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 4 Issue 4, December 2013

TABLE OF CONTENTS

CHPAMS

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.

ISSN 2325-1557 (Print)
ISSN2325-1549 (Online)

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).

Publisher:
The China Health Policy and Management Society

Address:
P.O. Box 1832, Tucker, GA 30085, USA

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

China Health Review

Volume 4 Issue 4, December 2013

EDITORIAL INTRODUCTION

The December 2013 issue of China Health Review includes an interview with **Dr. WANG Yu** (Director, Chinese Center for Disease Control and Prevention), a perspective article by **Dr. Neil Lunt** and **Prof. Ki Nam Jin**, and a special interview with **Professor Hengjin Dong**.

In the *Interview* section, **Dr. Wang Yu**, director of China CDC, recounts his education and career path, shares his views of China CDC's achievements in the last decade, as well as CDC's mid-term and long-term goals. Dr. Wang also discusses the impact of China's Healthcare Reform on public health, prevention strategy for chronic diseases, and China CDC's major international collaborative projects.

In the *Perspective* section, **Dr. Neil Lunt and Prof. Ki Nam Jin** discuss the drivers, size and scope of medical tourism. They describe the experiences from Korea and UK to showcase commonalities and distinctions of medical tourism treatments and their destinations. The authors also illustrate payment mechanism, potential challenges, and China's current medical tourism to Korea.

In the *Special Interview* section, **Professor Hengjin Dong**, Associate Editor of BMC Health Services Research and member of the editorial board of Pharmacoeconomics, provides a brief summary of the scope and focus of BMC Health Services Research and its manuscript reviewing process. He also offers his thoughts and suggestions to researchers from China.

Research Twitter provides *brief summaries of* articles with topics spanning from occupational exposure to magnetic fields, dietary intake and coronary heart disease, impact of government control on public hospitals on healthcare supply, health insurance reform in rural china, latent tuberculosis infection, impact of National Essential Medicines Policy on prescribing behaviors, engaging sub-national governments in addressing health equities, perinatal risk factors for young adults' suicide, alcohol use and respiratory disease, workplace capital and smoking, to metabolic syndrome.

Policy Practice and Updates includes six updates concerning topics including private funding of the elder care service industry, evaluation of county-level pilot sites for public health reform, pilot sites for using New Rural Cooperative fund to cover catastrophic illness insurance, health cooperative agreement between Hebei and Beijing, rural Anhui residents' access to inpatient care outside Anhui, and national and provincial pilot Information systems for New Rural Cooperative Medical Scheme.

In *About CHPAMS*, we introduce to you recent career and professional updates for **Prof. Youfa Wang** and **Prof. Xi Chen,** and recent publications lead-authored by CHPAMS members.

We wish you a prosperous New Year in 2014! Enjoy Reading!

导读：

2013 年 12 月刊《中国卫生评论》除常规栏目外，还包括中国国家疾控中心主任**王宇博士**的访谈， **Neil Lunt 博士**和**秦基南博士**的观点文章， 以及对**董恒进教授**的专访。

在*访谈*部分，中国国家疾控中心主任**王宇博士**讲述了他早年的教育和工作经历，以及在中国疾控中心度过的十年。王宇博士分享了过去十年间中国疾控中心取得的成就，以及未来发展的中期和长期目标。此外，王宇博士还介绍了中国医疗改革对公共卫生的影响、中国慢病防治战略，以及中国国家疾控中心的重点国际合作项目。

在*观点文章*部分，**Neil Lunt 博士**和**秦基南博士**讨论了医疗旅游业的医疗旅游的驱动来源、规模和服务范围。作者通过韩国和英国的相关经验，阐述了多样化的医疗旅游业及其所在地的共性和区别。此外，作者还介绍了医疗旅游业的付费机制、潜在的挑战和中国目前的医疗旅游业现状。

在*专访*栏目，《BMC 卫生服务研究》副主编、《药物经济学》编辑委员会成员**董恒进教授**讲述了《BMC 卫生服务研究》的刊物特点和审稿流程，并向中国的作者和研究人员提供了他的观点和建议。

在*研究动态*部分，我们提供了 11 篇最新的文章的简介。其主题包括：工作环境中的磁场暴露、膳食摄入与冠心病、政府对公立医院的控制对医疗供给的影响，中国农村医保改革、潜伏结核感染、国家基本药物政策对药品消费行为的影响、地方政府参与解决医疗公正问题、围产期危险因素与年轻人自杀行为、饮酒与呼吸系统疾病、职场社会资本与吸烟行文，以及代谢综合症。

*政策与新闻*栏目提供了包括民资进入养老服务业将获扶持、县级公立医院改革试点评估、新农合基金购买大病保险试点、河北与北京签署卫生合作协议、安徽农民省外定点医院住院政策、国家新农合信息平台试点等 6 个方面的最新消息。

在 *CHPAMS 之声*栏目，我们向您介绍**王友发教授**和**陈希教授**的近期工作和学术活动信息，以及 CHPAMS 成员近期发表的文章。

谨祝 2014 新年快乐！

阅读愉快！

INTERVIEW

Interview with Dr. WANG Yu (Director, Chinese Center for Disease Control and Prevention)

王宇博士(中国疾病与预防控制中心主任)

By *Dr. Chiu-fang Chou*
周秋芳博士

Dr. Wang Yu

Dr. WANG Yu graduated from Beijing Medical University in 1982. He continued onto his graduate study at the Institute of Hepatology, Beijing Medical University from 1983 to 1989 and received his Master's and Doctorate of Medicine during this period. From 1991 to 1993, he studied at the Jichi Medical School in Japan and received a Ph.D. degree in Preventive Medicine. In 1999, He completed Master of Business Economics program from the Chinese Academy of Social Sciences. Starting in 1985, he had been an assistant professor, associate professor, professor, deputy director and director of the Institute of Hepatology in Beijing Medical University, specializing on hepatology and viral molecular biology. Dr. Wang had participated in and chaired a number of national scientific and technological projects and programs, such as the Natural Science Foundation of China. He served as a committee member of the Chinese Medical Association and vice chairman of the Medical Virology Branch of the Chinese Medical Association. Since 1996, he had served as the Executive Vice-Director and Director of the Office of Scientific Research in Beijing Medical University, and Deputy Dean, School of Medicine, Peking University. From 2000 to 2003, he was appointed Deputy Director of the Center for Biological Engineering and Development, China Ministry of Science and Technology. From 2003 to 2004, he was Deputy Director of the Office of Rural and Social Development at the Ministry of Science and Technology. In June 2004, he was appointed as the Director of Chinese Center for Disease Control and Prevention under the Ministry of Health, China.

Dr. Wang was invited to have a phone interview with the China Health Policy and Management Society in August. The interview was conducted by Dr. Chiu-fang Chou on September 8, 2012. Drs. Zhuo (Adam) Chen and Zheng Li from CHPAMS also participated in the interview. CHPAMS acknowledges help from Ms. Doris Wang, Mr. Lin Wang, and Ms. Xuhong Ding in facilitating the interview.

王宇博士 1982 年毕业于北京医科大学基础医学系，1983 年至 1989 年北京医科大学肝病研究所攻读研究生，获医学硕士、博士(MD) 学位。1991 年至 1993 年日本自治医科大学预防生态学系留学，获理学博士学位（Ph.D）。1997 年至 1999 年中国社会科学院研究生院商业经济硕士结业。1985 年起北京医科大学肝病研究所助理研究员、副研究员、研究员、副所长、所长。学术专业为内科肝病，病毒分子生物学。自"六五"计划起，先后参加和主持多项国家科技攻关、"863"、"973"及自然科学基金、北京市重大科技项目。学术兼职中华医学会理事会学术工作委员会委员，中华医学会医学病毒学分会副主任委员等。1996 年起先后任北京医科大学科研处常务副处长、处长、副校长，北京大学医学部副主任。2000 年至 2003 年任科技部中国生物工程开发中心副主任。2003 年至 2004 年任科技部农村与社会发展司副司长。2004 年 6 月任卫生部中国疾病预防控制中心主任。

王宇主任应邀于 2012 年九月八日和中国卫生政策与管理学会周秋芳博士进行了电话访谈。陈茁博士及李峥博士也参与了访谈。中国卫生政策与管理学会感谢王晓琪女士， 王林主任，及丁旭虹女士协助安排访谈。

1. Education and Work Experience
教育和工作经历

Chiu-fang: What made you choose medicine as your career, and why did you select hepatology as your specialty?

周秋芳博士：您在 1989 年取得北京医科大学的博士学位，是什么原因促使您选择医学作为自己的职业?另外在各学科中您为什么选取肝病做为研究方向?

Dr. Wang: After graduated from high school, I worked for three years at a printing factory, because of the social structure at the time. In the first year when China resumed the College Entrance Examination, I took the exam and was accepted into the Beijing Medical University (now Peking University Health Science Center), thanks to my high school teachers for my solid academic foundation. I chose medicine as my career because of the influence from the society and idealism, and also because I had always been interested in health, health care, medicine and traditional Chinese medicine. Therefore, stepping out of a printing factory, I became a college student in a medical school.

After a few years in the medical school, I chose hepatology as my specialty again because of needs of the society and the profession. Hepatitis was a big problem in China at that time. In addition, I was very interested in immunology when I was in Beijing Medical University, and I recognized the importance of immunity in regulating human body's functioning, so I decided to focus my research on hepatitis virus.

王宇主任：因时代背景的关系，我当时是作为一位印刷工厂的工人考进大学的。我在印刷工厂工作不到三年时，国家恢复第一届高考。感谢高中老师的教导， 我没有忘记高中学的基础，所以我顺利被北医大(现北大医学部)录取。 选择医学是因为社会及理想主义的影响，又是因为喜爱健康，医疗，医学及中医。因此我从一位社会工人变成了医学系的大学生。

选择肝病做为研究领域，也是基于社会因素及专业学习需要的原因。 当时肝炎是中国的一大问题。 另外，我大学期间对免疫学很有兴趣，认识到免疫功能对调节人体的重要性，所以我就选择了进行肝炎病毒的研究。

Chiu-fang: After graduation, how did you find the opportunity to study abroad in Japan? While studying in the Jichi Medical School from 1991 to 1993, how did you adapt to the life as an overseas student? How did the several years of overseas study in Japan influence your career and life?

周秋芳博士：毕业之后您是如何争取到到日本留学的机会?在 1991 年至 1993 年在日本自治医科大学预防生态学系留学期间，您是怎么适应当时的海外学生生活?这几年的日本留学期间对您今后的职业生涯及人生有哪些影响?

Dr. Wang: China and Japan have a long and active history of medical exchange. My professor specializing in liver disease prevention was in close contact with his Japanese academic peers at the time, so I had many communications with Japanese experts when I was in graduate school. Plus China provided scholarship for studying abroad in many different countries, such as Japan, the United States, Australia and others, so I went to study in Japan with the support from the Chinese government.

Three years of study in Japan had a profound influence on me. At that time, there were few students from China and other Asian countries in the school, and professors had very good relationship with students. I got to know Japanese people, culture and society, in addition to Japanese language, which I think is better than my English. I also learned Japanese's attitudes towards study and research, witnessed their rigorous and serious demeanor, and recognized their hardworking and spirit of self-reliance. I worked in the lab for 365 days a year without a break, and only one or two days of rest in the New Year holiday break. Everyone was working around the clock in the lab, and our self-study and rigorous attitudes manifested in my academic research and in my life. I also completed a doctorate within a short period of time, and this experience led to my rigorous attitude towards work and scientific research.

王宇主任：在医学交流上，中日有很长的历史且非常活跃。 当时肝病防治的老师与日本有很好的关係，在学习的过程中与日本专家的交流接触很多。在加上当时国家支持公费留学到不同的国家如日本，美国，澳大利亚等地方留学，所以我以公费留学生的身份去日本留学。

当时在日本留学时，学校里的大陆及亚洲学生很少，所以教授们与同学的关係都很好。同学也都溶入了当地的生活习惯及工作学习态度。在日本的三年留学期间对我的影响很大。在日本社会中与日本人接触较多，对他们的社会基础瞭解也较多。 我觉得我的日语能力较英文能力好。 我在日本也瞭解到日本人的学习工作态度，也看到他们处事的严谨， 严肃的态度， 更认识到他们刻苦自力的精神。当时我在实验室中，365 天是没有休息的，只有在新年中休息一或二天。 大家都是日以继夜在实验室中工作，大家的自学及严谨的态度都表现在研究学术及生活上。我也在短短的时间内完成了博士学位，这段经历也造成日后我在工作态度及科学精神上的严格要求。

Chiu-fang: Can you talk about how you felt when you took over as the director of the China CDC in 2004?

周秋芳博士：可不可以谈谈您在 2004 当时接任中国 CDC 主任的心情?

Dr. Wang: At that time, I did not have any preparation in my mind at all because I was appointed to that position. After taking on the duty, I realized that it was a huge challenge as I could not expect what would be happening later on. Prior to this, I had been working on biochemical research development, and I had not managed on a macro scale, so it was a challenge. However, it was very helpful with the trust from the leadership and support from colleagues at the China CDC and those from the provincial, city and county CDCs. We often say that "the CDCs in the whole world are a family", because our work needs everyone's cooperation, which is different from the work in the hospital. Eight to ten years of work experiences at the China CDC, for me, are very meaningful, because I followed the development of the country and contributed to China's public health.

王宇主任：当时因工作关系由组织决定，我没有任何的思想准备。接下这个工作后，我觉得这是一个巨大的挑战，因为不知道接下后会成什么样。由于我在此之前一直是作生化研究研发，没有作过如此大的宏观的群体工作，当时觉得是挑战。但领导的信任及国家疾控中心及省市县同行的支持对我的工作帮助很大。我们常说"天下疾控是一家" ，因为我们的工作需要大家的合作，这与医院的工作是不同的。这八到十年多的工作对我来讲是非常有意义的，因为我跟着国家的发展作公共卫生的工作。

2. The decade at China CDC
疾控十年

Chiu-fang: 2012 is the tenth anniversary since China Center for Disease Control and Prevention was officially established. The accomplishments of China CDC are widely recognized. What do you think are the most outstanding achievements in the past decade and what should be the focus of future development?

周秋芳博士：2012 年是中国疾病预防控制中心正式组建成立十週年庆，中国疾病预防控制工作绩效显著是有目共睹，您认为过去十年中突出的成就和发展的重点工作是什么？

Dr. Wang: This is an important question. The basic characteristic of the China CDC is the renewed focus of "Prevention First", which is what the Chinese government has been advocating. During the emergency of the SARS epidemic, the importance of China CDC was abruptly raised to a new level. During the past decade, disease prevention and public health have received significant support from the Chinese government and especially, have been recognized by the society and the public.

After the establishment of the People's Republic of China, we used to have a good prevention framework. Unfortunately, it was weakened and ignored during the rapid development of the economic and social system. During the SARS epidemic, disease prevention demonstrated its importance. Chinese people realized that public health is closely related to the basic social structure and function, and that the defense of public health is one of the most basic conditions for the protection of the people. With such understanding, we received consensus and attention from the nation, provinces, cities and counties, so our prevention efforts can be successfully implemented.

王宇主任：这是一个重要的问题，中国 CDC 的基本特点是中国政府一直倡导的以预防为主的延续。中国 CDC 在非典的紧急情况下在原来的水平上一下子跃升到更大的层面。这十年来的疾病防治控制及公共卫生健康上得到政府高度重视与支持，特别是得到社会的认可及共识。

自建国以来，我们有过很好的防疫工作，但在经济及社会快速发展下，这体系被淡忘和忽略。在非典期间，防疫又体现出它的重要性。这让大家认识到社会最基本的结构及功能与民众健康息息相关，保卫健康是保障人民最基本的条件之一。 有此认识后，我们得到了国家，省，市及县的共识与重视， 所以工作能顺利开展。

Chiu-fang: What are the mid-term and long-term goals of the China CDC? How to achieve these goals?

周秋芳博士：未来中国疾病预防控制中心正的中期和长期目标是什么？将如何实现这些目标呢？

Dr. Wang: Ten-year is a long time for most people; however, from the perspective of social development, it is a very short period of time. During the past decade, in my opinion, we have built a basic public health framework, and we have only positioned disease control and prevention and public health in the government's public service system. The public have had a preliminary understanding towards our disease prevention and control institutions, for example, people recognize that specific infectious diseases, emergencies and chronic disease prevention and control should be handled by the CDC.

Next, we will need to focus on standardizing and continuously improving the public health system. Despite of the platform developed in the last decade, the disease prevention and control system in China still lacks standardization and systematization, compared with that of clinical medicine, which has hundreds of years of history and has developed into a standardized systematic discipline. In contrast, our disease prevention and control system has a long way to go on aspects like framework, infrastructure, mechanism, implementation, as well as the human resource development and distribution. Now that we have already known public health's social function and social positioning, how to make it a more perfect system is what China CDC will focus on in the next period.

王宇主任：人们通常认为十年是很长的时间，但从社会发展角度来看，十年是一段很短的时间。过去十年，依我看来我们搭起了基本框架，疾病防治及公共卫生在政府公共服务体系里的定位才刚成型。大家对疾病预防控制的机构有了初步的认识，社会上达到了一定的共识，比如说专业的传染病，突发事件及慢性病的防治都是由疾病控制队伍来处理。

接下来，最重要的是对体系进行规范化的建设，继续发展提高中国的实力。中国 CDC 虽有十年的发展平台，但疾病预防控制体系与临床医学来比较，从规范化到系统化，都差得很远。临床医学在世界上已有几百年的历史，也成为规范体系，很有系统。 但疾病预防控制体系在框架上，机制上，运行上，定位上，包括人力资源队伍的建设和配置，都与临床医学差得很远。现在我们已经知道它的社会功能及社会定位，但怎样让它成为更加完善的体系是中国 CDC 接下来要作的事。

Chiu-fang: What are the major international collaborative projects of Chinese CDC? Are there any collaborative or exchange projects with disease control agencies in other countries (such as the U.S. CDC)?

周秋芳博士：中国的 CDC 与国际合作的重大合作项目有那些？中国 CDC 和其他国家疾病控制部门（如美国 CDC）未来有什么合作交流项目？

Dr. Wang: Global health is the health issues and challenges need to be addressed by the entire world, which requires global cooperation. Infectious disease has no borders. Chronic disease prevention also requires global collaboration. On the other hand, in recent decades, China has had many great public health accomplishments with a modest investment, a huge population and an under-developed economy. China's experience could be adapted by other developing countries for their use. Globalized and undergoing reform, China should actively consider, explore and implement the appropriate means to introduce our experience to other developing countries, such as on vaccination and cholera prevention. Many diseases are under well control in China, but outbreaks still occur in other development countries, so we can provide our success stories for them.

In addition, the Chinese experts of disease prevention should also gain more global experience. We must step outside to understand the international public health, and get a better knowledge of the current development of public health and prevention in other countries. Only participating in international conferences and regular research is not enough to understand the social system and disease prevention in other countries, and the common international practices. If we don't understand the practices, it's impossible for us to communicate and discuss with experts from other countries. The US CDC has 9,000 to 10,000 employees and contractors, many of them have working experience in developing countries, ranging from one year to as many as eight years. And many experts stationed in China CDC from U.S. CDC have the same qualification.

In contrast, many of our experts had no experience working in the developing world until last year. Hence we should be more active in addressing globalization. Since last year (2011), we have collaborated with the World Health Organization, the U.S. CDC to send disease prevention experts to help Ethiopia and Namibia with planned immunization. Since the second half of last year (2011) until this year (2012), we have two groups of experts in Pakistan developing a program of immunization, with 10 experts from the China CDC and provincial CDCs implementing projects with the WHO team across Pakistan. In addition, we have a group in Cambodia to help eradicate the enterovirus-71 infection, provide reagents for children Hand Foot Mouth Disease and teach local staff members to screen for the virus.

We are very actively participating in global health efforts; with frequent international exchanges. Our experts go abroad to attend international conferences, and foreign experts visit to China CDC on every basis. Each year, we have more than 300 groups leaving abroad for exchange and study, and more than two hundred groups of visiting foreign experts.

王宇主任：全球卫生是全球共同面对的健康问题及挑战，要全球共同面对解决。传染病是没有国界的，是向全世界传染的。慢性病也要全球共同来应对，这都是有全球的共识基础。 另一方面， 中国在近几十年中，在投入少， 面对众多人口及相对经济落后的条件下，取得出色且辉煌的公共卫生效果，中国很多很好的经验适合发展中国家借鉴。如何将此经验介绍给发展中国家是我们身为国际化改革开放的中国应该要积极考虑，探索及实施的，比如有效控制疫苗可控制疾病的蔓延，或採取公共措施防止某些特殊疾病，如霍乱。这些疾病在中国已控制得很好，但在其他国家仍时有爆发的情况，所以我们可以提供很好的经验给他们。

另外中国疾病预防专家也要国际化。我们要走出去了解国际公共卫生，更深入了解卫生预防的现况。仅限于参加国际学术会议和一般的调研考查是没有办法了解其它国家社会体系及疾病预防的状况，包括国际常用规则。 如果我们不了解国际规则及惯例，我们就没有办法与他们沟通，进行讨论了解。 美国 CDC 有 9 千人到上万职员。大部份专家都有在发展中国家工作的经验，少则一二年，多则七八年。 很多到中国 CDC 的美国 CDC 专家都有此经历。

相比之下，去年以前，我们的专家都没有在发展中国家待过的经验。所以我们也应该积极地面向国际。去年(2011)开始，我们与世界卫生组织，美国 CDC 联手向非洲国家派出疾病预防专家去帮助埃赛俄比亚及那米比亚开展关于计划免疫的工作。去年后半年(2011)及今年(2012) ，我们开始有两批专家去巴基斯坦去发展计划免疫的工作，目前从中国 CDC 及省 CDC 派出的 10 人在巴基斯坦各地与世卫专家的队伍开展各项的工作。另外，我们正有一个工作团去柬埔寨帮助他们消灭肠道病毒 71 型感染，为儿童手足口病提供试剂，并教导当地人员自己检测病毒。

我们非常活跃地参与国际卫生事务，中国 CDC 的国际交流非常繁忙。我们每天都有专家出国参加会议考察交流，也有境外专家到中国 CDC 来，每年有三百多团出境，有二百多团组入境。

3. China's Health Care Reform and Public Health
中国医疗改革与公共卫生

Chiu-fang: What impacts do you think that China's healthcare reform as well as the development of the healthcare sector during 12th Five-Year planning will have on China's public health?

周秋芳博士：您觉得中国已推出的医疗保健制度改革及中国"十二五"时期医疗卫生事业的改革发展对公共卫生有何影响?

Dr. Wang: There will be long-term impacts. Treatment and disease prevention are like two legs, which are equally important. After the SARS event, China paid great attention to public health and disease prevention, and the government had invested tens of billions to develop the

infrastructure of prevention. To advance the health care reform, the primary issue is to solve people's problem in accessing a doctor, so our current focus should be placed here. At the same time, we should not ignore the development of disease prevention and control system. We must understand that solving people's health issues doesn't rely on treatment, and medical resources should not be completely focused on a specific disease or terminal illness; part of health resources should be placed on the prevention and disease control, and health promotion.

王宇主任：这影响是长期的。临床治疗与疾病防制就像两条腿一样。非典之后， 公共卫生及疾病预防得到国家很大的重视，国家投入上百亿的资金建设体係。目前深化卫生医疗的改革，首要解决老百性的看病问题，所以目前重点应先放在这裡。 同时，在医疗卫生的改革中不能忽视疾病预防控制的建设，必须认识到解决国家群体公众的健康问题不能光靠临床医疗，也不能完全集中在某疾病或病晚期的花费医疗资源，而是应将部份卫生资源放在疾病的预防控制及健康促进上。

Chiu-fang: China is experiencing a rapid economic growth, and people's diet has changed a lot. China's dramatic increase in the number of people with chronic diseases has become a major threat to public health. Are there any prevention efforts by the Chinese CDC for this?

周秋芳博士：中国经济急速起飞，人民的饮食生活与以前大不同，中国慢性病发病人数快速上升已成为威胁人民健康的主要因素，中国 CDC 对此有什么防治工作?

Dr. Wang: This is a global problem. Although it appears to be simple, this question is brought up within the last 10 or 20 years and no solution is available yet. Most people believe that unhealthy habits or behaviors could be changed through health education or improvement of health knowledge. However, some case studies are disturbing. For example, the tobacco-controls issue. Tobacco control is not an issue concerning just knowledge, as 60% of Chinese male doctors smoke; they do not lack health knowledge. Another example is obesity in the United States. We all know that obesity is not good and leads to many chronic conditions, but still we can't solve this problem. Therefore, health education alone isn't enough to identify a good solution, and we should continue to explore the effective methods of chronic disease control.

王宇主任：这也是目前全球面临的问题，这问题看似简单，但此问题是近 10 几或 20 年才提出的， 目前尚未找到好的方式。大多数的人都认为可以透过健康教育或提升知识文化水平可以改变不健康的生活习惯及行为。但一些例子困扰了我们的看法。如控烟问题，控烟并不是知识文化水平的问题，在中国的男医生中，60%以上都吸烟，他们并没有知识文化水平的问题。另一个例子是美国的肥胖问题。大家都知道肥胖不好会带来很多慢性病，但仍解决不了这问题。 因此单靠健康教育不能找出好的解决之道，我们继续探索对慢性病有效的控制方式。

Chiu-fang: What do you think is the most significant achievement of China's public health surveillance system? Which aspects need improvement?

周秋芳博士：目前中国公共卫生监测系统您认为做得最好的是什么，需要继续努力的是哪方面？

Dr. Wang: After the SARS event, we found out that we had a problem with the ability of real time reporting of outbreak information. Over the past decade, we have established the Internet-based epidemic detection and reporting network covering the whole country. The network plays a great role in epidemics such as Avian flu and H1N1 outbreaks and sporadic breaks of other infectious diseases. As for AIDS, tuberculosis and cholera, the network is able to show the movement of infected population.

However, this system is based on an electronic spreadsheet rather than a true Internet technology. Our next step is to combine with the development health information system under the aegis of the healthcare reform; through linking hospitals' electronic medical records system, community health records and the public health infectious disease information with modern IT technology, the important health-related information can always be presented anywhere in the country in real time, so as to establish a real health information network.

王宇主任：在非典之后，我们发现我们有疾病讯息即时报告的问题，近十年来，我们成立了覆盖全国的因特网疫情发现及报告的传输系统。像禽流感，H1N1 或零星发生的传染病， 网络都能发挥很好的作用。 至于爱滋病， 结核病及霍乱等也能敏感地显出疫情发生的人群动向。

但这个体系是基于电子表格而不是真正 IT 技术。 我们下一步的计划是结合医疗体制改革的信息化建设，把医院的电子病历系统，社区的数据化健康档案和我们需要的公共卫生传染病讯息用现代的技术结合起来，将重要的健康相关讯息能实时在全国体现，从而成为一个真正的卫生信息网络。

Chiu-fang: Is it possible that China CDC share its data with academic institutions or other organizations?

周秋芳博士：有没有可能中国 CDC 与学术界或其它单位共享中国 CDC 的数据?

Dr. Wang: In China CDC, there are two kinds of data. One is the work-related data, which is confidential, and only for CDC internal use; the other is the epidemiologic data, which is publicized monthly by the Ministry of Health, and the specific data can be accessed. At present, domestic universities and academics have published many top-notch articles using these data.

王宇主任：中国 CDC 有两方面的数据，第一是工作需要数据，这些是不公开的，仅供 CDC 内部使用；第二种数据是疫情数据，卫生部每月都会公布疫情讯息，这是公开的，具体的数据都可得到的。目前国内的学校及学者已用这些数据发表了很多很好的文章。

Chiu-fang: In your opinion, what are the challenges that China's public health is facing?

周秋芳博士：您认为中国公共卫生目前面临的挑战是什么?

Dr. Wang: The biggest challenge is how to properly disseminate the evidence-based disease prevention and control to the public, because health is the prerequisite for the development of the society. We must combine the evidence-based medicine with the needs of the public.

王宇主任：最大的挑战是如何把循证的疾病预防控制方式可以正确地传播给我们广大的公众，因为健康的发展是社会发展的必须条件和前提，我们要做的是将循证医学正确方式与大众的需求结合起来。

4. Words to the China Health Policy and Management Society
寄语中国卫生政策和管理学会

Chiu-fang: the China Health Policy and Management Society is a rapidly growing professional organization. Do you have any advices or suggestions for us?

周秋芳博士：中国卫生政策和管理学会是一个迅速发展的专业社团。您对我们有任何期望与建议吗？

Dr. Wang: Health policy and management is a very promising field in China. The health problems of over 1.3 billion Chinese people represent the health needs of billions of people in the world's

developing countries. We are exploring on how to promote the health of the public -- a process requires a large number of talents to provide support concerning health policy and management. With lots of questions but few answers, we especially need people to actively participate to meet the demand accompanying the development of the society. Especially with rapid economic growth and social development, there will be a lot of profound social transformations, which will bring a series of changes. This process requires extensive research, demands us to recognize these changes. Hence, the work of CHPAMS is very meaningful, and I hope we can continue to collaborate at different levels and aspects in the future, and together we contribute to China's public health.

王宇主任：中国卫生政策与管理是一个非常有前景的学科。中国十三亿多人口的健康问题也代表全世界几十亿发展中国家健康需求问题，在如何促进全民健康这个问题上，我们仍在探索渠道及途径。 在这过程中需要大批人才提供卫生政策及管理方面的帮助等支持。 问题很多但目前解决问题的方法却很少，所以特别需要大家能积极参与解决这个大的社会发展需求。由其在这快速的经济社会发展的过程中，会有很多深刻的变革，这些变革会带来一系列的变化。这些过程需要很多的研究工作， 也需要去认识这些变化。 你们的工作是非常有意义，希望以后我们能在不同的层面及角度上继续合作，共同为中国的健康事业多做工作。

PERSPECTIVE

Developments in Medical Tourism
医疗旅游业的发展

By *Neil Lunt, PhD, MA; Ki Nam Jin, PhD.*[*]

Summary[**]

As a newly emerging pattern of consumption and production of healthcare services, medical tourism is featured with particular regional characteristics in the range of service for patients elect to travel across international borders with the intention of receiving medical treatment. From perspectives of globalization and supply consideration, this article illustrates the drives, size and scope of medical tourism. Experiences from Korea and UK are introduced to explain commonalities and distinctions of diverse medical tourism treatments and their destinations. In addition, the authors also illustrate payment mechanism, potential challenges and China's current medical tourism patterns.

作为一种新兴的医疗服务供给消费模式，医疗旅游的一大特点是为选择出境接受治疗的患者提供了富有地域特征的医疗服务项目。本文从全球性和医疗服务供给的角度出发，介绍了医疗旅游的驱动源、规模和服务范围。作者通过韩国和英国的相关经验，阐述了多样化的医疗旅游业及其所在地的共性和区别。此外，作者还介绍了医疗旅游业的付费机制、潜在的挑战和中国目前的医疗旅游业现状。

Background


Dr. Neil Lunt

Across the world there are newly emerging patterns of consumption and production of healthcare services. These arise from the global flows of patients and healthcare professionals (doctors, nurses and allied healthcare staff), medical technology, capital funding and regulatory regimes (standards and accreditation) across national borders.


Prof. Ki Nam Jin

Particular attention has been paid to flows of patients who are being treated outside of their national jurisdiction. Patients, it would appear, are on the move and so-called *medical tourism* is on the rise. Medical tourism may be defined as when patients elect to travel across international borders with the intention of receiving medical treatment. Included within the definition are a broad range of medical services and innovations: dental care, cosmetic surgery, elective surgery, fertility treatment, transplantation, and stem cell therapy.

---

[*] Dr Neil Lunt is a Reader in the Department of Social Policy and Social Work, University of York, UK. He was the lead on a national-funded study exploring the implications of medical tourism for the UK public health system, and has given invited talks on medical tourism to both the OECD and WHO. He is co-coordinator of the Social Policy East Asian eXchange (SPEAX) a York-based network of scholars who study East Asian policy. Dr. Lunt can be reached at neil.lunt@york.ac.uk. Professor Ki Nam Jin (秦基南) is a professor in the Department of Health Administration, Yonsei University, South Korea. His major field of interest is medical sociology. He has undertaken several government-sponsored projects on promoting medical tourism in Korea. He leads a project developing wellness tourism products for ski resorts hosting the 2018 Winter Olympics. He was also involved in establishing a national credentialing system for medical tourism coordinators. Professor Jin can be reached at jinkn@yonsei.ac.kr. The collaboration between Dr Neil Lunt and Professor Ki Nam Jin is supported under the British Academy International Partnership and Mobility Scheme - IPM 2012, with an award for 'East Asian and European insights on global medical travel' (2012-13).

** The bilingual summary is provided by Zongshuan Duan, CHR editorial assistant.

Setting the boundary of what is health and counts as medical tourism is not straightforward. For example, cosmetic surgery for aesthetic rather than reconstructive reasons would be considered outside the health boundary under OECD definitions for the purposes of trade accounts (OECD, 2010, pp. 30-31). Similarly, stem cell therapies are distinguished from stem cell *treatments* when there is lack of clinical efficacy data and supporting evidence.

Medical tourism in some European settings is related to the broader notion of health tourism which, in some countries, has longstanding historical antecedents of spa towns and coastal localities, and other therapeutic landscapes. In countries such as Hungary this strong wellness tourism tradition continues alongside the development of medical treatments and interventions. Within a number of Asian settings, Oriental medicine is a major specialty that is offered. Clearly, the range of services sought and offered has a particular regional texture and as research scholarship develops it is beginning to understand far more the commonalities and distinctions of diverse medical tourism treatments and their destinations.

The size and scope of medical tourism

Some places may be simultaneously acting as countries of origin and destination in a medical tourism marketplace. High-income countries may treat overseas elites whilst at the same time their citizens choose to travel as medical tourists to Lower and Middle Income Countries for treatments. Thus, Harley Street in the UK and facilities including the Mayo and Cleveland Clinics in the United States have longstanding reputations in the international provision of healthcare. But UK and US patients themselves travel outwards for treatments subject to a range of push and pull considerations.

Drivers of medical tourism include dimensions of globalisation – economic, social, cultural and technological. Many domestic health systems are undergoing significant challenges and strain – heightened expectations, tightened eligibility criteria, waiting lists, and shifting priorities for health care may all contribute. The role of Information Technology in promoting new products and information, as well as greater availability of air travel and travel visas are also significant. Medical tourists may be diaspora or second-generation migrants, and liable to travel back to countries where there are historical, cultural and familial connections. Familiarity, availability, price, quality and legality may thus all be factors within complex decision-making frames of medical tourists.

There are also supply considerations. For example, as economic growth slows in western industrialised countries and austerity bites, public and private healthcare organisations are seeking additional income from a range of sources, including international patients. A range of national policy characteristics will shape the involvement of domestic healthcare providers in delivering treatments to medical tourists including:

- *the regulatory framework (including the lack of one)* which may present constraints on the services that may be offered to inward patients;
- *state and regional support for the development of medical tourism;*
- *professional bodies' support and involvement within medical tourism;*
- *the structure of health care provision (e.g. sole practitioner practices; entrepreneurial approaches and less socialized approaches to medicine);*
- *cultural and ethical standpoints of providers on offering particular treatments*; some providers may be prepared to offer treatments that are more risky, or to place different emphasis on the ethical issues involved;
- *economic position, exchange rate and comparative advantage*;

- *health care reform and existing capacity within systems* will dictate, to a large extent, whether providers will engage in treating overseas patients;
- *the role of national/international quality frameworks may shape the way in which* countries engage;
- *the willingness of professionals to treat individuals who lie out with safety guidelines and normal professional criteria (age, weight, medical history).* Thus, are particular treatments offered that would not routinely be offered by providers in the same country or in overseas countries? (Lunt et al., 2013a)

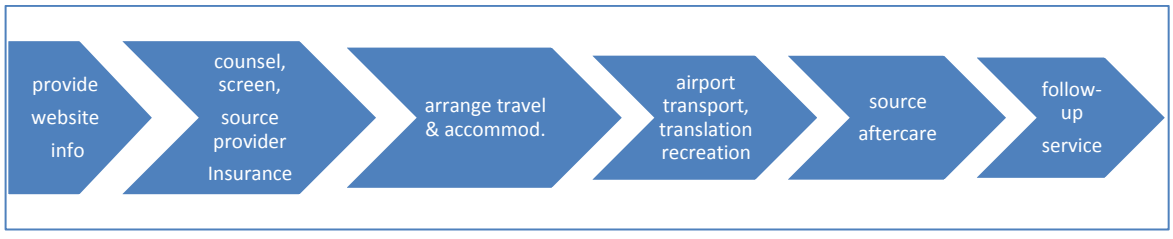
Despite the global push for many countries to offer both high-end and/or relatively low-cost treatments, we currently know very little about many of the key features of medical tourism. There are no authoritative data on the number and flow of medical tourists between nations and continents. So although there is broad agreement that the medical tourism industry has grown significantly over the past decade, there is wide speculation on its actual size. The Deloitte management consultancy for example suggested a figure that has been regularly reproduced in the literature, that total worldwide figures lie somewhere between 30 and 50 million medical tourists travelling for treatment each year (Ehrbeck et al., 2008). Even where commentators avoid placing a figure on the number of medical tourists, the frequent citation of medical tourism as a $60bn industry can be traced back to Deloitte's report (MacReady, 2007; Crone, 2008; Keckley and Underwood, 2008; for criticism see Connell, 2013 and Lunt et al., 2013b).

Medical tourist destinations differ in how much they openly promote the cultural, heritage and recreational opportunities. It is likely that for some treatments the vacation and convalescence functions will be more marginal, for others it could be a more significant component of consumer decision-making. The reputation of places as highly customer-focused service providers is also a prevalent focus of advertising. An emphasis on marketing services as high technology and high quality is common, as well as identifying clinicians that have overseas experience (training, employment, registration).

The experiences of Korea and the UK

Medical tourism as an emerging global industry has a range of commercial interests including health care providers, website providers, brokers and facilitators, accommodation, and conference and media services (See Figure 1). A range of national government agencies are also involved and policy initiatives have sought to stimulate and promote medical tourism in their countries (these include countries as diverse as Korea and the UK). Within Asia (for example, Thailand, India, Singapore, Malaysia), Europe (including Hungary and Poland) and beyond, governments promote their comparative advantage as medical tourism destinations at large international trade fairs, via advertising within the overseas press, and official support for activities as part of their economic development and tourism policy (see Lunt et al., 2011; Reisman, 2010).

Figure 1: Medical Tourism Pathways



Faced with global economic recession and an aging population, the Korean Government sought to find ways to boost the economy and after 2009 the Korean Government allowed hospitals/clinics to fully market health services to foreign patients. The process of promoting the medical tourism industry was expected to generate job opportunities and be a new growth engine for economic development. To this end a medical visa was also adopted (Yu and Ko, 2012; Kim et al., 2013).

The actual development and delivery of medical tourism policy is undertaken by public organizations including Korea Health Industry Development Institute (KHIDI) and the Korea Tourism Organization. KHIDI, under the Ministry of Health and Welfare has two purposes: to improve the national health industry by providing comprehensive and professional support programmes; and second, to strengthen the competitiveness of the national health industry. Its department of international cooperation has five teams actively involved in promoting medical tourism (see also, Kim et al., 2013).

Domestically many Korean medical institutions and leading hospitals and clinics have supported the venture. Particularly, they sought to increase revenues by treating foreign patients, charging premiums far above domestic insurance rates. Participating providers hoped that treating foreign patients would bolster their domestic reputation for medical excellence, and there were anticipated benefits for improving service quality, because many medical institutions in Korea are accredited by Joint Commission International. Under Korean law, any medical institutions that intend to treat foreign patients are required to be registered by the Ministry of Health and Welfare. Within Korea, the percentage of medical institutions registered has increased from 2.6% to 3.6% between 2009 and 2011. Nearly 98% of tertiary hospitals are registered.

Table 1: Source country of medical tourists to Korea 2009-2011

Nation	2009	2010	2011	Average growth rate (%)
USA	13,976 (32.6%)	21,338 (32.4%)	27,529 (27.1%)	40.3
Japan	12,997 (30.3%)	11,035 (16.8%)	22,491 (22.1%)	31.5
China	4,725 (11.0%)	12,789 (19.4%)	19,222 (18.9%)	101.7
Russia	1,758 (4.1%)	5,098 (7.7%)	9,651 (9.5%)	134.3
Mongolia	850 (2.0%)	1,860 (2.8%)	3,266 (3.2%)	96.0
Source: Statistics on International Patients in Korea, 2011 (KHIDI)				

Within the UK, measures to support international activities of the public health system (to treat private international patients in parallel to public taxpayer funded UK patients) include NHS Global established in 2010, and the launch of the Healthcare UK Scheme in 2012 promoting wider health interests. Attempts to attract international patients must be placed in the wider context of countries offering a suite of expertise and services – consultancy, training, and education around health provider development and delivery.

How treatment is funded

Payment mechanisms for medical tourism funding are three-fold: outsourcing, insurance, and out of pocket.

- Outsourced patients
  Those are patients opting to be sent abroad by health agencies using cross-national purchasing agreements. Typically, these sorts of agreements are a short-term measure driven by long waiting lists and a lack of available specialists and specialist equipment in the home country. Middle-East countries including Kuwait, UAE and Saudi Arabia support patient to travel to countries in Europe including Germany and the UK. Plausibly, the health systems within source countries (including UK, Germany and the United States) could develop relations with off-shore medical tourism facilities to leverage cost savings – providing individuals with a choice of overseas destinations. This could also reduce waiting lists – and reflects a form of outsourcing or more 'collective' medical travel. However, even if opportunities for financial benefit exist and medical tourism is an option in a number of countries there are significant political objections and sensitivities. This for example helps explain why Medicaid and Medicare in the United States do not support patients travelling abroad for treatments despite arguments that doing so would deliver significant financial savings.

- Individual out-of-pocket payments for treatment
  People who want access to private treatment can afford it themselves, drawing on income, savings, loans, and family and community support.

- Insurance
  A potentially lucrative source of income is private and workplace health insurance systems. To date there has been relatively limited success by medical tourist providers in tapping these insurance revenue streams. Most insurance policies in the UK for example explicitly exempt overseas treatment, whilst standard policy exclusions include conception, cosmetic, reconstructive or weight loss treatment and dental/oral treatment. These are the sorts of treatments where evidence suggests patients then choose pay out of pocket, both domestically and abroad. Within the United States, examples of more institutionalised arrangements do exist but are rare. In 2009, following its achieving international accreditation, a hospital in Mexico arranged a deal with a US-based insurance group which enabled Blue Cross and Blue Shield members to utilise that hospital's services. Singapore is one example of a country that has allowed some portability with insurance.

Evidence base for medical tourism

Despite the huge amount of speculation and expectations around medical tourism hard evidence on many aspects is difficult to find (see Lunt and Carrera, 2010 for review). Alongside the dearth of empirical data is the tendency for discussions to be focussed on marketing and market growth, without being critical of assumptions. Fortunately this gap is beginning to be addressed and scholarship has encompassed discussion of North American (Crooks et al., 2010; Johnson and Garman, 2010), Australasian (Barrowman et al., 2010), Asian (NaRanong and NaRanong, 2011; Pocock and Phua, 2011; Wongkit and McKercher, 2013) and European contexts (Hanefeld, et al, 2013; Legido-Quigley at al., 2011). Within the UK, a national-funded study is soon to report on the implications of medical tourism for the NHS (see Lunt et al., 2013c)

Emerging challenges: clinical and programme levels

The policy, programme and clinical recommendations concerning medical tourism should be underpinned by broader understanding of trends, clinical implications, and wider system level implications

As well as patient motivations, decision-making, experience and satisfaction, this should include understanding of treatment outcomes. How patient information flows across national boundaries is an important question for the medical tourism industry, with continuity of care affected if patient records are not shared. Patients should receive appropriate information, advice and input at all stages of the caring process. This includes informed consent and advance warning that redress may be more difficult if treatment is received outside of country of residence. Whilst ethical and legal issues arise for all forms of medical care – informed consent, liability and legislating for clinical malpractice – these are intensified for medical tourism. 'Cosmetic tourism', 'fertility tourism', 'transplant tourism', to say nothing of recent developments in the areas of 'stem cell'-tourism' and 'euthanasia tourism', raise ever-more complex medico-legal and ethical questions.

Legal dilemmas for medical tourists include that pursuing a case overseas brings particular difficulties. Should complications arise during medical tourism, patients may not be covered by insurance or indemnity policies that are carried by the hospital, the surgeon or physician treating them, and they may have little recourse to local courts or medical boards. One reason US health care is so expensive is the size of malpractice premiums, an indication that US citizens are litigious and value their right to seek legal redress.

The public health aspects of medical tourism have not been adequately studied. Of significance is the potential for hazardous micro-organisms transferring between hospitals located in different parts of the world on the body of a medical tourist (Green, 2008; Lunt et al., 2012). These could include antimicrobial resistance, such as the potential for *Clostridium difficile*, VRSA, XDRTB, or a dangerous pathogen, such as SARS.

Given asymmetries of information in healthcare, patients place significant trust in training, qualifications, motivations and competence of health care professionals. When we step outside our national health system questions arise concerning robust clinical governance arrangements and quality assurance procedures in provider organisations, intended to safeguard the quality of care provided.

System level challenges

Countries seeking to develop medical travel earnings have options of growing their own health service (public and private) or inviting partnerships with large multinational players. Securing accreditation from international programmes may be a part of the development of services and an attempt to badge quality. Achieving partnerships with overseas hospitals and universities (e.g. Asian countries' relations with the American private sector), can fulfil a similar role. We need to know far more about these relationships across the globe.

Patients travelling to countries with developed healthcare systems raise important questions for comparative healthcare policy and management. Knowing more about revenue generation (health treatment and wider associated non-health income) and whether infrastructural investments and favourable spill-overs benefit local patients is important. Does trickle down of best practice occur and can we identify processes of technological transfer and surgical learning? Similarly, what is the impact on staff retention (international/internal brain retention and return) of such medical tourism activities (see Lunt et al., 2013a)?

The lack of data is problematic if countries are to keep fully informed about the significance (potential or actual) of medical tourism for their health systems. Mechanisms are needed that help us track the balance of trade around medical tourism on a regular basis – how many people travel,

where and for what? Currently, the evidence base is scant to enable us to assess winners and losers at the level of system, programme, organisation and treatment.

China

Turning to China: what is the emerging evidence about inward and outward flows? As an importer of medical tourists we know relatively little of the developments despite a number of institutions aiming to treat overseas patients. This knowledge base may develop with the establishment of the Shanghai International Medical Zones after 2015. Regarding outflows, some evidence is beginning to emerge, regarding relationships with Taiwan (Liu, 2012), Hong Kong (Ye et al., 2011) and Korea (KHIDI, 2011). There has been a steady growth of travellers to Korea from 4,725 in 2009 to 19,222 in 2011 (KHIDI, 2011). Over 70% of Chinese patients to Korea are women, and a large percentage is aged 20 to 39. China is first ranked in plastic surgery, where Chinese patients occupy nearly 59% of market share in Korea. The challenge is to build on this emerging scholarship more systematically and conceptually. Certainly, the future of medical tourism regionally – and perhaps globally – will involve an enlarged understanding of Chinese patient flows both inwards and outward, the benefits and drawbacks at the levels of individual, institution and system.

References

Barrowman RA, Grubor D, Chandu A. 2010. Dental implant tourism. *Australian Dental Journal* 55(4):441-5.

Connell J. 2013. Contemporary medical tourism: conceptualisation, culture and commodification. *Tourism Management* 34: 1-13.

Crone RK. 2008. Flat Medicine? Exploring Trends in the Globalization of Health Care. *Academic Medicine* 83: 117-121.

Crooks V, Kingsbury P, Snyder J, Johnston R. 2010. What is known about the patient's experience of medical tourism? A scoping review. *BMC Health Services Research* 10: 266.

Ehrbeck T, Guevara C, Mango PD. 2008. Mapping the Market for Medical Travel. *The McKinsey Quarterly* [Online]. Available: https://www.mckinseyquarterly.com/Mapping_the_market_for_travel_2134

Green ST. 2008. Medical tourism – a potential growth factor in infection medicine and public health. *The Journal of Infection* 57, 429.

Hanefeld J, Horsfall D, Lunt N, Smith R. 2013. Medical tourism: a cost or benefit to the NHS? *PLOS ONE*, August, doi: 10.1016/S0140-6736(13)61675-X.

Johnson TJ, Garman AN. 2010. Impact of medical travel on imports and exports of medical services. *Health Policy* 98: 171-177.

Keckley PH, Underwood HR. 2008. Medical Tourism: Consumers in Search of Value. Washington: Deloitte Center for Health Solutions.

KHIDI (Korea Health Industry Development Institute). 2011. Statistics on International Patients in Korea, Seoul: KHIDI (Korea Health Industry Development Institute).

Kim S, Lee J, Jung J. 2013. Assessment of medical tourism development in Korea for the achievement of competitive advantages. *Asia Pacific Journal of Tourism Research*. 18(5): 421-445

Legido-Quigley H, Passarani I, Knai C, Busse R, Palm W, Wismar M, McKee M. 2011. Cross-border healthcare in the European Union: clarifying patients' rights. *BMJ*. 342.

Liu I-C, 2012. The research of medical tourism policy network in Taiwan. *Sociology Mind* 2 (4): 458-464.

Lunt N, Carrera P. 2010. Medical tourism: assessing the evidence on treatment abroad. *Maturitas: An international journal of mid-life health* 66: 27-32.

Lunt N, Smith R, Exworthy M, Green ST, Horsfall D, Mannion R. 2011. *Medical tourism: treatments, markets and health system implications: A scoping review*. Paris: Directorate for Employment, Labour and Social Affairs, OECD.

Lunt N, Green ST, Mannion R, Horsfall D. 2012. Quality, safety and risk in medical tourism. In *Medical tourism: the ethics, regulation, and marketing of health mobility* Hall MC (ed); Routledge.

Lunt N, Mannion R, Exworthy M. 2013a. A framework for exploring the policy implications of UK medical tourism and international patient flows. *Social Policy & Administration* 47 (1): 1–25.

Lunt N, Hanefeld J, Smith RD, Exworthy M, Horsfall D, Mannion R. 2013b Market size, market share and market strategy: three myths of medical tourism, *Policy & Politics,* doi:10.1332/030557312X655918.

Lunt N, Smith RD, Mannion R, Green ST, Exworthy M, Hanefeld J, Horsfall D, Machin L, King H. 2013c. *Implications for the NHS of Inward and Outward Medical Tourism: a policy and economic analysis using literature review and mixed methods approaches.* Final Report to the National Institute for Health Research HSR Project: 09/2001/21, NIHR, forthcoming.

MacReady N. 2007. Developing countries court medical tourists. *The Lancet* 369: 1849-1850.

NaRanong A, NaRanong V. 2011. The effects of medical tourism: Thailand's experience. *Bulletin of the World Health Organisation* 89 (5):336-44.

OECD. 2010. Health Accounts Experts, Progress Report. *Trade in Health Care Goods and Services Under the System of Health Accounts.* Paris: OECD.

Pocock NS, Phua, KH. 2011. Medical tourism and policy implications for health systems: a conceptual framework from a comparative study of Thailand, Singapore and Malaysia. *Global Health* 7:12.

Reisman, D. 2010. *Health Tourism: Social Welfare Through International Trade.* Cheltenham: Edward Elgar.

Wongkit, M. and McKercher, B. (2013) Towards a typology of medical tourists: A case study of Thailand. *Tourism Management* 38: 4-12.

Ye BH, Qiu HZ, Yuen PP. 2011. Motivation and experiences of Mainland Chinese medical tourists in Hong Kong. *Tourism Management* 32 (5): 1125-27.

Yu J-Y, Ko T. 2012. A cross-cultural study of perceptions of medical tourism among Chinese, Japanese and Korean tourists in Korea. *Tourism Management* 33(1): 80-85.

Special Interview

Prof. Hengjin Dong, Associate Editor, BMC Health Services Research
董恒进教授访谈，《BMC 卫生服务研究》副主编


Dr. Hengjin Dong

Professor Hengjin Dong joined the Center for Health Policy and Management Studies, Zhejiang University School of Medicine in July 2009. Prior to that, he was the lead of Junior Group of International Health Economics and Health Financing at Institute of Public Health, Heidelberg University since 2006. He was a Senior Research Fellow at Brunel University (2004-2006) and Heidelberg University (2000-2004). He also had served 14 years at Fudan University Shanghai School of Public Health (formerly Shanghai Medical University) before he moved to Europe. His research focuses on health policy, health economics, healthcare financing, pharmaco-economics and health technology assessment. He has been an associate editor of BMC Health Services Research since 2012 and he is a member of the editorial board of Pharmacoeconomics. Ms. Yan Ding (PhD candidate) interviewed Professor Dong on April 24, 2013.

董恒进教授于 2009 年 7 月起就职于浙江大学医学院卫生政策与管理学中心。2006 至 2009 年，他在德国海德堡大学公共卫生研究所担任国际卫生经济与卫生筹资研究组组长。他曾分别在英国布鲁内耳大学（2004 到 2006 年）和德国海德堡大学（2000 年到 2004 年）担任高级研究员。在此之前，他在复旦大学（原上海医科大学）公共卫生学院工作了 14 年。董教授的研究兴趣是卫生政策、卫生筹资、药物经济学及卫生技术评估等。他于 2012 年担任《BMC 卫生服务研究》副主编，同时是《药物经济学》编辑委员会成员。丁燕于 2013 年 4 月 24 日与董教授进行了此次访谈。

1. Related information of BMC Health Services Research
《BMC 卫生服务研究》 相关信息

Yan: Could you please briefly talk about BMC Health Services Research?

丁燕：您能简要地介绍一下《BMC 卫生服务研究》的特点吗？

Prof. Dong: First of all, it is an open access journal, which offers readers with free access to all its articles. In addition, it focuses on the topics of health services research, in particular healthcare financing, health services utilization, etc.

董教授：首先它是一个开放的学术刊物，读者可以免费阅览刊物内的学术文章。其次，它关注的主题是卫生服务研究，主要包括卫生筹资、卫生服务利用等等。

Yan: Has the journal ever changed its focus areas over the years?

丁燕：这些年，它关注重点是否有转移？

Prof. Dong: It is hard to tell whether the journal's emphasis has ever been changed. It focuses mainly on health services research, which includes capacity building, healthcare financing, health equity, etc. We cover a wide range of topics, while the exceptions of clinical studies, which we usually do not publish.

董教授：很难说有侧重点的转移，主要是卫生服务研究，这是它的重点，包括培训、卫生筹资、公平性等等。涵盖的面比较广，一般不发表临床方面的研究。

2. Manuscript reviewing process
审稿流程

Yan: Could you tell us about the manuscript review process?

丁燕：您能介绍一下审稿流程吗？

Prof. Dong: First of all, the editorial office receives manuscripts submitted through the online submission system. The editorial office will distribute the manuscripts to associate editors while trying to match the subject area of the manuscript and the associate editors' expertise. After being assigned a manuscript, an associate editor will start the initial review, and make a judgment whether an external review is warranted. If the associate editor concludes that the manuscript fails to meet the journal's standard even after a revision, he/she will recommend to the editorial office rejecting this manuscript. If a manuscript is recommended rejection by an associate editor, the chief editor might review again. If the chief editor concurs, he/she will make a final decision of rejecting the manuscript. If the associate editor concludes the manuscript could be considered for publication, external referees will be invited for peer review. Then the associated editor and external referees will provide their comments and recommendation for revision to the editorial office. The editorial office will then notify the author a decision of revise and resubmit for the manuscript. When a revised manuscript is received, an associate editor will evaluate it with the review comments in mind, and generally it is not necessary to send the manuscript back to the referees for review again. However, if the referees have raised a lot of critical comments, we may send the revised manuscripts back to them for review.

董教授：首先（作者）网上投稿到编辑部，编辑部根据文章内容和各个编辑的专长，把文章分发给相关编辑。编辑收到文章后自己先看，个人判断是否需要外审。如果责任编辑觉得这篇文章即使修改也不会符合杂志要求，则建议编辑部拒稿。对于责任编辑建议直接拒稿的文章，相关部门主编可能会再审阅一次。如果编辑部也觉得文章确实不符合要求，会最终拒稿。如果责任编辑在审阅文章后觉得文章可以考虑发表，则会外送文章进行同行评议。之后责任编辑会将外部同行评议人及自己对文章的意见和修改建议反馈给编辑部。对于觉得文章经过修改后有可能达到发表要求的文章，编辑部联系作者建议修改。文章修回，责任编辑会结合之前的建议重看，一般不用再发给外评专家评阅。如果之前外评专家对文章提出了很多重大修改建议，在收到这些修回的文章时一般还会发给外评专家评阅。

Yan: Is there a situation that the associate editor and the referees disagree? If so, how would you manage that?

丁燕：有没有责任编辑和同行评议人意见不一致的情况？如果不一致，怎么处理？

Prof. Dong: personally, I would attach more importance to the peer reviewers' comments. Sometimes peer reviewers think a revised manuscript does not meet the journal's standard, and I will reject it according to their recommendations. If they consider a manuscript not suitable for publication in its current stage but can be improved, I would return it to the author for further revision. If I, as an associate editor, disagree with the peer reviewers, I would report the comments and recommendations to the editorial office for them to make the final decision.

董教授：我基本上根据同行评议的意见。有些同行评议觉得（修回的）文章不太好，我会拒绝发表该文章。如果觉得虽然不是很完美，但是可以修改，那继续返回修改。如果我作为编辑和评审专家意见不同，我会把相关意见和建议返回编辑部，最终的决定权在编辑部。

3. The selection criteria of peer reviewers
同行评议人的选择标准

Yan: How do you select the peer reviewers?

丁燕：您如何选择同行评议人呢？

Prof. Dong: I would select the peer reviewers according to the manuscript's topic, as well as the research area, such as the country where the study was conducted, etc. Thanks to the well-developed internet technology, we can simply type in a manuscript's subject in the search box and look for researchers who have published on a related topic. In addition, I also choose researchers who I personally know that they are experts in the field and have the capacity as peer reviewers. In general, we have selected external peer reviewers from the pools of both domestic and abroad research communities.

董教授：根据文章的主题，还有研究范围，如国家等。现在网络比较发达，在网上输入文章主题后能检索出哪些人发表过类似文章，可以从中选择一些人作为同行评议人。另外，有些我认识的人，我知道他们在这方面做得比较好，有这方面的知识可以帮助评审，我也会选择他们作为同行评议人。总体而言，有一些来自中国的外部评议人，也有一些来自国外的外部评议人。

4. How long does the reviewing take?
审稿所需时间

Yan: How long does it usually take from receiving a manuscript to making a decision of rejection or sending it for external peer review?

丁燕：从您接到编辑部发过来的文章到做出拒绝或送外审的判断，一般多久？

Prof. Dong: It usually takes 3 days. According to the requirements of the editorial office, the associate editor must provide feedback and suggestions within three days after a manuscript is distributed.

董教授：三天。按照编辑部要求，文章由编辑部发到责任编辑处，三天内责编向编辑部反馈意见。

Yan: How about the peer review? Does it usually take two weeks?

丁燕：对于同行评议，一般两周，对吗？

Prof. Dong: The peer review takes about two weeks in principle, but not every peer reviewer could complete the review within two weeks. Some people are very busy, and they may decline the peer review invitation, so I need to invite other peer reviewers. Some people may accept our invitation, but could not complete the review, so we will send an email reminder. If they could finish reviewing the manuscript before the due date after the reminder, we have to select another peer reviewer. Including the associate editor, we need comments and suggestions from at least three reviewers on each manuscript.

董教授：同行评议，理论上是两周时间，但是不是每位同行评议人都可以两周内完成评阅。有些人比较忙，收到评阅邀请时会拒绝评议，那么我需要继续邀请其他同行评议人。有些人同意评阅，但是两周内没有完成评阅，我们会发邮件提醒。如果经过提醒还是不能在规定时间内完成，那么我们需要重新选择另外的同行评议人。包括我在内，至少要有三个人提出对来稿的意见和建议。

5. Authors from China and the characteristics of their manuscripts
中国投稿者及其文章特点

Yan: Are there many authors from China who submit to the BMC Health Services Research?

丁燕：向《BMC 卫生服务研究》投稿的中国作者多吗？

Prof. Dong: There are authors from China, but not a lot. I have about 30% of manuscripts from China.

董教授：中国投稿者有，不是很多，从我手上大概 30%左右。

Yan: In general, what are the characteristics of manuscripts from China?

丁燕：总体上，中国投稿者的文章有哪些特点？

Prof. Dong: Overall, the quality of their manuscripts is good. The advantage of these manuscripts from China is the relatively large study sample size. But because English is not the authors' native language, writing is the weakness. In some cases, the research method was not presented in detail, but mostly a general introduction. In addition, regarding the discussion section, it sometime fails to tie closely to their results or findings, and the discussion section in some manuscripts is too broad and thus lacks focus. Generally there is no problem with the statistical analysis. However, sometimes the statistical analysis is not in-depth, and many of the manuscripts conducted only descriptive analysis.

董教授：总体上写得不错，中国作者的优势是样本量一般比较大。不过因为英语不是母语，相对而言，语言上有些欠缺。研究方法有时写得不是很详细，笼统介绍的比较多。另外在讨论部分，讨论没有紧扣结果/发现部分，有些来稿讨论部分拓展得比较大，比较宽泛。统计分析基本上没什么大问题。不过有时有些分析不是很深，描叙性的比较多。

Yan: Is the journal not interested in descriptive studies?

丁燕：这份期刊对于描叙性研究不太感兴趣吗？

Prof. Dong: No, this journal is definitely interested in descriptive studies. But we are focusing mainly on identifying the causes and interpretations of the results, and we need analyses beyond descriptive studies.

董教授：不，（这份期刊对）描叙性研究当然也感兴趣，但主要是要找出原因解释结果，找出描叙性研究背后的东西。

Yan: It is relatively difficult for the Chinese authors to grasp the essence of discussion. Sometimes they may have gone too far away from their results, and sometimes they just stop at a simple conclusion or description without digging into the causes and effects.

丁燕：觉得讨论比较难把握。有些时候走得太远，有些时候又停留在简单的总结描述上，没有深入进去。

Prof. Dong: That's correct. Some discussions on causes can be offered in the discussion section, which should be provided in details. More references are needed to support the findings or to interpret the hypothesis. If authors from China could address these issues in the discussion section, the quality of their manuscripts could be substantially improved.

董教授：对。结果分析中应该有些原因分析，讨论再深入些，多引用相关文献以佐证发现、解释假设。这些方面能做得更好的话，中国文章是很不错的。

Yan: Besides the several aspects above, do you have any other suggestions for Chinese authors who plan to submit their manuscripts to BMC Health Services Research?

丁燕：除了加强上述几点，对于打算向《BMC 卫生服务研究》投稿的中国人，您有哪些建议？

Prof. Dong: Before submission, it is helpful to take a close look at the authors' guidelines and get familiar with the requirements of a journal. The authors' guidelines are available on the official website of a journal.

董教授：投稿前，仔细看杂志的指南，熟悉相关杂志的标准。这些作者指南都可以在杂志的官网上找到。

6. Notable China Health Issues
值得关注的中国卫生问题

Yan: Regarding health issues in China, do you have any topics in your mind that interests you?

丁燕：对于中国卫生，您觉得哪些内容值得研究人员关注？

Prof. Dong: There are a lot of notable topics in the China Healthcare Reform. The most successful story in the reform is the New Rural Cooperative Medical System (NRCMS). Some interesting topics related to NRCMS include management, fund utilization, as well as potential problems.

董教授：中国医疗改革值得关注的内容很多。中国改革最成功的是新农合，但是怎么来进行管理，怎么有效地使用资金，存在哪些问题等？

Yan: Personally I do not know too much about the NRCMS. And some friends of mine who are familiar with this topic commented that there are too many studies on NRCMS and they couldn't find innovative perspectives.

丁燕：关于新农合，我个人了解不多，但研究新农合的朋友反映相关研究太多，他们找不出有新意的地方。

Prof. Dong: That's true, and it depends on perspective. For instance, from the perspective of society, one interesting topic is the possible policy interventions to address the difficulty of getting medical service with the NRCMS.

董教授：对，看你从哪个角度分析。比如管理方面，如果站在社会角度，怎么利用新农合解决看病难问题，这个政策调整的问题（就值得深入研究）。

Prof. Dong: Another notable topic is the reform of public hospitals. A lot of topics are interesting, such as how to improve the efficiency and equity of the public hospitals, how to address the difficulties of getting medical service, and how to improve the patient's process of visiting hospitals.

董教授：另外是公立医院的改革。怎么提高医院效率提高公平性，解决看病难问题，解决医院流程问题。好多东西都值得去研究。

Prof. Dong: Another topic I would recommend is on private hospitals. There are many private hospitals emerged over the past decades. However, research on private hospitals is limited. Studies on how to encourage private investment in hospitals would be useful.

董教授：还有对医院办医的研究。现在民营医院比较多，但对民营医院的研究不多，怎么鼓励民营投资值得研究。

Prof. Dong: The hospital payment system is also an interesting topic. A research project could compare the efficiency of different hospital payment systems by Diagnosis Related Group (DRG) or Fee for Services. In order to do that, we first need to know the cost of medical services, which are unknown even to many hospitals. Hospitals may know the total cost, but they may have no idea about the unit cost for a single medical service. In addition, we need to understand the clinical treatment protocols, which are related to the clinical practice, as these are disease-specific protocols. We would know the medical services involved if we have the protocols. As a result, we would know the total costs to treat the diseases, including the pharmaceuticals, once we have the unit costs of all the services. If we could combine and summarize the data from all hospitals, DRG-based payment system could be developed after some adjustments. Although DRG-based payment system may be difficult to implement and it does have some limitations, it has a clear advantage in cost control.

董教授：同时支付机制方面也值得关注。哪种医院支付机制比较好，是按病种支付还是按服务项目支付等等。首先需要知道服务的成本，这个很多医院不知道。医院知道总成本但是不一定知道单元服务成本。另外按照什么标准治疗疾病，这涉及到临床路径，对特定疾病要有标准的治疗方法。如果制定标准治疗方法，能知道涉及哪些服务内容。如果知道各服务单元的成本，相关疾病的治疗成本包括药品就知道了。把所有医院的这些资料统计在一起，再进行一些调节，可以设计按病种支付的方法。难是比较难，按病种支付也有它的缺点，但它在控制成本方面有优势。

RESEARCH TWITTER

Wenjin Li, Roberta M. Ray, David B. Thomas, Michael Yost, Scott Davis, Norman Breslow, Dao Li Gao, E. Dawn Fitzgibbons, Janice E. Camp, Eva Wong, Karen J. Wernli, and Harvey Checkoway. **"Occupational Exposure to Magnetic Fields and Breast Cancer Among Women Textile Workers in Shanghai, China."** *American Journal of Epidemiology*, 2013, 178: 1038-45.

A nested case-cohort study was conducted to investigate the association between occupational exposure to magnetic fields (MFs) and the risk of breast cancer within a cohort of 267,400 female textile workers in Shanghai, China. The study included 1,687 incident breast cancer cases diagnosed from 1989 to 2000 and 4,702 noncases selected from the cohort. Subjects' complete work histories were linked to a job–exposure matrix developed specifically for the present study to estimate cumulative MF exposure. No association was observed between cumulative exposure to MFs and overall risk of breast cancer. The hazard ratio for the highest compared with the lowest quartile of cumulative exposure was 1.03 (95% CI: 0.87, 1.21). Similar null findings were observed when exposures were lagged and stratified by age at breast cancer diagnosis. The findings do not support the hypothesis that MF exposure increases the risk of breast cancer.

Danxia Yu, Xiao-Ou Shu, Honglan Li, Yong-Bing Xiang, Gong Yang, Yu-Tang Gao, Wei Zheng and Xianglan Zhang. **"Dietary Carbohydrates, Refined Grains, Glycemic Load, and Risk of Coronary Heart Disease in Chinese Adults."** *American Journal of Epidemiology*, 2013, 178: 1542-49.

The authors prospectively examined intakes of carbohydrates and staple grains as well as glycemic index and glycemic load in relation to of coronary heart disease (CHD) among 117,366 Chinese women and men (40–74 years of age) without history of diabetes, CHD, stroke, or cancer at baseline in Shanghai, China. Diet was assessed using validated food frequency questionnaires. Incident CHD cases were ascertained during follow-ups and confirmed by medical records. Carbohydrate intake accounted for 67.5% of the total energy intake in women and 68.5% in men. Seventy percent of total carbohydrates came from white rice and 17% were from refined wheat products. Positive associations between carbohydrate intakess and CHD were found in both sexes (all *P* for heterogeneity > 0.35). The combined multivariate-adjusted hazard ratios for the lowest to highest quartiles of carbohydrate intake, respectively, were 1.00, 1.38, 2.03, and 2.88 (95% CI: 1.44, 5.78; *P* for trend = 0.001). The combined hazard ratios comparing the highest quartile with the lowest were 1.80 (95% CI: 1.01, 3.17) for refined grains and 1.87 (95% CI: 1.00, 3.53) for glycemic load (both *P* for trend = 0.03). High carbohydrate intake, mainly from refined grains, is associated with increased CHD risk in Chinese adults.

Jay Pan, Gordon G. Liu, Chen Gao. **"How does separating government regulatory and operational control of public hospitals matter to healthcare supply?"** *China Economic Review*, 2013, 27: 1–14.

This paper evaluates the effect of regulatory reform separating the operational control and regulatory oversight of public hospitals in China. Using city-level data and a difference-in-difference (DID) model, this paper estimates the changes in healthcare supply in response to the regulatory reform. Based on the DID estimates, in Weifang between 2006 and 2008, the reform led to a 39.3% increase in the number of doctors per 10,000 residents and 40.1% increase in the number of health workers per 10,000 residents. Similarly, in Suzhou between 2005 and 2008 the reform led to increases of 60.5%, 30.8% and 36.6% for hospital beds, doctors and health workers per 10,000 people, respectively. Moreover, the magnitude of this impact appears to increase over time. Furthermore, the effect of the reform is consistent regardless of whether the separation reform takes place inside

or outside the government. This paper concludes that the government should focus only on the regulation of healthcare markets, while leaving hospital operation to the free market.

Martine Audibert, Jacky Mathonnat, Aurore Pelissier, Xiao Xian Huang, Anning Ma. **"Health insurance reform and efficiency of township hospitals in rural China: An analysis from survey data."** *China Economic Review*, 2013, 27: 326–38.

From a database of 24 randomly selected township hospitals observed over the period 2000–2008 in Weifang Prefecture (Shandong), this study examines the efficiency of township hospitals through a two-stage approach. As curative and preventive medical services delivered at township hospital level use different production processes, two data envelopment analysis models are estimated with different orientations to compute scores. The results show that technical efficiency has declined over time. The factors explaining technical efficiency are mainly environmental characteristics rather than internal ones. Among these environmental factors, New Rural Cooperative Medical Scheme (NRCMS) has in average a negative effect on the evolution of township hospitals (THs) efficiency, although efficiency has improved for some of them. Results also suggest that, in the context of China, the efficiency of THs is influenced by unobservable factors. From the findings, the authors suggest five main orientations to improve THs efficiency.

Yi Hu, Qi Zhao, Linlin Wu, Weibing Wang, Zhenan Yuan, and Biao Xu. **"Prevalence of latent tuberculosis infection and its risk factors in schoolchildren and adolescents in Shanghai, China."** *European Journal of Public Health*, 2013, 23: 1064-69.

This study aimed to determine the prevalence and risk factors associated with latent tuberculosis infection (LTBI) in schoolchildren and adolescents from Shanghai, China. In this cross-sectional study, the authors administered T-SPOT.TB and TB infection risk factor questionnaire to children and adolescents aged between 10 and 18 years in 2010 in Shanghai. A total of 1,106 schoolchildren and adolescents were enrolled, of which 46.1% were male, and 91.8% were vaccinated with Bacille Calmette Guerin (BCG). Overall, 52 (4.7%) children had a positive T-SPOT.TB result, with significant increase in age distribution. However, none of the participants demonstrated TB-related abnormality on X-ray examination. Multivariate analysis showed that LTBI was associated with no BCG vaccination (odds ratio: 2.40; 95% CI: 1.182–5.335) and a history of TB exposure (odds ratio: 6.89; 95% CI: 3.095–15.35). For 46 children and adolescents with history of TB exposure, contact hours per week of TB cases were significantly associated with risk of LTBI. This study concluded that prevalence of LTBI in schoolchildren and adolescents in Shanghai is relatively low compared with other high epidemic areas of TB. A higher risk of LTBI was observed among children with no BCG vaccination and those with a history of TB exposure, which suggests that the prevalence of LTBI among schoolchildren could be further reduced by strengthening BCG vaccination under the national immunization programme and enhancing contact investigation of active TB patients.

Lianping Yang, Chaojie Liu, J. Adamm Ferrier, Wei Zhou and Xinping Zhang. **"The impact of the National Essential Medicines Policy on prescribing behaviours in primary care facilities in Hubei province of China."** *Health Policy and Planning*, 2013, 28: 750-60.

This study assessed the impact of the National Essential Medicines Policy (NEMP) on the use of medicines in government-owned primary care institutions in Hubei province of China. A systematic random sampling strategy was employed to select 55,800 prescriptions from 18 primary care organizations who progressively implemented the NEMP from January 2009 to July 2011. The facilities that implemented the NEMP at a later stage served as control. This study found an immediate increased uptake of essential medicines of all drugs prescribed which ultimately neared 95%. In total, 38,151 prescriptions (68%) involved antibiotics and there was no evidence of reduction

after the NEMP interventions. A high percentage (59–66%) of prescription drugs were administered through parenteral routes and no reduction was found after the NEMP interventions. Although the average number of medicines per prescription remained unchanged (nearly four), the average cost per prescription declined significantly after the NEMP interventions (¥ 44.67 vs ¥ 26.67 CNY, $P < 0.03$). This study concluded that the NEMP interventions reduced the average cost per prescription; however, the irrational use of antibiotics and unnecessary parenteral administration remains prevalent. The goals of the NEMP are partially achieved; the authors therefore recommend a strategic approach involving all stakeholders to comprehensively achieve all aspirations.

Hana Brixi, Yan Mu, Beatrice Targa and David Hipgrave. **"Engaging sub-national governments in addressing health equities: challenges and opportunities in China's health system reform."** *Health Policy and Planning*, 2013, 28: 809-24.

The authors describe the recent trend in health inequalities in China, and analyse government expenditure on health in the context of China's decentralization and intergovernmental model to assess whether national, provincial and sub-provincial public resource allocations and local government accountability relationships are aligned with this goal. Results show that government expenditure on health at sub-national levels, which accounts for ~90% of total government expenditure on health, is increasingly regressive across provinces, and across prefectures within provinces. Increasing inequity in public expenditure at sub-national levels indicates that resources and responsibilities at sub-national levels in China are not well aligned with national priorities. China's health system reform (HSR) would benefit from complementary measures to improve the governance and financing of public service delivery. Drawing on China's institutional framework and ongoing reform pilots, the authors present possible approaches to: (1) consolidate key health financing responsibilities at the provincial level and strengthen the accountability of provincial governments, (2) define targets for expenditure on primary health care, outputs and outcomes for each province and (3) use independent sources to monitor and evaluate policy implementation and service delivery and to strengthen sub-national government performance management.

Ying-Yeh Chen, David Gunnell, Chin-Li Lu, Shu-Sen Chang, Tsung-Hsueh Lu and Chung-Yi Li. **"Perinatal risk factors for suicide in young adults in Taiwan."** *International Journal of Epidemiology*, 2013, 42: 1381-89.

This study investigated the association of early life social factors—maternal age, single motherhood, socioeconomic position, birth order and family size—with future risk of suicide in Taiwan. It used a nested case-control design and used linked data from Taiwan's Birth Registry (1978–93) and Taiwan's Death Registry (1993–2008) and identified 3984 suicides aged 15–30 years. Conditional logistic regression models were estimated to assess the association of early life risk factors with suicide. It found that younger maternal age (<25 years), single motherhood, lower paternal educational level and higher birth order were independently associated with increased risk of suicide. Stratified analyses suggest that lower paternal educational level was associated with male, but not female suicide risk ($P_{interaction} = 0.02$). Single motherhood was a stronger risk factor for suicide in female than in male offspring [odds ratios (95% CI) = 2.30 (1.47, 3.58) vs. 1.50 (1.01, 2.20), $P_{interaction} = 0.12$]. There was a suggestion that in families with large sibship size ($\geqslant$4 siblings), the excess in suicide risk was greater among later born daughters compared with later born sons ($P_{interaction} = 0.05$). The findings provide support for the results of European studies, suggesting that early life social circumstances influence future risk of suicide.

Chen Shen, Michael Yuxuan Ni, C. Mary Schooling, Wai Man Chan, Siu Yin Lee, Tai Hing Lam. **"Alcohol use and death from respiratory disease in a prospective Chinese elderly cohort study in Hong Kong."** *Preventive Medicine*, 2013, 57: 819–23.

This paper assessed the adjusted associations of alcohol use with death from respiratory disease using a population-based prospective cohort of 66,820 Chinese aged ⩾ 65 years enrolled from July 1998 to December 2001 at all the 18 Elderly Health Centers of the Hong Kong Government Department of Health and followed till May 30, 2012. During ten-year follow-up, 4,065 deaths from respiratory disease occurred. Most current drinkers were occasional drinkers (< 1 day/week). Both moderate and occasional drinking (< 1 day/week) were associated with a lower risk of death from respiratory disease, but the point estimates and pattern of associations were similar between these two types of drinkers. This paper concluded that the typical drinking pattern, i.e. occasional drinking (< 1 day/week), which is unlikely to have any biological effect, was similarly associated with a lower risk of respiratory disease as moderate alcohol use, suggesting the attributes of being a typical drinker may be protective.

Junling Gao, Eric J. Nehl, Hua Fu, Yingnan Jia, Xingdi Liu, Pinpin Zheng. **"Workplace social capital and smoking among Chinese male employees: A multi-level, cross-sectional study."** *Preventive Medicine*, 2013, 57: 831–36.

This study aimed to investigate the associations between workplace social capital and smoking status among Chinese male employees. A cross sectional study with a two-stage stratified sampling procedure was conducted in Shanghai in 2012. In total, 1,603 male workers from 35 workplaces were involved. Workplace social capital was assessed using a validated and psychometrically tested eight-item measure. This study found that overall, 54.2% of the subjects smoked currently. After controlling for individual covariates (age, education level, marital status, occupational status and job stress), compared to workers in the highest quartile of individual-level social capital, the prevalence ratios of smoking for workers in the third quartile, second quartile and lowest quartile were 1.26 (95% CI: 1.11–1.38), 1.35 (95% CI: 1.19–1.50) and 1.39 (95% CI: 1.24–1.51) respectively. However, there was no relationship between workplace-level social capital and smoking status. This study concluded that higher individual-level social capital was associated with a lower likelihood of smoking among Chinese male employees. By contrast, no clear association was found between workplace-level social capital and smoking.

Bo Xi, Dan He, Yuehua Hu, Donghao Zhou. **"Prevalence of metabolic syndrome and its influencing factors among the Chinese adults: The China Health and Nutrition Survey in 2009."** *Preventive Medicine*, 2013, 57: 867–71.

This study aimed to estimate the up-to-date prevalence of metabolic syndrome (MS) and its influencing factors among the Chinese adults. Data were obtained from the China Health and Nutrition Survey conducted in 2009, which was a cross-sectional and partially nationally representative study including a total of 7,488 Chinese adults (age ⩾ 18 years). This study found that the overall age-standardized prevalence estimates of the MS were 21.3% (95% CI: 20.4%–22.2%), 18.2% (95% CI: 17.3%–19.1%) and 10.5% (95% CI: 9.8%–11.2%) based on definitions of revised NCEP ATPIII, IDF and CDS criteria, respectively. Individuals who were women (compared to men: odds ratio [OR] = 1.37, 95% CI = 1.16–1.61), 40 years or older (compared to less than 40 years old: OR = 2.82, 95% CI = 2.37–3.34 for 40–59 years; OR = 4.41, 95% CI = 3.68–5.29 for 60 years or older), overweight/obese (compared to normal weight: OR = 4.32, 95% CI = 3.77–4.95 for overweight; OR = 11.24, 95% CI = 9.53–13.26 for obese), and living in urban area (compared to living in rural area: OR = 1.27, 95% CI = 1.12–1.43) were more likely to have a higher prevalence estimate of MS. In addition, frequency of alcohol consumption and cigarette intake were also found to be significantly associated with probability of MS. The results suggest an urgent need to develop national strategies for the prevention, detection, treatment and control of obesity and MS in China.

POLICY AND PRACTICE UPDATES

Support for Injecting Private Funding into Elder Care Service Industry

The recent State Council Executive Meeting proposed to promote private capital as the main force pushing development of China's elder care industry. Analysts predict that in the next few years, government will likely provide support to all components of elder care, such as elder health care, services, and real estates.

There were also proposals to strengthen various aspects of elder care, such as construction, services, and model innovation. While the emphasis will be on home care of the elderlies, it is also important to simplify and standardize procedures, reduce administrative fees, support building of elder care facilities using societal capital, and encourage oversea investment in the elder care service industry.

Data from National Committee on Ageing indicates that the current consumer demand for elder care services exceeds ¥3 trillion, and is projected to reach ¥5 trillion by 2050. Faced with this hugely profitable new industry, investors are beginning to mobilize.

Currently the most active area is the construction and management of retirement communities. Many insurance companies are already investing in building these communities in places such as Hebei and Hubei.

民资进入养老服务业将获扶持
来源：经济参考报 2012 年 08 月 19 日
http://www.zgylbx.com/sihcqlbknew52244_1/

国务院常务会议日前提出，要在政府“保基本、兜底线”的基础上，推动社会力量成为发展养老服务业的“主角”。分析人士预测，未来几年，养老服务业所涉及的养老医疗、地产、服务甚至金融业都有望得到政策支持，养老地产项目也有望开启新的成长窗口。

会议要求，将从建设、服务、模式创新等多个方面加强养老服务业的发展。在重点发展居家养老的同时，通过简化和规范程序，减免行政事业性收费，支持社会力量举办专业化养老机构，鼓励境外资本投资养老服务业。此外，将推动医养融合发展，探索医疗机构与养老机构合作新模式，促进养老服务与医疗、家政服务、保险、教育、健身、旅游等领域互动发展。到 2020 年建成以居家为基础、社区为依托、机构为支撑的覆盖城乡的多样化养老服务体系。

来自全国老龄工作委员会的数据显示，目前我国养老服务市场消费需求在 3 万亿元以上，2050 年左右将达到 5 万亿元，一个潜力极大的新兴产业正在形成。面对如此庞大的市场，各路资本也都蠢蠢欲动。目前来看，社会资本参与养老产业已有所发展，其中以养老社区开发运营为主的养老地产最为集中，这一领域的活跃投资者包括民营养老服务机构、地产商、保险公司、境内外财务投资者等。

而各大险企中，除泰康人寿、新华保险等几家已着手建设养老社区的公司外，中国人寿、合众人寿也分别在河北及湖北规划了养老社区项目。全国工商联商业不动产专委会主任朱凌波认为，随着越来越多的保险企业获得不动产投资“牌照”，“百舸争流”的局面已经形成。

State Council Medical Reform Office Beginning to Evaluate County Level Pilot Sites that were Part of the Public Hospital Reform

State Council Medical Reform Office, together with the Central Office, the Development and Reform Commission, the Ministry of Finance, the Ministry of Human Resources and Social Security, the National Health and Family Planning Commission, and the Administration of Traditional Chinese Medicine, will begin to evaluate the county level public hospitals that were the earliest pilot sites for the public hospital reform.

According to recently released "Notice on Launching Self Evaluation of County Level Public Hospital that Served as Comprehensive Reform Pilot Sites", the initial work will be focused on finishing self-evaluation by August 20. This evaluation will help summarize reform implementing experience, spread the success stories and useful tips, and identify problems and obstacles.

国务院医改办启动县级公立医院改革试点评估工作
来源：新华网 2013 年 08 月 30 日
http://news.xinhuanet.com/2013-08/06/c_116832543.htm

8 月 30 日，从国家卫生计生委获悉，国家卫生计生委近日印发了《关于进一步完善乡村医生养老政策提高乡村医生待遇的通知》，要求各地将乡村医生队伍建设和养老保障作为深化医药卫生体制改革的重要内容，严格落实相关政策。

根据《通知》要求，各地要加快制订并完善乡村医生养老政策，采取多种形式提高乡村医生养老待遇，确保其养老金收入不低于当地居民最低生活保障水平。有条件的地方可结合乡村卫生服务一体化管理将取得执业（助理）医师资格的乡村医生纳入乡镇卫生院编制统一管理。同时，建立乡村医生到龄退出机制，原则上年满 60 周岁的乡村医生不再在村卫生室执业，如情况特殊可延长工作年限。

为确保乡村医生合理收入不降低，《通知》提出，各地应当采取先预拨、后结算的方式发放乡村医生补助，由县级财政部门直接将补助经费的 80%以上按月拨付乡村医生，余额经考核后发放，不得挪用、截留。为落实乡村医生补偿政策，原则上将 40%左右的基本公共卫生服务任务交由村卫生室承担，考核后将相应的服务经费拨付给村卫生室。合理制订村卫生室一般诊疗费标准，原则上为 10 元左右，并确定新农合支付标准和办法。

在严格乡村医生执业管理方面，《通知》指出，乡村医生准入管理要严格依法进行，在村卫生室从事预防、保健和医疗服务的人员必须具备乡村医生执业证书或执业（助理）医师证书。

National Health and Family Commission and Ministry of Finance: Insurance Policy for Serious Illnesses Purchased Using the New Rural Cooperative Fund

As part of the medical reform, the New Rural Cooperative Funds will be used to purchase insurance for serious illnesses for both rural and urban residents. This new policy will be pilot tested in certain areas to better understand the relationship between the supply of New Rural Cooperative funds and demand of insurance policies by residents, to determine a reasonable level of investment. Local governments are encouraged to start working on insurance plans for serious illnesses, and to ensure rural residents who participate in these insurance plans will have comparable benefits. Local governments are also encouraged to involve commercial insurance companies, and bring market forces into play.

By the end of 2012, around 262 cities and districts at the county level had already ensured services for the New Rural Cooperative Funds to commercial insurance companies, reaching about 10% of all regions that are piloting the New Rural Cooperative Funds.

卫计委财政部：新农合基金购买大病保险试点将全面推开
来源：中国政府网 2013 年 09 月 17 日
http://www.cnma.org.cn/sy_Infos.asp?id=1240

国家卫生计生委、财政部近日就做好今年新农合工作发出通知，要求全面推开利用新农合基金购买城乡居民大病保险的试点，制定大病保险的基本政策要求，完善招标、协议、监管、保障、基金结余管理等方面的政策措施，确保大病保险试点工作顺利起步。

通知说，试点地区要根据新农合基金承受能力和群众大病保障需求等因素，合理确定大病保险的筹资水平。鼓励以地市或省为单位开展大病保险工作，做好大病保险与新农合重大疾病保障的衔接，积极创造条件逐步向大病保险统一，确保参合农民待遇不降低。同时，通知要求，加快推进商业保险机构参与新农合经办服务有关工作。完善委托商保机构经办服务的准入、退出机制和激励约束机制，充分发挥市场机制作用，提高新农合经办服务水平，力争在更大范围和更高统筹层次上推进商保机构经办新农合服务。

据悉，截至 2012 年底，委托商业保险机构经办新农合业务的县（市、区）数达到 262 个，占新农合统筹地区的 10%，实现了管办分开、政社分开。

Hebei and Beijing Signed Health Cooperative Agreement

Hebei Province and City of Beijing recently signed an agreement to strengthen their medical service cooperation. The two sides will establish a network allowing easier transfer of medical cases, remote diagnosis, and joint consultation on difficult cases. With this new agreement, patients in Hebei Province will have an easier time reaching the medical experts in Beijing.

Currently, Hebei Province already has a system where experts from county and provincial hospitals have joint consultations through remote communication, allowing patients with serious illnesses access to provincial level experts without leaving local hospitals. Once Hebei Province and Beijing perfect their remote diagnosis system, patients will have access to more medical experts without leaving the provincial capital. Beijing hospitals will also send experts to Hebei Province to provide training, while doctors from the Province can be trained in Beijing hospitals, increasing the management and service capacities for non-primary hospitals in Hebei.

Due to lower pay and less active research environment, medical experts tend to migrate away from Hebei Province, resulting in a sizeable gap between levels of expertise in Hebei and Beijing. With this new agreement, medical professionals in Hebei will receive more training, be more capable of providing quality local care for patients, and alleviate the pressure on Beijing's medical system.

河北与北京签署卫生合作协议 新农合医保将互通
来源：河北青年报 2013 年 10 月 24 日
http://hebei.hebnews.cn/2013-10/24/content_3559053.htm

近日，河北省和北京市签署了关于卫生合作框架协议，将从建立双向转诊制度、远程诊疗系统、疑难重症会诊制度，设立专科医院等方面加强卫生合作。京冀双方将建立双向转诊制度、方便河北患者享受北京专家服务。

目前河北省内已开展省级医院与县级医院远程会诊试点，重症患者不出县即可享受省级专家服务。若京冀建立完善远程会诊，就意味着省会就诊患者不出市即可让北京专家看病。　　双方将建立相应制度，由北京市属医院将对河北省环首都地区的二级以上医院禁行对口支援。同时，北京将通过向河北派驻专家、河北选派优秀医师到北京进修等方式，提高河北二级以上医院的管理和服务能力。

根据框架协议，双方将积极探索将“双方共建医院”及“符合条件的协作医院”，确定为双方城镇职工医保、城镇居民医保和新型农村合作医疗的定点医院。同时，将积极探索建立异地医保结算机制，首先推动新型农村合作医疗省级信息系统平台的互联互通，逐步实现参合农村居民信息资源共享、定点医疗机构互认和跨省网上实时监管，努力实现两地参合农民在定点医疗机构刷卡就医、即时结报。

河北省因待遇、科研、环境、学术氛围等导致人才流失，致使河北省医学专家水平较北京差距大。从而使得目前的省会只是冀南地区的医疗中心，环京津地区的患者多流向北京。而通过开展合作，把北京技术引向河北，可以达到双方优势互补，不仅可以提高河北医疗水平，减少患者进京就医负担，同时也可以减轻北京医疗卫生机构的压力。

Anhui: Rural Residents Able to Have Inpatient Care in Participating Hospitals outside Home Province

According to recent news from Anhui Province Department of Health, New Rural Cooperative Insurance agencies from 21 cities and counties already signed agreements with hospitals from other provinces, allowing rural residents from these localities in Anhui to be treated and pay for the treatments in the participating hospitals.

Currently, the national and Anhui provincial databases are already connected. Once the national database enables inter-provincial information exchanges, rural residents participating in the New Rural Cooperative Insurance will be able to access information from other provinces and instantly pay for treatments.

Anhui Province has been testing the best way to reimburse medical treatments rendered outside the province. To date, there are 21 localities in Anhui Province that signed hospital service agreements with more than 40 hospitals in Guangdong Province, and cities of Xuzhou, Nanjing, and Wuhan, allowing instant medical treatment reimbursement services.

However, with greatly increased medical treatment reimbursements from outside Anhui Province, the already limited New Rural Cooperative Funds might be stretched even thinner. These services make life easier for patients to seek care outside their home province, but could increase the outflow of patients, and further upset the balance for the new insurance scheme. Further reforms are needed to allow these agreements to work.

安徽：农民省外定点医院住院可即时结报
来源：健康报 2013 年 10 月 25 日
http://www.jkb.com.cn/htmlpage/39/391548.htm?docid=391548&cat=0D&sKeyWord=null

据安徽省卫生厅农合办近日提供的消息，截至目前，安徽省已有 21 个市、县的新农合经办机构和省外医院签订了异地结报协议，这些地方的农民在外省定点医院就医，可即时结报。

目前，安徽省与国家平台已经联网，一旦国家平台启用跨省信息交流，安徽省参合农民即可通过国家平台与外省联网，实现跨省即时结报。安徽省的跨省异地结报已经摸索了三四年，目前都还是点对点的模式。2009 年，该省歙县与浙江省湖州市吴兴区织里镇医院达成协议，歙县农民在该院看病，出院即可在该院完成报销，3 万多名在织里镇打工的歙县农民首试跨省即时结报。随后，不少外出务工人员较多的统筹地区陆续和省外医疗机构达成协议。迄今，安徽省已有淮北市、滁州市、阜阳市等 21 个统筹地区与徐州市、南京市、武汉市、广东省等地的 40 余家医疗机构签订了服务协议，开通了即时结报服务。

但是，考虑到新农合资金总量有限，如果异地报销多了，会更吃紧。跨省即时结报，方便了病人报销，但也确实加剧了病人外流，对新农合基金平衡可能会造成一定的影响。因此，跨省即时结报还需要设计配套管理措施，

比如支付方式改革、起付线差异应对、跨省联合监管等，确保新农合基金安全。

The New Rural Cooperative Medical Insurance Plan: National and Provincial Information Platforms Connection Pilot Tested

The National Information Platform for the New Rural Cooperative Medical Insurance is currently pilot testing connection with Provincial Information Platforms from Beijing, Inner Mongolia, Jilin, Jiangsu, Anhui, Henan, Hubei, Hunan, and Hainan. National Health and Family Planning Commission will evaluate the completeness of Provincial Information Platforms, synchronize internet environment, perform interface tests, and pilot data exchanges. All these activities will help to establish a functional network for treating patients across provincial borders and allowing instant reimbursement for these treatments.

Ministry of Health has been pushing for the establishment of a strong information system from the beginning of medical reforms. A fully integrated information system is needed to strengthen the monitoring of the New Rural Cooperative Funds and allow rural residents easier access to medical treatments.

Data from monitoring the national medical reform indicates that about 90% of the counties in the country launched New Rural Cooperative Funds Agencies and are working on inter-province treatment and reimbursement agreement. Across the country, about 61% of the counties already successfully implemented a single-payment system for medical treatments within and outside the province.

国家新农合信息平台试点联通 9 省份
来源：健康报 2013 年 10 月 25 日
http://www.jkb.com.cn/htmlpage/39/391583.htm?docid=391583&cat=02&sKeyWord=null

10 月 23 日，国家卫生计生委基层司合作医疗处相关负责人表示，国家新农合信息平台目前已开展与北京、内蒙古、吉林、江苏、安徽、河南、湖北、湖南、海南 9 个省级平台的试点联通，国家卫生计生委将根据各省级新农合平台的完善程度，开展网络环境联调和接口测试，试点数据交换，为跨省就医费用核查和结报奠定基础。

为加强基金监管和方便农民参合就医，卫生部自新农合制度实施之初，就积极推进统筹区域内即时结报和新农合信息化建设。为进一步方便参合农民跨省就医费用核查和结报，原卫生部自 2011 年起委托中国医学科学院医学信息研究所建设国家新农合信息平台，经过大量的前期准备工作，制订了《国家新农合信息平台联通技术方案（试行）》，指导国家新农合信息平台与省级平台的联通。

全国医改工作进展监测数据显示，截至 2013 年 3 月底，全国 90%的县（市、区）开展了新农合经办机构与省内异地医疗机构即时结报，61%的县(市、区)实现了新农合省内异地就医一卡通。国家卫生计生委将根据各省级新农合平台的完善程度，开展网络环境联调和接口测试，逐步探索跨省就医费用核查和结报试点，并继续扩大联通范围，力争“十二五”期间参合农民跨省就医结报工作有较大推进。

ABOUT CHPAMS: MEMBERS' UPDATES

CAREER AND PROFESSIONAL APPOINTMENT

Dr. Youfa Wang, a CHPAMS founding member, recently become Professor and Chair of the Department of Social and Preventive Medicine at the State University of New York at Buffalo. Before joined SUNY Buffalo in November 2013, Dr. Wang was an Associate Professor at the Johns Hopkins University Bloomberg School of Public Health and School of Medicine. He was the founding director of the Johns Hopkins Global Center on Childhood Obesity (JHGCCO). During nine years of service at Hopkins, among his many contributions, Dr. Wang and his team, secured $23 million of research funding from the National Health Institutes (NIH), published more than 120 peer-reviewed papers, and mentored more than 50 graduate students, visiting scholars and junior faculty members. Dr. Wang, whose work enriched the research and training programs at the Johns Hopkins University, led the University-wide effort to secure a five-year, $16 million NIH U54 Center grant in 2011, thus establishing the JHGCCO and positioning JHU at the frontline of the global effort to fight the obesity epidemic. Dr. Wang has served on numerous national and international expert panels and committees including many leadership positions.

MEMBERS FEATURED IN MEDIA

Dr. Xi Chen's study "Gift Escalation and Network Structure in Rural China: Utilizing a Unique Long-term Spontaneous Gift Record" was recently featured in the popular magazine Economist (http://econ.st/1cMWoop). Dr. Chen was also interviewed by the MacMillan Report for the research. The interview can be accessed through http://youtu.be/EPlKoyft3dc. Dr. Chen is an assistant professor in the Yale School of Public Health.

NEW PUBLICATIONS

Tsung-Mei Cheng. Explaining Shanghai's Health Care Reforms, Successes, and Challenges. *Health Affairs*. 2013, December.

Harry H.X. Wang, Samuel Y.S. Wong, Martin C.S. Wong, et.al. Patients' experiences in difference models of community health centers in Southern China. *Annuals of Family Medicine*. 2013, Nov-December.

Hui-Ming Luo, Yong Zhang, Xin-Qi Wang, et.al. Identification and Control of a Poliomyelitis outbreak in Xinjiang, China. *The New England Journal of Medicine*. 2013, November.

Guang-Hui Dong, Zhengmin (Min) Qian, Jing Wang, et.al. Home renovation, family history of atopy, and respiratory syndromes and Asthma among children living in China. *American Journal of Public Health*. 2013, November.

Wei He, Sherman A. James, M. Giovanna Merli, and Hui Zheng. An increasing socioeconomic gap in childhood overweight and obesity in China. *American Journal of Public Health*. 2013, November.

Sarah L. Barber, Michael Borowitz, Henk Bekedam and Jin Ma. The hospital of the future in China: China's reform of public hospitals and trends from industrialized countries. *Health Policy and Planning*. 2013, April.

Xiaopeng Zhang, Yuqi Xiong, Jing Ye, et.al. Analysis of government investment in primary healthcare institutions to promote equity during the three-year health reform program in China. *BMC Health Services Research*. 2013, March.