息化建设的指导意见》，《意见》提出，到 2020 年,建立完善实用共享、覆盖城乡的全国卫生信息化网络和应用系统，为实现人人享有基本医疗卫生服务目标提供有力的技术支撑。

《意见》在肯定近年来中国卫生信息化建设阶段性成果的基础上，同时也指出长期以来存在的多项问题：卫生信息化建设缺乏顶层设计与规划,标准和规范应用滞后，导致信息不能互联互通,信息资源共享程度较低；居民电子健康档案和电子病历数据资源库建设滞后，难以适应当前深化医药卫生体制改革的需要,不能有效满足人

民群众的健康保障需求。同时，卫生信息化管理和专业人才缺乏,卫生信息化对卫生事业改革发展的技术支撑作用难以得到充分发挥。

《意见》要求，建设国家、省、区域(地市或县级)三级卫生信息平台，加强公共卫生、医疗服务、医疗保障、药品供应保障和综合管理等五项业务应用系统,建设居民电子健康档案、电子病历等两个基础数据库和一个业务网络,将三级卫生信息平台作为横向联系的枢纽，整合五项业务的纵向功能和应用,以居民健康卡为联结介质，促进互联互通,实现资源共享。到 2015 年，初步建立全国卫生信息化基本框架。到 2020 年,建立完善实用共享、覆盖城乡的全国卫生信息化网络和应用系统,为实现人人享有基本医疗卫生服务目标提供有力的技术支撑。

此外，《意见》还对信息化工作的其他方面提出了具体要求：各级卫生行政部门要研究完善卫生信息化有关管理制度；同财政、发展改革部门把卫生信息平台建设、应用系统运行维护和卫生信息化管理经费纳入各级财政预算；各地要以互联互通、资源共享为目标,按照国家统一规划和卫生信息化建设总体框架,制订本地区卫生信息化建设规划；要研究制订本地区的卫生信息化人才培养规划,完善卫生信息化人才的引进、培养、使用和激励机制。

China Setting Sight on 2020: Basic Medical and Public Health Services for Everyone

Recently, Ministry of Health and National Administration of Traditional Medicine jointly published "Guidance on Strengthening the Building of Health Information System", identifying the establishment of a functional nation-wide health informatics system as essential for delivering medical and health services to every citizen in the country.

The Guidance affirmed recent gains in building China's health informatics system, but also pointed out long-standing problems such as lack of top quality system design, planning, standardization, and implementation, that lead to inefficient information communication and exchange. There is a shortage of subject experts and professionals, further delaying the development of health informatics system.

The Guidance recommends building informatics platforms at the national, provincial, and local levels to serve as hubs for databases containing residents' electronic health and medical records, and strengthen the delivery of five major health services, including public health, medical service, medical insurance, medicine provision, and integrated management of these services. Using personal health information card as the connector, each citizen's health and medical records could be accessed at each platform level regarding his or her received health or medical services.

The Guidance projects the establishment of basic framework for national health informatics system in 2015, and expansion of the improved system to every jurisdiction in the country by 2020, providing vital technical support to achieve the goal of health services for every person.

国家人权行动计划：2015 年医保基本实现全覆盖
来源：搜狐健康 2012-06-12
http://health.sohu.com/20120612/n345389029.shtml

6 月 11 日，中国国家国务院发布了国家人权行动计划(2012-2015 年)(下称“计划”)。计划包含经济社会权利、公民权利与政治权利、少数民族、妇女、儿童、老年人和残疾人的权利、人权教育四大部分。

在社会保障权利方面，计划指出到 2015 年，医疗保险基本覆盖城乡居民。职工医疗保险、城镇居民医疗保险、新型农村合作医疗（以下简称“新农合”）参保（合）人数较 2012 年新增 6000 万人以上。城乡基本医疗保险参保(合)人数达到 13.2 亿人。提高对城镇居民基本医疗保险和新农合财政补助标准。职工医保、城镇居民医保和新农合在政策范围内住院医疗费用支付比例均达到 75%左右。城镇居民医保和新农合门诊统筹覆盖所有统筹

地区，支付比例提高到 50%以上。到 2015 年，城镇居民医保和新农合政府补助标准提高到每人每年 360 元以上，新农合参合率稳定在 95%以上。

在健康权利方面，计划指出要研究制定精神卫生法，基本医疗卫生保健法，中医药法和药品标准管理办法。不断提高人均期望寿命。到 2015 年，人均期望寿命达到 74.5 岁。加强基层医疗卫生机构和全科医生培养基地建设。到 2015 年，通过转岗培训、在岗培训和规范化培训培养 15 万名全科医生。促进基本公共卫生服务逐步均等化。落实现有人均基本公共卫生服务经费不低于 25 元标准，到 2015 年提高至 40 元以上。为城乡居民免费提供建立健康档案、健康教育、预防接种等多项服务。加大慢性病防治力度，普及慢性病防治知识，慢性病防治核心信息人群知晓率达到 50%以上。加强主要慢性病及高风险人群的早期发现和干预管理，35 岁以上成人血压和血糖知晓率分别达到 75%和 50%，高血压管理率和糖尿病规范管理率均不低于 40%。在全国 30%的癌症高发地区开展对重点癌症的早诊早治。

National Human Rights Action Plan (2012-2015)

On June 11, China's State Council introduced National Human Rights Action Plan (2012-2015). The Plan is divided into four major sections that include socioeconomic rights; citizen and political rights; minorities, women, children, elderly, and disabled persons' rights; and education rights.

In the section detailing rights for social security, the Plan stated that by 2015, most citizens, both in urban and rural settings, should have health insurance coverage. Combining workers' insurance, urban residents insurance, and new rural cooperative insurance, the number of insured should increase by more than 60 million people compared to 2012, bringing the total insured to 1.32 billion.

Regarding the rights to a healthy life, the Plan pointed out the need for mental health laws, basic medical health laws, traditional medicine laws, and medical standard and management plans. The Plan's stated goals for 2015 include reaching life expectancy of 74.5 years; training 150,000 qualified general medical practitioners; achieving ¥40 per capita medical expenditure; providing free services such as establishing health record database, health education and vaccination; and increasing prevention of chronic diseases through screening and education.

卫生部门槛放宽 诊所和股份制医院可“非营利”
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http://news.10jqka.com.cn/20120522/c527757994.shtml

继国务院办公厅《关于进一步鼓励和引导社会资本举办医疗机构的意见》明确要求加快形成多元化办医格局以来，为促进非公立医疗机构持续健康发展和医药卫生体制改革的深化，昨日(5 月 21 日)卫生部在其官方网站上发出通知，就社会资本办医的经营性质和级别进行明确。

在社会资本办医经营性质层面，卫生部提出，社会资本可以按照经营目的，自主申办营利性或非营利性医疗机构。原本城镇个体诊所、股份制医疗机构等一般定为营利性医疗机构的相关规定今后将不再适用。

针对社会资本办医级别，卫生部强调，卫生行政部门在设置审批社会资本举办的医院(含中外合资合作医院)时，应当根据《医疗机构管理条例》、《医疗机构设置规划》以及该医院的功能任务、服务半径等，及时确定其级别，并在《设置医疗机构批准书》“其他”栏目中予以明确。

根据卫生部 16 日发布一季度全国医疗服务数据，社会资本办医的快速增长再次得到印证。截至 3 月底，民营医院数量为 8864 所，同比增长 21.23%。国家医改专家咨询委员会专家刘国恩表示，政策层面上将把社会资本办医的障碍减到最少，“十二五”期间社会资本办医发展速度将超过公立医院发展速度。

Ministry of Health to Allow Private "Non-Profit" Hospitals

In order to stimulate the healthy development of private medical institutions and deepen the reform of public medical facilities, Ministry of Health posted announcement on their website on May 21 to further shed light on classification of private medical facilities.

The Ministry stated that privately owned medical centers could apply to be either "for-profit" or "non-profit" depending on their business goals, in contrast to past practice that label all privately owned medical facilities as "for profit".

According to national medical service survey, privately owned medical centers grew at a faster rate than their public counterparts, reaching 8,864 by the end of March, a 21.23% increase compared to last year. Current policies will create a favorable environment for this trend to continue.

卫生部部长陈竺：依靠机制控制医疗费用不合理增长，新农合力求实现病种全覆盖
来源：新华网 2012-05-16
http://news.xinhuanet.com/health/2012-05/16/c_123139729.htm

"新农合筹资水平增长很快，但不合理的医疗费用会消耗新农合资金，依靠大处方、不合理检查、过度医疗服务来补偿医疗技术劳务收入不足的现象还未能从根本上得到解决。"卫生部部长陈竺 16 日接受新华社记者专访时表示，要通过新农合支付方式改革，利用机制引导医疗机构控制医疗费用的不合理增长，提高参合农民的实际受益水平。

陈竺表示支付方式改革是通过推行按病种付费、按床日付费、门诊总额预付等付费方式，将医疗服务的付费模式由传统的单纯按项目付费向混合支付方式转变，实现规范服务、控制费用的目的。医疗服务由于不再按项目收费，同时限定收费总额，客观上迫使医疗机构在总额控制的前提下调整医药费用结构，控制不合理检查、不合理用药，间接提高了医务人员的技术劳务收入，改变了医疗卫生机构服务成本的补偿机制，建立了医疗机构对费用的自我约束机制和费用结构的自我调整机制。

陈竺同时强调，依据卫生部、国家发改委、财政部近日联合发出《关于推进新型农村合作医疗支付方式改革工作的指导意见》，要求各地从 2012 年开始积极推进统筹区域内定点医疗机构和病种全覆盖的支付方式改革试点工作，并逐步扩大实施范围，争取到 2015 年实现在所有的统筹地区全面实施的目标。新农合支付方式改革要力争覆盖统筹区域内所有定点医疗机构，覆盖所有住院病人以及享受新农合门诊（统筹）补偿的病人。各地应保证支付方式改革方案覆盖最大化。

Minister of Health Comments on New Rural Cooperative Medical Insurance

"Funding for the New Rural Cooperative Medical Insurance is growing fast, but unreasonable medical expenses such as unnecessary checkups, prescription of expensive medicines or over prescription of treatment have not been satisfactorily dealt with and could waste these funds", commented CHEN Zhu, Minister of Health, when interviewed on May 16th.

The Minister pointed to medical payment reforms as an essential component of the New Rural Cooperative Medical Insurance to increase rural residents' medical benefits. Medical payment reforms aim to transition from the traditional "pay by service" to mixed payment methods, such as pay by diagnosis-related groups (DRGs), days of hospital bed used, and prepayment of outpatient fees. With the payment reform and cap on total chargeable cost, medical facilities need to restructure their payment system, such as reducing unnecessary tests ordered and medicine prescription, to find a balance between delivering patient care and receiving fair compensation.

The Minister also pointed to the recent joint guidance from Ministry of Health, National Development and Reform Commission, and Ministry of Finance. The guidance requested that medical payment reform to be implemented in all designated medical facilities within each coordinated region as preparation for 100% coverage by 2015.

医药“十二五”规划发布 医改“第二季”启动

来源： 21 世纪经济报道 2012-03-23

http://www.21cbh.com/HTML/2012-3-22/yNMDY5XzQxMTgyNA.html

3 月 21 日，国务院印发了《“十二五”期间深化医药卫生体制改革规划暨实施方案》（以下称“实施方案”）提出，到 2015 年，“个人卫生支出占卫生总费用的比例降低到 30%以下，看病难、看病贵问题得到有效缓解。”

实施方案明确提出“把建立全科医生制度作为强基层的关键举措”，“保基本、强基层、建机制”仍是“十二五”医改的基本原则。而在重申基层仍是未来医改的重点的基础上，实施方案还强调成立“卫生国资”以及完善基药考评两个方面。

在公立医院方面，实施方案提出，“按照‘四个分开’的要求，以破除‘以药补医’机制为关键环节，以县级医院为重点，统筹推进管理体制、补偿机制、人事分配、药品供应、价格机制等方面的综合改革，由局部试点转向全面推进。”而针对办医职能，实施方案明确提出“研究探索采取设立专门管理机构等多种形式确定政府办医机构，由其履行政府举办公立医院的职能，负责公立医院的资产管理、财务监管、绩效考核和医院主要负责人的任用。”值得关注的是，实施方案中还特别提出“公立医院资源丰富的城市，可引导社会资本以多种方式参与包括国有企业所办医院在内的部分公立医院改制重组。”实际上，这是引导社会资本针对医疗资源存量所进行的改革。

在基本药物方面，“十二五”期间将推进村卫生室实施基本药物制度，而对非政府办基层医疗卫生机构，各地政府可结合实际，采取购买服务的方式将其纳入基药实施范围。而公立医院和其它医疗机构，则鼓励其优先使用基本药物。就即将进行调整的基本药物目录，实施方案要求“适当增加慢性病和儿童用药品种，减少使用率低、重合率低的药品，保持合理的基本药物数量。”同时，“基本药物由省级人民政府统一增补，不得将增补权限下放到市、县或基层医疗卫生机构。要合理控制增补药品数量。”

实施方案还明确提出，“十二五”期间将坚持基本药物以省为单位网上集中采购，落实招采合一、量价挂钩、双信封制等采购政策。为确保质量优先、价格合理，未来将完善基本药物质量评价标准和评标办法。此外，实施方案还提出“对独家品种和经多次集中采购价格已基本稳定且市场供应充足的基本药物试行国家统一定价。对用量小、临床必需的基本药物可通过招标采取定点生产等方式确保供应。”

Release of the Twelfth Five-Year Plan for Medicine: Second Season of Medical Reform

On March 21st, State Council released the document “Deepening Reform of Medical and Health System during the Twelfth Five-Year: Plan and Implementation” (Implementation Plan from now on). The Implementation Plan projects that by 2015, private medical expenditure will only occupy less than 30% of the total, and difficulties in obtaining affordable medical care will be effectively alleviated.

The Implementation Plan’s basic concepts are still focused on “Ensuring the Basics, Strengthen the Grass-root Medical System, and Building Sustainable Infrastructure”, and identified establishment of a holistic general practitioner system as the essential building block of a stronger medical system.

For public hospitals, the Implementation Plan stressed that reform should focus on County hospitals and later extend to the entire system through a coordinate, multi-faceted reform that impacts management systems, payment methods, personnel distribution, medicine supply and pricing. The implementation Plan also clearly states that dedicated governing bodies should be established to fulfill government obligation in building public hospitals, and manage hospital financial and personnel resources. Cities with rich public hospital resources could also consider involving private funding streams in building the medical care system.

Essential medicine is also considered within the Twelfth Five-Year Plan. During the next few years, village medical offices will start implementing the Essential Medicine List, and grass-root level non-governmental medical facilities could be incorporated into the local government's implementation of the Essential Medicine List if local conditions permit. Public hospitals and other medical facilities are encouraged to first use the medicines listed in the Essential Medicine List.

The Essential Medicine List is undergoing adjustment, and the Implementation Plan suggests that more medicines for chronic or children's diseases should be added, and redundant or under-utilized medicines should be eliminated, and only Provincial level government has the authority to modify the Essential Medicine List and purchase listed medicines. For medicines that are patented by a single company or medicines that have a stable market price and supply, a nationally unified price could be established and tested. For essential medicines that are required for certain diseases but only in small quantities, manufacturers could be contracted to produce the medicine only when needed.

陈竺捐赠资金 40 万 中华医学会设立卫生政策奖
来源: 中国健康界网站
http://weibo.com/1558405975/yDZdEC0OF

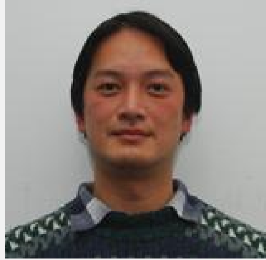
"把稿费和获奖项目奖金捐出来，做一点有意义的事情，是我的夙愿。今天终于达成心愿，我感到十分欣慰。"卫生部长陈竺在中华医学会卫生政策奖捐款仪式上说，希望通过设立卫生政策奖，鼓励更多的学者和专家投身到卫生政策研究中。

Minster CHEN Zhu Donated ¥400,000 to Chinese Medical Association to Create the Health Policy Award

"I have always wished to do something meaningful with my award money and royalties for my published work. I am really happy that my wish is fulfilled today", said CHEN Zhu, Minister of Health, at Chinese Medical Association's Health Policy Award Donation Ceremony. He hopes that by establishing this award, more researchers and experts will devote their time and energy to study health policies.

ABOUT CHPAMS: FEATURE MEMBER

Lu Shi, PhD MA



Lu Shi, PhD, MA

Lu Shi received his PhD in Public Policy Analysis from *Frederick*. S. Pardee RAND Graduate School and an MA in media studies from Syracuse University. He had three years of work experience as a journalist in China before coming to the United States for graduate education. He spent four years in UCLA School of Public Health after his PhD, developing a microsimulation model to forecast future health trends for the national and state populations. Currently an assistant professor in the Department of Public Health Sciences at Clemson University, he is continuing to improve and expand the microsimulation tool to simulate and assess health interventions. He is also interested in the neurological and economic aspects of mindful awareness, a topic that is related to his background in cognitive and behavioral research as well as his personal interest in meditation practice.

1. *What do you think is the most neglected field of science or medicine at the moment?*

The neglected field, given my bias as a mindfulness enthusiast, is the biomedical and economic research of the mindful awareness practice. Why are more mindful people happier than their comparable peers? Why is mindfulness practice associated with less dementia risk? Will a more mindful person allocate more of his or her money to others when he or she is in a position to decide wealth distribution? This ancient practice has shown evidence of effectiveness in many different therapeutic areas but more research in basic science and social science is urgently needed to understand why it works and how it can work better.

2. *Who is your favorite politician and why?*

Let me pick one from a Chinese list: Zhang Jian (张謇) from Nantong, Jiangsu. This guy was a pragmatic moderate in the late Qing Dynasty's movement for China's first Constitution, willing to compromise and able to find a peaceful solution for crises. He was better remembered as an industrialist and an educator, building more than twenty enterprises and more than three hundred schools.

3. *If you had not entered your current profession, what would you have liked to do?*

A part-time mindful awareness facilitator, plus a part-time book broker, plus a freelance journalist/writer.

4. *What one discovery or invention would most improve your life?*

A drug or a therapy that can drastically delay aging, so that my parents can stay healthy. From a cost-effectiveness viewpoint, that therapy will simultaneously delay the onset of a lot of diseases. Not everyone realizes this and thus research into anti-aging is seriously underfunded, especially from the private sector.

5. *Do you believe there are other life forms in the Universe?*

As Curiosity already found signs of water on Mars, it is hard to believe that there are no other life forms in the Universe.

6. *If you were Bill Gates, how would you spend your fortune?*

I believe that the Gates Foundation has already figured out the most cost-effective way of helping the world: inoculate children in economically dilapidated countries. However, my Chinese Avatar of Bill Gates might introduce a scholarship program to help those economically disadvantaged Chinese families with a second or a third child, particularly if that second or third child is a girl.

ABOUT CHPAMS: FROM THE PLANNING COMMITTEE

CHPAMS AND THE WESTLAKE YOUTH FORUM 2012

中国卫生政策和管理协会（海外）与2012年西湖青年论坛

By Jing Li (University of California, Berkeley) and Xin Xu, PhD (University of Illinois, Chicago)
This report is translated by Yan Ding (Heidelberg University) into Chinese。

作者：李婧 （加州大学伯克利分校），徐昕（伊利诺伊大学芝加哥分校）
本文由丁燕（海德堡大学）翻译成中文。

On August 3-6, 2012, with funding from the China Medical Board (CMB), Zhejiang University School of Medicine hosted the very first Westlake Youth Forum in Jinxi Hotel. The China Health Policy and Management Society (CHPAMS) played a critical role both in organizing the event and in the forum. CHPAMS helped to select overseas scholars for the travel fellowship offered by the organizer. In addition, CHPAMS members actively participated in constructively critiquing the CMB grant report, panel discussion, as well as in holding a session of its own.

在美国中华医学基金会资助下，浙江大学医学院组织了第一届西湖青年论坛。论坛于 2012 年 8 月 3 日-6 日在杭州金溪山庄举行。中国卫生政策与管理协会（CHPAMS）在组织及参与论坛活动中发挥了重要作用。CHPAMS 帮助组织者在海外学者中选拔旅行奖学金的获得者。同时 CHPAMS 成员积极参与论坛活动，建设性地评议美国中华医学基金会（CMB）资助项目汇报，参与小组讨论，并举办了 CHPAMS 之夜活动。

1. Screening of the Travel Fellowship Applications for the First Westlake Youth Forum
筛选第一届西湖青年论坛旅行奖学金申请者

CHPAMS was invited by the Zhejiang University School of Medicine and the China Medical Board (CMB) to assist in organizing the very first Westlake Youth Forum. Compared with the Westlake Forum series, the Westlake Youth Forum provides an opportunity for young scholars from within and outside of China to better communicate, network, and collaborate with each other.

CHPAMS undertook the responsibility to select overseas young scholars to attend the forum. Call for applications were circulated through the CHPAMS mailing list and through personal networks.

CHPAMS received 63 submissions, of which 33 were determined eligible. A six person reviewing committee was organized. Dr. Shufang Zhang, Dr. Zhuo (Adam) Chen co-chaired the committee, which also included Dr. Xin Xu, Dr. Lu Shi, Prof. Qi (Harry) Zhang, and Dr. Yi Pan. Committee members ranked the submissions independently, according to criteria including: potential to contribute to the discussion at the Forum, intention to seek collaboration with HPSS scholars in China, and potential to seek Health Policy and Systems Sciences (HPSS) career in China, as well as academic credentials. Sixteen young scholars were selected to participate in the Forum. The majority of the selected applicants majored in health services research, health economics, or health systems research. Most of the applicants are from the United States with one applicant from Heidelberg University in Germany.

CHPAMS 受浙江大学医学院及美国中华医学基金会（CMB）之邀协助举办第一届西湖青年论坛。与西湖论坛相比，西湖青年论坛给海内外的年青学者提供了一个更好的沟通和合作平台。CHPAMS 深知选拔海外青年学者参与论坛的责任，通过 CHPAMS 邮件名单及个人关系网络呼吁青年学者参与申请。

在 63 名申请者中，33 名申请者符合申请标准。CHPAMS 成立了 6 人评阅委员会，张术芳博士和陈茁博士同为委员会主席，其他委员包括徐昕博士，史律博士，张琪教授以及潘翌博士。委员会成员独立为申请者评级，依据的标准包括：参与论坛讨论的潜力，与国内卫生政策与卫生系统科学领域学者合作的意愿，以及学术能力。16 名海外年青学者获选参与论坛。多数奖学金获得者的研究领域为卫生服务研究，卫生经济或卫生系统研究。多数来自美国，另一位来自德国海德堡大学。

2. Participating in the Westlake Youth Forum 2012
参与 2012 年西湖青年论坛

On August 3-6, 2012, over 100 scholars from China and abroad gathered in Hangzhou's Jinxi Hotel by the West Lake to attend the first Westlake Youth Forum. The active participation of senior researchers and young scholars alike contributed to the tremendous success of the first Westlake Youth Forum. CHPAMS members actively participated in constructively critiquing the CMB grant report, panel discussion, as well as in holding a session of its own.

100 多名海内外学者于 2012 年 8 月 3 日到 6 日在杭州金溪山庄参与第一届西湖青年论坛。资深学者与青年学者都积极参与论坛活动，为第一届青年论坛的成功举办做出了巨大贡献。CHPAMS 成员积极参与论坛活动，建设性地评议 CMB 基金汇报，参与小组讨论，并举办了 CHPAMS 之夜活动。

2.1 Constructive Critiques
建设性地评议

One of the main purposes of the Westlake Youth Forum is to review the progress of ongoing CMB grants. Eighteen Principal Investigators of the CMB supported open competition projects, young faculty seed grants and "991" projects presented the progress of their ongoing research. Furthermore, one senior researcher paired with an overseas young scholar, also a CHPAMS member, together served as discussants for each presentation. This arrangement proved highly effective in facilitating discussions among scholars from domestic and overseas institutions, often with varying and mutually complementing perceptions. In particular, the comments of CHPAMS members were well received by the presenters and other forum attendees.

西湖青年论坛的主要目的之一是评阅 CMB 基金项目的进度。CMB 资助的公开竞争项目、青年种子基金项目以及"911"项目的 18 位主要研究人员汇报了所负责项目的进展情况。每项汇报都由一名资深学者与一名来自 CHPAMS 的海外青年学者作为评议员给予评议。两名评议员常从不同角度评议，充分互补，结果证明这一安排高效地促进了海内外学者的讨论。CHPAMS 成员的评议建议在汇报人员及其他参与者间反响良好。

2.2 CHPAMS's Session
中国卫生政策和管理协会（海外）活动

A CHPAMS session was held on the evening of August 5th in a conference room in Jinxi Hotel with over 50 members and guests. This event was organized by the CHPAMS planning committee and graciously facilitated by Zhejiang University School of Medicine. The meeting started around 7:30PM. With the presence of many new CHPAMS members, Dr. Zhuo Chen and Dr. Shufang Zhang, the lead members of the planning committee, introduced the mission and objectives of CHPAMS. Roman Xu, Director of the CMB Beijing Office, further elaborated on the origin, history and development of CHPAMS. As senior researchers, Professor YU Hai from Zhejiang University and Professor HU Shanlian from Fudan University both shared their thoughts with regard to the future of CHPAMS and the expectations of young scholars.

Next, several faculty members introduced their research institutions in China and present potential job opportunities for CHPAMS members. Professor LING Li introduced the Center for Migration Health in the Sun Yat Sen University. Faculty members from the Sichuan University also introduced

their center on health policy. Professor DONG Hengjing introduced the Center for Health Policy at Zhejiang University School of Medicine. All of them in their speeches sent out warm invitations to young scholars for collaboration.

Afterwards, all participating CHPAMS members were invited to introduce themselves. Hao Jing hosted the self-introductory session. The introduction was accompanied by slides with biographical information of each member. During self-introduction, many members also expressed sincere gratitude towards the CMB and Zhejiang University School of Medicine for building such an amazing platform to facilitate the network and self-development of young scholars in Health Policy and Systems Science (HPSS). Dr. Xiaohui Hou from the World Bank was originally invited to give a presentation on impact evaluation, but had to cancel it because of prolonged and enthusiastic communication among session participants. Dr. Hou has kindly agreed to share the presentation with those interested. The heated discussion and networking continued after the formal meeting was over, and many CHPAMS members stayed until after 10PM.

8 月 5 日晚，CHPAMS 活动于金溪山庄会议室举行，超过 50 名 CHPAMS 会员与客人参与了此次活动。这一活动由 CHPAMS 策划委员会组织，得到了浙江大学医学院的大力支持。活动于晚上 7 点半开始。陈茁博士和张术芳博士作为策划委员会的领导者介绍了 CHPAMS 的主旨与目标。随后，美国中华医学基金会北京办事处的徐东主任介绍了 CHPAMS 的来源、历史以及发展。作为资深研究人员，浙江大学的余海教授、复旦大学的胡善联教授分享了他们对 CHPAMS 未来发展的思索以及对年青学者的期望。

接着，一些中国研究机构的工作人员介绍了他们的单位，并向 CHPAMS 会员介绍了他们单位的工作机会。凌莉教授介绍了中山大学流动人口研究中心。四川大学的几名工作人员也介绍了他们的卫生政策研究中心。另外，董恒进教授介绍了浙江大学卫生政策与管理中心。在他们的讲话中，他们都向 CHPAMS 的年青成员发出了热情的合作邀请。

随后，来自 CHPAMS 的郝静主持自我介绍环节。每位 CHPAMS 成员都准备了一张介绍自己的幻灯片，所有 CHPAMS 成员受邀自我介绍。在自我介绍环节，很多成员都表达了对 CMB 以及浙江大学医学院举办此次青年论坛的感激之情，感谢这次论坛作为一个神奇的论坛促进了卫生政策与卫生系统科学领域的年青学者的交流与发展。来自世界银行的侯晓辉博士原本受邀汇报影响评价，但最终由于与会人员的热情讨论与交流而不得不取消。侯博士友善地允诺与感兴趣的人员分享她准备的幻灯片。正式活动结束后，讨论与交流继续，活动持续到晚上 10 点以后。

3. **Summary**

结语

The Westlake Youth Forum is the culmination of the persistent effort of the CMB, Zhejiang University School of Medicine, CHPAMS and many leading institutions to cultivate the next generation of researchers and policy leaders on China's healthcare delivery system. It brings young scholars to the forefront of academic and policy debate by providing them with a unique opportunity to showcase their work and learn from each other. As an integral part of the forum, the CHPAMS session further allowed many young scholars in HPSS, especially those from abroad to better communicate and network with their peers. The community established by CHPAMS for young scholars are likely to exert profound impact on their career development, and on the future improvement of China's healthcare delivery system.

西湖青年论坛是美国中华医学基金会, 浙江大学医学院，CHPAMS 以及许多领军研究机构不懈努力培养中国卫生系统下一代研究人员与政策领军人物的结晶。它把年青学者带到了学者与政策论战的前沿，为他们提供了展示自己及向彼此学习的独特平台。作为论坛的一个组成部分，CHPAMS 活动为卫生政策及卫生系统科学领域的年青学者，尤其是来自海外的年青学者进一步提供了沟通的平台。CHPAMS 为年青学者建立的社区很有可能对他们的职业发展产生深远影响，进而在将来改善中国卫生系统。

ABOUT CHPAMS: MEMBERS' UPDATES

CAREER AND PROFESSIONAL APPOINTMENT

Xuesong Han, Ph.D., Research Assistant Professor and Marilyn Gentry Fellow in the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill, joined the American Cancer Society as a Senior Epidemiologist in September, 2012.

Lu Shi, Ph.D., Research Scientist with the School of Public Health, UCLA where he focused on prevention and early detection of chronic diseases, joined the Department of Public Health Sciences at Clemson University as an Assistant Professor with tenure-track in September 2012. At Clemson University, Dr. Shi's research focuses on modeling and cognitive/behavioral economics. He also teaches hospital operations management and research methods.

NEWS AND ANNOUNCMENTS

JOB ANNOUNCEMENT

DIRECTOR, WEST CHINA RESEARCH CENTER FOR RURAL HEALTH DEVELOPMENT

Title: Director (Academic leader)
Section: Full-Time Academic (Permanent, Tenure Track or Tenured)
Location: Chengdu, Sichuan, China
JEL Classification: I -- Health, Education, and Welfare
Salary Range: RMB150,000-RMB500,000

Department Background

Based in Sichuan University, a leading comprehensive University in Western China, the Center was established in 2010 supported by the China Medical Board and the University. In its next-step development plan, the Center will target health inequity issues in rural Western China through multidisciplinary research collaboration, and will focus on capacity building of young researchers in the field of Health Policy and Systems Sciences (HPSS) through project oriented training and research.

Job Summary

Reporting to the Executive Vice President of Sichuan University, the Center's academic leader is responsible for the administration, development, coordination and delivery of all activities particular to the Center. S/he works with the Center's academic committee members to advise and guide on the Center's strategic development whilst actively promoting awareness of the Center within the international health research community.

Please visit our website (http://wcums.scu.edu.cn/news_en.asp?ID=139) for more information about this position.

Application Instructions:

Interested applicants should send a letter for application, enclosed a CV, selected publications, a statement of current and future research interests, and three names of referees through email to: hpc.scu@gmail.com; oip@scu.edu.cn. If the applicants are shortlisted for this vacancy, we will arrange the interview as soon as possible.

CONFERENCE ANNOUNCEMENT

THE SECOND CHINA-U.S. HEALTH SUMMIT

The Second China-U.S. Health Summit (www.hci-bj.org), co-hosted by Harvard School of Public Health, Peking Union Medical College and Tsinghua School of Public Policy and Management, will be held on October 31, 2012 at China National Convention Center in Beijing. Themed "Healthcare Reforms: Balancing Roles of Government, Market and Professionalism", Minister CHEN Zhu of Ministry of Health of China and Mr. SUN Zhigang, Vice Chairman of National Development and Reform Commission (国家发展和改革委员会) and Director of the National Coordinator of Health Care Reform of China (深化医药卫生体制改革工作领导小组办公室), will attend the 2012 summit along with many leading Chinese health policy makers, experts, industry leaders and their counterparts in the U.S. and beyond to share and discuss important perspectives and experiences.