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CHPAMS

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China Health Review Volume 5 Issue 2, December 2014

EDITORIAL INTRODUCTION

Lu Shi, Ph.D., Clemson University, USA, Issue Editor

The draft legislation for Traditional Chinese Medicine (TCM) sparked a new wave of debate and discussion about the future of complementary and alternative medicine in mainland China. This is by no means the first time scholars and physicians debate how the government should intervene with TCM. Banning TCM, at least from the public sector, was very much on the media agenda as early as the 1910s and 1920s. This round of TCM controversy came at a time when healthcare expenditure rapidly increased over the last decade and costs associated with drugs constitute a much larger part of healthcare expenditure in China than in developed nations. Will the government's investment in TCM provide a possible solution to the rising health care expenditure? Or shall the payers hold TCM to the same drug trial standard as modern medicine? Is it fair to ask taxpayers to finance TCM drugs that could not survive a Phase III trial required for modern drugs?

In this issue, two researchers with background in traditional Chinese medicine contributed their prompt feedback to the draft version of the TCM legislation. They both noted the inadequacy of existing TCM workforce training: apprenticeship-based education and experience-based practice. Even if we fully assume that the theory of TCM is as credible as modern medicine, a training system largely reliant on apprenticeship could not serve the need of a modern society where most citizens need clinical care from cradle to grave. Secondly, from the perspective of pharmacoeconomics, the perpetual curse for herbal medicine lies in the fact that "natural drugs" are intrinsically hard to patent: spending millions of dollars on clinical trials to prove the therapeutic effect of orange peel will not bring much profit for the sponsor of the trial, since patients can simply respond to the trial results by preserving orange peel themselves. If the current model of trial sponsorship defies the private sector's motive of testing natural drugs, then some alternative mechanisms could be introduced to encourage the research and development in this field.

Many people realize that China is not alone in dealing with its traditional or folk medicine. In this issue, Dr. Pan noted the Japanese approach toward its traditional medicine. Many pondered why Japan dominated the international TCM drug market ("TCM drug" here is broadly defined, including Korean and Japanese branches deeply rooted in TCM), and our authors' discussion of standardizing the pharmaceutical regulation of TCM could provide one clue for improving the international competitiveness of China-made TCM drugs: quality of production and authenticity of drugs.

One very common research gap lies in the lack of debate about other complementary and alternative medicine in China: traditional Tibetan medicine, traditional Uighur medicine, traditional Mongolian medicine, etc. Whatever policy and procedure are implemented for TCM, they should be applicable for the traditional medicine practiced among minority ethnicities as well.

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Dr. Lu Shi is an assistant professor in the Department of Public Health Sciences at Clemson University, USA. He serves as the Director of Academics of CHPAMS and the Editor for this issue.

INTERVIEW

Interview with Prof. Sara Markowitz at Emory University

By Jing Xu, Ph.D.

Dr. Sara Markowitz is an Associate Professor of Economics at Emory University and Research Associate at the National Bureau of Economic Research. Dr. Markowitz's research interests are on the economics of healthy and unhealthy behaviors, with an emphasis on the health of children and adolescents. She publishes widely in general and specialty academic journals, and serves as an editor of the *Southern Economic Journal*. Her research has been featured in media publications such as the *New York Times*, *Wall Street Journal*, and *Business Week*. Markowitz has also won numerous research and teaching awards. She is a 1998 graduate of the PhD program in economics from the Graduate School of the City University of New York.

Prof. Sara Markowitz

Jing: Paul Samuelson once remarked that health economics and environmental economics might be the areas where major breakthroughs occur. Do you think that the moment has come for health economics?

Sara: I think that some of the big breakthroughs in health economics have already happened. Back in 1972, Michael Grossman changed the way economists think about human health with his seminal work on the demand for health. His insights into health as both an investment and a commodity that is produced with inputs have made a tremendous impact on the discipline. Before then, the field was often referred to as "medical economics" reflecting the assumption that health and medical care are more or less the same thing. We now know it as "health economics" due to large part to the shift in our thinking that resulted from Grossman's work showing that medical care is a small part of a larger story. There is now a staggering amount of research that arose from Grossman's ideas that examines all aspects of the demand for health both in conjunction with, and separately from, medical care. We also have a wealth of information on how all sorts of public policies can affect health outcomes. Much of this work uses the advances in econometrics to help establish causal relationships and credit goes to those individuals who bridged the fields. We now need to do a much better job getting the information out to the public health community, the politicians and the general public.

Jing: What advice do you have for young students and scholars in health econ? Or for female health economists?

Sara: I think it's becoming more and more difficult for young scholars to identify research topics that both contribute to our knowledge of the world and push the literature forward in new ways. The training that often comes along with a PhD in economics tends to focus on the methods and details at the expense of a bigger picture. I have seen tremendously sophisticated theories and models generated for the most uninteresting of questions. My advice to the young scholars in health economics is to start any research topic by asking themselves the following questions: Why should I do this research? Who will care about it? How big is the problem that the research addresses, or is it even a problem at all? These are basic questions that are far too often overlooked. But they are also tough question to answer since they require scholars to reject their own ideas. Research that is done because "it's easy to do" or "the data are available" or "no

one has done it before" are not good reasons on their own. Remember, no one will be impressed by your superior ability to take derivatives if there is no point to the exercise.

But the work does not stop with a good idea. Another challenge many young scholars face is in their ability to tell a good story when writing papers. The research question needs to be well motivated and should be very clear about how the work makes a contribution. The paper's arguments should be spelled out in lay terms before anything technical is presented. The health economist has a difficult job in that research should be aimed at two audiences, those in the profession and those in the public health community. But only through effective communicating can researchers advance our collective knowledge and work towards solving some of the major problems of our time.

RESEARCH PERSPECTIVE

Challenges and Opportunities to Conduct Cancer Care Research in China: Experience from a Pilot Project

By Nengliang Yao, Ph.D., Virginia Commonwealth University, USA; Xiaojie Sun, Ph.D., Shandong University, China

Abstract

Background: Cancer has become the leading cause of death in China. Effective cancer control and population science research programs are desperately needed in China. The China Medical Board (CMB) funding has provided us with an opportunity to build a research team specializing in cancer care utilization and access research and demonstrate the usefulness of the accrued data. The CMB-funded project will describe patterns of cancer screening, incidence, and treatment in Shandong Province in China and enable the researchers to understand possible causes of disparities in cancer control in China.

Findings: Although CMB projects do not provide salary support for affiliated American faculty, they do provide Chinese scholars in the U.S. an excellent opportunity to help improve health care in China. There are many challenges and opportunities in health care service and utilization research in China. For example, public data for cancer care research does not exist. We had to acquire secondary data from several governmental organizations andreconciled regional variations in data management. After acquiring all the data, we could create the most comprehensive cancer access, utilization, and outcomes research database to date in China and possibly expand this research in Shandong and other provinces. Students and analysts need to be trained to ensure the confidentiality of data linked to personal identifiers of patients and providers. At the same time, users need to learn how to manipulate and analyze large scale, messy, secondary data.

Discussion: We hope that the key findings will identify innovative scientific opportunities to improve cancer control and reduce inequities in communities. We intend to prepare manuscripts and reports in Chinese to disseminate findings to communities, policy makers, health care providers, and the scientific community. From the policy perspective, this study is a demonstration project drawing policy makers' attention to the importance of comprehensive cancer prevention and control data collection, both for accurate assessment and informed decision making with a high likelihood to effect desired change.

Keywords: China; Cancer Care; Health Policy; Research Data

Background

Dr. Yao: I am a health services and policy researcher primarily interested in cancer care and based in the U.S. My current research is supported by the National Cancer Institute and the Komen Breast Cancer Foundation and focuses on cancer care in older American patients. I initiated my research in cancer care in China as a PhD student when I was at The Pennsylvania State University but could not find any cancer related public data. During my last semester of PhD training, I saw the call for applications for Health Policy and Systems Sciences Open Competition projects on the China Medical Board (CMB) website. The project required a principle investigator from one of 17 Chinese universities. I was doubtful that any Chinese researchers would be interested in writing a CMB proposal with a PhD candidate from the US and did not know any health policy researchers in these 17 universities. However, **the China Health Policy and Management Society (CHPAMS)** monthly emails listed Shandong University's recruitment information and contact person, Dr. Xiaojie Sun. I contacted Dr. Sun who was very interested in collaborating. We exchanged several emails and had phone discussions, which became the basis for future collaborations.

We wrote and submitted the letter of intent or pre-proposal at the end of March 2013. CMB received 119 pre-proposals and in May we were notified that we were one of 25 teams invited to submit a full proposal in June. In order to make the team stronger, I invited several cancer care researchers and physicians to serve as consultants and Dr. Sun invited administrators at local cancer hospitals to join the research team. Reviewers liked our ideas and research design but were skeptical about the feasibility of the data collection because no published studies have used a similar data collection plan in China. We provided additional data acquisition and analysis information in the revision and were notified in December that they would receive $150K to study "Patterns of Cancer Screening, Incidence, and Treatment and Disparities in China."

Cancer in China

Cancer is the number one killer in China, the most feared and most expensive health condition. Evidence from well-designed studies reveals the heavy population burden; cancer has become the leading cause of death in China (374.1 per 100,000 person-years) [1]. Both cancer incidence and mortality in China are increasing [2]. The most recent data show that 13% of deaths in China were caused by malignant neoplasm and every minute, six people in China are diagnosed with cancer [2]. However, relatively few resources have been dedicated to cancer prevention and control research. In contrast, in the United States, the Division of Cancer Control and Population Sciences was established in 1997 to enhance the US National Cancer Institute's (NCI) ability to alleviate the burden of cancer through research in epidemiology, behavioral sciences, health services, surveillance, and cancer survivorship. Since that time, the division has grown and evolved into the model for cancer control research. Most NCI designated cancer centers in the US have a cancer control and prevention research program that aims to generate basic knowledge about how to monitor and change individual and collective behavior and cancer care practice. This provides a path for knowledge translation into practice and policy rapidly, effectively, and efficiently. This project aims to promote similar pervasive cancer prevention and control research in China, tailored to the needs and context in China.

The project officially started in January 2014. The project has two phases: a pilot phase and a main study. The one-year pilot study aims to examine the completeness and accuracy of population based secondary data. In addition, the pilot study includes the development and testing of a survey questionnaire for patient interviews. This paper reports the challenges and opportunities the study has faced thus far.

Findings

CMB encourages collaboration between Chinese and overseas researchers

CMB is a highly focused independent American foundation targeting its grant and support activities to "carefully selected Asian institutions", especially a small number of Chinese universities. CMB encourages overseas researchers to establish relationships directly with CMB-affiliated Chinese and Asian institutions. They believe that all 11 funded projects in the 2013 cycle have a research team that crosses country boundaries. Since CMB supports very few Chinese institutions, oversea researchers may have a hard time finding a collaborator if he or she wants to initiate a CMB project, especially if he or she has never worked with Chinese researchers before. **The China Health Policy and Management Society (CHPAMS)** can possibly play a role to facilitate communication between China-based scholars and overseas researchers.

CMB grant is relatively small for soft-money faculty

We have to use $150,000 (total cost) to cover the expenses of a three-year research project requiring both primary and secondary data collection. Compared to an NIH grant, we are using an R03 grant amount to do an R01 project. Although Dr. Sun is actually running the project, Dr. Yao has to spend substantial time in designing the study and assisting with research implementation. For those in a soft-money faculty position, CMB grant money will not cover salary and may not be a cost-effective way to get tenured in a medical school in the U.S. However, cancer care policy research is really important and urgent in China and could save lives. We hope that our research will lead to policies directed to reducing cancer care disparities, improving quality of care, and controlling treatment costs. Other funding sources may also support American faculty to study health policy in China, but the amount of funding is not significantly larger than the CMB grant. In order to cover my salary, I have to apply for other grants to study American healthcare issues at the same time.

The review process is smooth and efficient

We received brief comments about our pre-proposal. Those comments were encouraging but not very helpful in developing the full proposal. Three reviewers provided comments on their full proposal. Reviewers' comments were encouraging, but only one reviewer provided detailed comments and suggestions besides the scores on significance, innovation, and feasibility. We basically addressed all the reviewers' concerns by adding more information and references to the revision. It took about 10 months from drafting the pre-proposal to receiving the grant notification. We did not need to deal with the burdensome paperwork that NIH requires. CMB sent the award funding on time so we could allocate funds to kick off the project right away. We feel the whole process was transparent, smooth, and efficient. CMB announced the review results on their Weibo account. Proposal templates were provided when the call was announced, which we found very helpful. Readers can refer to the 2013 October issue of *China Health Review* for more information about the review process. Three grantees have provided their opinions from the perspective of China-based faculty.

The key to success: two committed collaborators

We had not worked jointly when we decided to write the proposal together. We had many virtual meetings through Skype and QQ while writing the proposal. We both committed to designing a rigorous study. Dr. Yao wanted to introduce his cancer care research into China, and Dr. Sun had to evaluate feasibility and discuss the project with many other researchers and administrators in China to find an effective way to implement the research. Although this is a three-year project, we are determined to develop and promote cancer care and policy research in China. We plan to offer our data and data analysis training to other Chinese researchers in the third year. With Dr. Sun's help and guidance, Dr. Yao has learned a lot in the past year about the Chinese health care system and the way to conduct academic research in China. Although most Chinese speaking researchers in the US were born and raised in Mainland China, they may lack basic knowledge about China healthcare since China is changing so fast. Commitment to rigorous health care research has kept our heads up and feet on the ground.

Cancer care is understudied in China

Cancer incidence and mortality rates have been analyzed in China, while the patterns of cancer screening, treatment, and disparities have not been rigorously examined. China National Cancer Center (CNCC) is a bureau (*jú*) level non-government organization affiliated with the National Health and Family Planning Commission (NHFPC). To our knowledge, CNCC,

established several years ago, has not done much population based cancer care research through either extramural or intramural programs. Although cancer care physicians in cancer hospitals and general hospitals are motivated to do research and to publish, they are more likely to be involved in basic and clinical science research. Not many health services and policy researchers in China study cancer care, because they need to have substantial clinical knowledge of cancer or collaborate closely with cancer doctors. We are optimistic that we can find physician collaborators in China as long as we can help them publish in highly ranked clinical science or health care journals.

Data acquisition is the most difficult job

There is no public data at all for cancer care and policy research in China. We identified all possible cancer related data sources, which were mostly collected for administrative purposes rather than for research. We then found the data source owner organizations and used the personal connections in Shandong to establish a working relationship with these owner organizations. We are collecting data from five rural counties and one metropolitan area, since there is not a provincial level organization that can provide data from all study regions. We collaborate with three or four organizations in each county or city. In addition, we have found regional variations in data management. Same data may be managed by different organizations in different places. Dr. Sun has to spend enormous amount of time and efforts on trust building for the research collaboration. Obtaining secondary data from government organizations is difficult from any position on the career ladder. It is not easy for a full professor, a center director, or a dean. Dr. Yao has consulted a well-known faculty who returned to China a decade ago from the US. There is no better way than requesting data while conversing around the dining table. It is extremely difficult to acquire data in a province or an area if the researcher does not have any personal connections in healthcare related sectors. If we can demonstrate the value of cancer care research through this project, it may be possible to get political support for data acquisition from the provincial government or the central government in the future. For example, we could create the largest cancer care research database in the world if Shandong provincial government supports us to collect data from the entire Shandong province (100 million population). This vision motivates the whole team to work diligently.

Data safety and analysis are challenging

We will receive data with personal identifiers and information about the providers. Since the data will only be stored and analyzed in China, this study received expedited review in Virginia Commonwealth University and full review in Shandong University. Dr. Yao has trained students to ensure the confidentiality of individuals included in the data. It is also important to consider the privacy of providers, because unless cancer physicians and hospitals' privacy is protected, it could compromise their willingness to cooperate in the future. None of us has ever used cancer related data from so many organizations. Although Dr. Yao has rich experience with similar large data sets in the US, we expect the incoming data will be different in terms of structure, completeness, and regional variations. Dr. Yao has discovered several limitations in the data. For example, the stage of diagnosis is missing for most cancer patients in the cancer registry data. Therefore, we have to find other data sources to supplement the registry data. In addition, we do not have skilled data analysts or research assistants to do statistical programming. Junior faculty members in China are normally not eligible to formally mentor PhD students. Their mentees are master level students who often lack rigorous training in programming, data analyses, and statistics or econometrics. They have limited experience with messy, large secondary data. The bright side is that the data will include patients younger than 65 who are excluded from US studies because of data limitations. Also data owners are making efforts to improve the data quality and completeness.

Publish or perish

Both American and Chinese universities require research faculty to publish in reputable English journals. We think it is relatively hard to publish non-US studies in US-based health policy or clinical journals such as *Medical Care, Health Affairs, Health Services Research, Journal of Clinical Oncology*, and *Cancer*. We may have a better chance of publishing the results from this study in UK-based journals such as some BMC journals, which are not popular journals for American health policy researchers. Similarly, we expect that our research will only have a slim chance of being accepted as oral presentations at premier health policy research conferences such as AcademyHealth Annual Research Meeting and clinical conferences such as American Society of Clinical Oncology Annual Meeting. Sometimes publishing in English journals is not directly aligned with the non-academic goals of a research projects in China. We want to identify innovative scientific opportunities to improve cancer control and reduce inequities in communities experiencing an excess burden of cancer. We want to disseminate findings to communities, policy makers, and health care providers and to the scientific community. The key findings of this project will be submitted to the NHFPC through some of Dr. Yao's ex-colleagues. In order to accomplish these goals, we want to write Chinese articles and reports. Dr. Yao is not confident that Chinese publications will help his career development but believes that it is the right thing to do.

Example results from the pilot survey data

We collected both primary and secondary data in this project. We also conducted a survey on the lasting effects of treatment on employment, finances, health insurance coverage, and life in general. The pilot survey in Feicheng county of Shandong revealed that most breast patients were diagnosed when cancer symptoms were present, while most breast cancer patients in the US were diagnosed through screening. [3] We have also asked cancer survivors if the cancer experience had any positive impact on their life (Table 1). It seems that US survivors responded more positively to the cancer experience than survivors in Feicheng, China [4]. Chinese cancer patients may be sicker than US survivors after diagnosis and treatment.

Table 1. Positive Response to Cancer Experience

Have any of the following been positive things about your experiences with your cancer, its treatment, or the lasting effects of that treatment?	Feicheng, China (N=148)	US (MEPS data, N=1,419)
It has made me a stronger person	35.1%	58.8%
I can cope better with life's challenges	44.6%	59.4%
It became a reason to make positive changes in my life	23.0%	57.2%
It has made me have healthier habits	54.1%	61.7%

Conclusions

Cancer has become the leading cause of death in China. The patterns of cancer screening, treatment, and disparities have not been rigorously examined. In addition, cancer care costs remain unexamined with relatively rigorous methods in China. We believe that effective cancer control and population science research programs are desperately needed in China, which motivated us to collaborate on promoting cancer care and policy research. CMB provides a

good opportunity to build up a research team specializing in cancer care research. Although CMB projects do not provide salary support for American faculty, they provide Chinese scholars in the US an excellent opportunity to help improve health care in China. From the economic perspective, health care research in China may have a greater impact on people's wellbeing than in the United States if the effect of research on health has reached the point of diminishing returns in the US.

This project will clarify the pattern of cancer screening, incidence, and treatment in China and facilitate our understanding of possible causes of disparities in cancer control. We will identify new and innovative scientific opportunities to improve cancer control and reduce inequities in communities experiencing an excess burden of cancer. Disseminating the data and methods of data analysis in the Chinese community will invite others to do the same. From the policy perspective, this study is a demonstration project drawing policy makers' attention to the power and utility of data collection on cancer prevention and control. We hope interests from the academia and the government will lead China to increase cancer control and population science research. There are many challenges and opportunities in this type of research project. First, China lacks of public data for cancer care related research. We had to acquire several different types of secondary data from multiple governmental organizations. We also found regional variations in data management. Once we acquire all the data, we could create the most extensive cancer care research database in China to date and possibly expand this research in Shandong and other provinces. Since we receive a lot of data with personal identifiers of patients and providers, they trained students and analysts to ensure data confidentiality. We have also discovered limitations of the data. We have to train students and analysts to use large scale, messy secondary data. It is relatively hard to publish non-US studies in US-based health policy or clinical journals. Despite of all these challenges, we hope that the key findings will identify innovative scientific opportunities to improve cancer control and reduce inequities in communities. We also intend to write Chinese articles and reports to disseminate findings to communities, policy makers, and health care providers and to the scientific community.

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References:

[1] He J, Gu D, Wu X, Reynolds K, Duan X, Yao C, et al. Major causes of death among men and women in China. *New Engl J Med*. 2005; 353: 1124-1134.
[2] Hao J, Chen WQ. *Chinese Cancer Registry Annual Report*. Beijing: Military Medical Science Publishing House; 2012
[3] Anderson RT, Yang T-C, Matthews SA, Camacho F, Kern T, Mackley HB, et al. Breast Cancer Screening, Area Deprivation, and Later Stage Breast Cancer in Appalachia: Does Geography Matter? *Health Services Research*. 2014 Apr;49(2):546-67.
[4] Yabroff, K. R., Dowling, E., Rodriguez, J., Ekwueme, D. U., Meissner, H., Soni, A., ... & Virgo, K. S. (2012). The Medical Expenditure Panel Survey (MEPS) experiences with cancer survivorship supplement. *Journal of Cancer Survivorship*, *6*(4), 407-419.

COMMENTARY

The Statute of Traditional Chinese Medicine (TCM) in China

By Xi Pan, Ph.D. Clemson University, USA

Abstract: This commentary discusses the significance and improvement of the drafted regulation on Traditional Chinese Medicine (TCM) proposed by the Chinese government. The draft regulation is significant in emphasizing the need of evidence-based scientific and evaluation research of TCM; guiding the design of deliverable and high-quality TCM healthcare service to urban as well as rural communities in China; and confirming the scientific value of TCM. However, a few sections in the draft need to be readdressed and spelled out. Pharmaceutical formulae and medicine production shall require license and certification; experienced TCM professionals should be invited to teach and evaluated by students to substitute the "master-to-apprentice" training; specific plans that lead to qualitative change of TCM and legal liability related to TCM practice need to be elaborated; and the consequence of violation of the regulation shall be specified.

As the cradle of Traditional Chinese Medicine (TCM), China is responsible to embrace the application of TCM and take the leadership of its development. To achieve such a goal, the Chinese government has prepared a draft of the statute to promote TCM practice. Generally, the draft regulation designates the existing weakness of TCM application and addresses the related development in six areas: healthcare service, pharmaceutical production, education, research, evaluation, and legal liability. It significantly contributes to TCM education and related research in two specific areas. First, it proposes TCM related research in domains including international communication and collaboration, funding resources, laboratory experiment, and publications. Existing literature suggests that the effectiveness of TCM is not convincing due to lack of evidence-based research and scientific evaluation (Konkimalla & Efferth, 2008; Xu, Towers, Li & Collet, 2006). So far, randomized case-control studies with large sample sizes based on clinical trials are generally accepted as the gold standard for research of TCM (Yu et al., 2006). For instance, Kampo, the unique system of Japanese herbal medicine, derives from TCM, is widely practiced in Japan and the West, which is fully integrated into the modern healthcare system. The success of Kampo is due to its ready-to-use formulae, which is based on clinical evidence and laboratory studies (Yu et al., 2006). Additionally, evidence based on laboratory experiment reveals that herbal extract from traditional Chinese medicine reduces lipid levels among mice with obesity as effectively as the Western obesity drug Rimonabant (Qiu, 2007). In recent years, Chinese researchers used qualitative methods exploring self-reported effectiveness of TCM practice among Chinese with cancer to develop clinical evaluation programs for TCM (Xu et al., 2006). What is more, clinical research utilized metabonomic method along with fingerprint and target analyses to examine potential mechanisms of berberine action in the treatment of type 2 diabetes and dyslipidemia among Chinese patients (Gu et al., 2010). Despite these efforts, the number of clinical research of TCM in China is limited. The draft regulation will provide a foundation for more research to provide clinical evidence for TCM efficacy and international quality standards for TCM products. Second, the draft highlights the importance of integrating Western medicine and TCM for disease diagnosis and treatment. In the West, TCM is used as a complement to Western medicine, particularly in pain management and supplementary therapy for cancer (Konkimalla & Efferth, 2008). In China, integrating Western medicine and TCM is perceived as the optimal therapy by patients with cancer in various stages in the clinic (Xu et al., 2006). Whereas, such a regulation is practically meaningful in improving the communication between physicians in Western medicine and TCM in order to effectively serve patients.

Regarding healthcare service, the draft emphasizes extending professional TCM healthcare service supply and delivery to communities, particularly communities in rural China. Access to professional TCM programs or certified TCM practitioners is insufficient in most urban communities, and those are even rarer in rural China (Arcury et al., 2006; Xu, Toobert, Savage, Pan & Whitmer, 2008b). Due to lack of professional guidance, TCM practice is not a promising healthcare approach. Such a regulation would guide the design of deliverable and high-quality TCM healthcare service to urban as well as rural communities in China.

The draft also affirms the value of TCM as medicine and a significant Chinese culture. TCM has been practiced for at least 2000 years in China. It is characterized with two important theories: *yin-yang* theory and five element theory. The first theory posits the equilibrium of *yin* and *yang* that ensures the harmony of the body (Lao, Xu & Xu, 2012). The second theory describes the relationship between the human body and the external environment (Lao et al., 2012). These theories imply two substantial philosophies. First, health is not merely the absence of physical disease or infirmity, but a state of complete physical, mental, and social well-being, which corresponds to the concept of health defined by the World Health Organization (WHO) in its constitution since 1948. Second, in contrast to Western medicine, which uses disease-based diagnosis, TCM emphasizes patient-based diagnosis and the dynamic progression of disease (Yu et al., 2006). Diverse TCM modalities including herbal medicine, acupuncture, moxibustion and massage are rooted in these philosophies. As one of the oldest continuously surviving means to treat diseases and maintain good health, TCM has been recognized as the major and the largest category of complementary and alternative medicine (CAM) by WHO, the National Center for Complementary and Alternative Medicine in the U.S., and other authoritative medical organizations worldwide (Yu et al., 2006). Compared to other CAM strategies, TCM is based on a clear rationale, a complete diagnosis-to-treatment system, and a well-established theoretical framework (Xu et al., 2006). Since the beginning of this century, TCM has been widely utilized by individuals with chronic disease, such as cancer and diabetes, to manage their disease and associated complications along with Western medicine in the West (Xu et al., 2006; Lao et al., 2012).

Although the draft is promising in multiple ways to guide the development of TCM, some sections need to be readdressed and spelled out. First, registration for producing pharmaceutical medicine is not sufficient to control for the quality of pharmaceutical formulae albeit traditional methods. Pharmaceutical formulation shall require license and certification. Standards should be constructed and used to evaluate and monitor the pharmaceutical products and the formulating process. These standards must be applied to any level of government-funded and private healthcare institutions. Furthermore, punishment for infringements against the regulation needs to be specified. Second, the "master-to-apprentice" education is lack of professionalism, thus not beneficial for systematic TCM training and scientific development of TCM. Experienced TCM professionals should be invited to teach in TCM educational institutes. Their teaching has to be evaluated by students and their peer colleagues. Launching TCM education to the public is in favor of its sustainable development. Third, the current draft is ambiguous in addressing "how to do" in healthcare service, education, and management and evaluation. Without specific principles, strategic plans might not occur to lead to qualitative change. Last, the drafted regulation is unclear in elaborating specific legal liability related to TCM practice. The legal responsibility of related authorities, which monitor and reinforce the regulation, is not specified. Additionally, the consequence of violation and related punishment is not explicit. Certainly, major concerns from the Chinese public are execution of these principles and monitoring to the execution. After all, TCM would prosper only if the written propositions are translated into actions.

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References:

Arcury, T. A., Bell, R. A., Snively, B. M., Smith, S. L., Skelly, A. H., Wetmore, L. K., & Quandt, S. A. (2006). Complementary and alternative medicine use as health self-management: Rural older adults with diabetes. *Journal of Gerontology Series B: Psychological Sciences and Social Sciences*, *61*(2), S62–S70.

Gu, Y., Zhang, Y., Shi, X., Li, X., Hong, J., Chen, J., … Ning, G. (2010). Effect of traditional Chinese medicine berberine on type 2 diabetes based on comprehensive metabonomics. *Talanta*, *81*, 766–772.

Konkimalla, V. B., & Efferth, T. (2008). Evidence-based Chinese medicine for cancer therapy, *Journal of Ethnopharmocology*. *116*, 207–210.

Lao, L., Xu, L., & Xu, S. (2012). Traditional Chinese Medicine, A. Längler et al. (eds.). *Integrative Pediatric Oncology, Pediatric Oncology* (pp.125–135). Berlin Heidelberg: Springer-Verlag.

Qiu, J. (2007). A culture in the balance: Traditional Chinese medicine and Western science face almost irreconcilable differences. Can system biology bring them together? *Nature*, *448*, 126–128. doi:10.1038/448126a

Xu, Y., Toobert, D., Savage, C., Pan, W., & Whitmer, K. (2008b). Factors influencing diabetes self-management in Chinese people with type 2 diabetes. *Research in Nursing & Health*, *31*, 613–625.

Xu, W., Towers, A. D., Li, P., & Collet, J.-P. (2006). Traditional Chinese Medicine in cancer care: perspectives and experiences of patients and professionals in China. *European Journal of Cancer Care*, *15*, 397–403.

Yu, F., Takahashi, T., Moriya, J., Kawaura, K., Yamakawa, J., Kusaka, K., … Kanda, T. (2006). Traditional Chinese Medicine and Kampo: A review from the distant past for the future. *The Journal of International Medical Research*, *34*, 231–239.

COMMENTARY

Comments on the Draft of Traditional Chinese Medicine Act

评《中华人民共和国中医药法》征求意见稿

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Abstract
The Draft of Traditional Chinese Medicine (TCM) Act was published by the State Council Legislative Affairs Office in June. This is an important step to formalize the governance of TCM. This paper briefly reviews the history of TCM, the advantage of TCM, and the challenges towards TCM. The commentary highlights the needs in the education, research, and regulation of TCM in China.

在 2014 年初全国中医药工作会议上，刘延东副总理作出了重要批示：中医药作为我国独特的卫生资源、潜力巨大的经济资源、具有原创优势的科技资源、优秀的文化资源和重要的生态资源，在经济社会发展的全局中有着重要的意义。紧接着国家卫生计生委李斌主任提出要推动中医药发展上升为国家战略[1]。于是在同年 7 月，国务院法制办公室公布了《中华人民共和国中医药法（征求意见稿）》，欢迎有关单位和各界人士提交意见。无疑这是中医药界欢欣鼓舞的一件事，说明国家立法层面开始关注到中医药在中国已逐渐衰退，希望通过立法来扶持和促进中医药，保护公众健康。这些都表明了党和国家支持中医药发展的鲜明态度，这是中医药生存和发展的根本保证。

1. 中医药立法的必要性

正如中国社会科学院经济研究所研究员陈其广所说：中医药是中华民族用数千年时间和亿万人生命实践不断发现、创造、积累、检验和完善所形成的一个原创、独立、完整的知识理论和方法技能体系，在中华民族五千年来生生不息、日渐强盛的过程中功不可没。中医药从养生保健、疾病防治多个方面都具备了成为我国医药战略基石的特性和价值[2]。中医学理论是建立在中国古代哲学理论"气一元论"的基础之上的，中医的"天人合一"观念、阴阳五行学说、经络系统与五脏六腑等基础理论，强调局部与整体的统一协调，是通过四诊八纲，对病情进行归纳分析和辨证论治，并创建了一套以中草药、针灸、推拿按摩等为主要治疗手段的综合性自然疗法[3]。尽管中医药在中国存在了几千年，它的临床疗效也非常显著，但由于它的阴阳五行、表里虚实、辨证施治等医学理论人们不易了解，中草药的药性归经人们更不易掌握，加之中医的治疗效果很难用数字说话，从药物到治疗都难以验证、复制，不了解中医药的人就很容易对中医药的科学性产生疑问，甚至有些学者发起"废除中医"运动。说明当今社会在现代医学的冲击下，仍有部分人对中医药没有持客观、正确的认知态度[3]。中医与西医对于疾病应用不同的治疗方法，属于不同的理论体系，试图用西医的理论来理解中医的路是行不通的，试图用研究西药的方法来研究中药也是行不通的。正如著名学者钱学森先生说过的一句话："中医、西医是两个不同的体系，没有办法结合。"外行人对中医的偏见尚可理解，但最近笔者与一位在综合性医院的主治中医师的谈话却更让人担忧中医能否得到继承。对话如下：笔者:"最近中医药法即将出台，有没有特别高兴？"中医师："不知道这事。"笔者:"中医药法一出台，你们就不用担心中药房被撤掉，中医科在医院的地位也会得到提高。"中医师："中药房被撤掉更好，开中药方要背汤头，很累，还是开西药简单些。"故笔者认为国家此时出台立法保护中医药确实是及时雨，非常有必要通过立法保护中医药，救中医药于频危之中。

2. 中医的优势

2.1 疾病的预防

成书于 2000 多年前的《黄帝内经》就已经强调了疾病预防的重要性，书中写到："圣人不治已病治未病，不治已乱治未乱。"唐代药王孙思邈对治未病有更明确的表述,他在《备急千金要方》中说:"上医医未病之病,中医医欲病之病,下医医已病之病"。中医在二千多年的发展过程中逐渐形成了"未病先防，已病防变和瘥后防复"的中医学防治思想[4]，而养生则是中医治未病的基础。

“养生”一词最早见于《庄子·内篇》，又称摄生或道生。所谓“生”，就是指生命和生长的意思，所谓“养”是指调养、补养、保养和护养的意思[5]。养生就是指通过精神调养，使内心平静，减少喜、怒、忧、思、悲、恐、惊等情志对人造成的伤害，同时顺应四时节气的变化，根据个体体质分类（8 种体质，即气虚、血虚、阴虚、阳虚、气郁、血瘀、痰湿和阳盛），结合食物和药物的性味归经进行合理膳食以调养身心，增强体质，达到预防疾病的目的。主要的方法有精神养生、睡眠养生、饮食养生、运动养生等。

2.2 疾病的治疗

杨海丰等的研究结果表明中医优势病种在中医内、外、妇、儿、骨伤、眼、耳鼻喉科都有分布，但以中医内科和外科为主。中医内科主要的优势病种有中风、腰痛、项痹、眩晕、消渴、胸痹心痛、面瘫、胃脘痛、肝著、咳嗽。中医外科主要的优势病种有痔疮、肛漏、脱疽、肛裂、久痢、颈痈、脱肛、股肿、混合痔疮、湿疮[6]。同时，大量临床研究结果表明中医在治疗儿童消化及营养不良、女性月经不调和不孕不育、肿瘤化疗后恢复骨髓造血功能及胃肠道功能方面有明显优势[7-12]。由此可见，中国人是多么的幸运，较之西方人多了一种医疗选择！

3. 中医药目前存在的问题及解决办法

3.1 传统中医师执业资格

《中华人民共和国中医药法》第二十三条中提到传统中医师仅从事传统中医药服务。传统中医师执业应当经县级人民政府中医药主管部门实绩考核、登记，在登记的地域范围、执业范围内开展中医相关诊疗活动。从此条例中我们能看到国家已注意到许多有传承、临床疗效好的中医，长期没有合法的行医资格，这些中医往往又无法通过 2006 年中华人民共和国卫生部 52 令制定的传统医学师承和确有专长人员医师资格考核考试办法，降低这些有专长的中医师的准入门槛让他们取得正当的行医资格，使其“从地下转为地上”，能为更多的患者服务。

3.2 目前国内中医院概况

目前国内的中医院大多数名字是中医院，实则为中西医结合医院。以笔者本人所在的城市为例，单纯经营中医药的只有一家公立的国医堂门诊和一家私人投资的瑞来春堂门诊。笔者有幸采访了瑞来春堂门诊的林总。林总认为有临床疗效好的中医师，关键还得有质量好的中药。瑞来春堂聘请的中医师皆是当地有名的中医，尤以传统中医师为多，这些中医师深得民间百姓信任，口口相传。这些中医师也愿意来瑞来春堂坐诊，因为这里能提供品质保证的中药。瑞来春堂有专门经营中药的药材公司和饮片加工厂，自己到民间收购药材再加工成饮片供给门诊部使用，保证了医师诊断及用方正确的情况下能用上最好的中药，从而保证了良好的临床疗效。同时也正因为该门诊专营中医药，使得老百姓想看中医时自然会到瑞来春堂。林总说目前经营状况良好且有盈利。笔者认为既然私人中医门诊在政策支持力度小，没有医保政策支持，没有使用昂贵且效果不好的中药颗粒剂的情况下都能盈利，那公立的中医院怎么能一边拿着国家的补贴，一边在大力发展西医，大量用着中药颗粒剂呢！笔者建议应该让公立的中医院中药销售量至少达药品销售额的 90%，而不是目前的 30%，且中药颗粒剂只能是中药销售量里的 10%。其他达不到标准的医院均应改名为中西医结合医院，不能象现在挂着羊头，超一半在卖着狗肉，却还要拿着国家的羊肉补贴费！

3.3 教育

中医是我国的国粹，是中国传统文化的一部分。要让中医得以传承并得到发展一定要从娃娃抓起。鼓励幼儿园小朋友及小学生在背诵诗歌、三字经的同时，强调背诵汤头歌诀、药性赋、脉诀的重要性。并且在小学阶段的科学或实践课程中开设常见中药材识别及标本制作课程，让孩子们在融入大自然的同时了解中医中药文化，从而产生浓厚的兴趣，储蓄潜在的中医药后备人才。中医药大学在招生时应该更注重评估学生是否真正对中医感兴趣，对文言文的解读能力如何?对于终身立志成一代中医大师，有良好的文言文功底的学生应适当降低分数并重点培养。目前国内有部分中医学院的学生精通外语，却不懂文言文；精通细胞和 DNA，却不懂阴阳虚实；懂 B 超和核磁共振，却不会望闻问切；部分中医学生毕业分配进了医院不安心当中医，当中医也非其兴趣所在，只是为了就业而已，往往在读硕士博士时转了西医。故笔者认为中医专业的学生不必学习外语，而是需要学习文言文，并在大学期间遍读古代医学典籍，方是中医发展之大计。

3.4 研究

当代中医并无再出现特别卓越类似叶天士这样的中医大师，故笔者认为目前中医应注重继承，发展目前仍比较困难。目前的中医院科研建议重点支持以下几方面的研究：①注重医药古籍的研究及宣传。注重古籍的通俗易懂化，让更多的普通大众能读懂这些古籍并可应用于日常养生的生活中，达到预防疾病发生的目的。② 注重中药传统剂型的研发，如丸散膏丹剂。虽现在大多数医院都有提供汤药煎煮加工服务，但其携带和保存均麻烦，且味道不好喝，慢性病需要服用较长时间汤药的患者往往会放弃中医治疗。而注射剂从来不是传统中药剂型，且中药成分复杂，不容易提到单体或有效部位，注射剂杂质含量多，容易发生严重不良反应，故应严格控制中药注射剂的研究开发。③ 注重中药汤剂、丸、散、膏、丹剂的作用机理及临床应用研究。减少资助从单味中药中分离纯化出单体或有效部位的研究，因一旦分离到单体并发展成新药后，这个新药属于西药管理，而不再是中药了。④注重中医药整体论思维方式研究，如经络研究、藏象病机证侯研究、阴阳理论研究等。

3.5 中药材

为加强中药材及饮片管理，保障公众用药安全，国家食品药品监督管理总局近期组织开展了中药材及饮片专项抽验。共从全国 31 个省有关中药材及饮片的生产、经营和使用单位抽取蒲黄、柴胡、川贝母、血竭、薄荷、木通、苍术、附子、制川乌和制草乌等 10 个品种 772 批样品， 并在 2014 年 09 月 23 日 对 93 批不符合标准规定的中药材及饮片进行了通报。

国家食品药品监督管理总局在此次专项检查的汇报结果上写到：总体上看，抽验的中药材及饮片的质量状况不容乐观，染色、增重、掺伪、掺杂等问题仍然比较突出。除薄荷、木通和制川乌外，其余 7 个中药材及饮片均检出不符合标准规定产品。同时也表明了对中药材及饮片进行染色、增重、掺伪、掺杂等违法行为，严重危害公众用药安全，欺骗消费者的行为进行严厉打击的决心。

这次检查主要是针对中药饮片的染色、增重、掺假、炮制不当等手段加工中药饮片。而中药材的种植、采收、流通、销售等过程中也存在的诸多问题，如滥施农药化肥、应用转基因技术、滥挖滥采、人为炒作、囤积居奇、哄抬药价等也应一并整治。建议在中医药法中体现出严格杜绝不合格中药材流入中药市场、饮片厂和药房，且应有惩罚措施。

参考文献

[1] 中国中医药报，2014 年 2 月 24 日第 2 版.
[2] 中国医药报，2014 年 4 月 1 日第 5 版.
[3] 李艳. 中医药发展存在的问题探析.中医药管理杂志，2014，22(1):8-10.
[4] 裴兰英，牛乐，申杰. 中医“治未病”理论与现代预防医学的区别和联系. 中 医 学 报.2014,193(6):823-824.
[5]彭艳，尹艳，杨智荣. 关于中医养生治未病. 针灸临床杂志，2010, 02(12):59-60.
[6]杨海丰, 崔志伟，王茂等. 我国中医优势病种分布状况及特点. 中医杂志, 2012, 53(4):285-287.
[7]王丽英. 中医预防保健小儿营养不良 60 例观察. 浙江中医杂志, 2014, 49(6): 439.
[8]金炫廷, 马堃, 单婧. 补肾活血中药治疗多囊卵巢综合征导致排卵障碍性不孕的临床研究. 中国中药杂志, 2014, 39（1）:140-143.
[9]赵旭. 调经促孕类中药治疗月经不调不孕症的疗效观察. 中医临床研究, 2014, 6（14）；78-79.
[10] 王兆炯. 中医对于恶性肿瘤化疗后骨髓抑制的临床研究. 长春中医药大学学报，2014, 27(2):203-204.
[11]颖扉,潘磊.中药预防肺癌患者化疗后胃肠道反应观察.肿瘤学杂志, 2008, 14(6):503-504.
[12]杭冬新,张东焱.半苏散敷脐治疗放化疗后恶心呕吐的疗效观察.河北中医药学报, 2008, 23(2):26.

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COMMENTARY

Medical hierarchy in professional ranking and its implications in China

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Medical hierarchy is a system where health professionals are ranked according to certain criteria. While hierarchy helps identify the seniority and mentorship to which junior practitioners can refer, it can also become a barrier in medical practice and sometimes lead to undesirable perceptions and consequences for both medical professionals and patients. Physicians in Denmark perceived the hierarchical position as a major determinant of influence on technical and ethical decisions.[1] German physicians complained about the monarchy-like system in clinical positions that led to a negative working atmosphere and reduced health-related quality of life among young physicians.[2] Srivastava[3], drawing from the author's own medical practice in the US, showed that blind adherence to hierarchy defined by medical specialties could lead to disastrous outcomes.

Doctors' professional ranking in China presents another rigid medical hierarchy. Following residency, there are three steps in ranking ladder — attending physician, deputy chief physician, and chief physician. The ranking title is deemed to be more valuable in China, because it not only is linked with the physicians' basic salary, but also is the symbol of prestige and reputation. Thus, the ranking title is even used in preference to the designation of M.D.

Two questions can be raised here. One is the evaluation criteria for ranking that do not necessarily reflect clinical capability. The other is the perceived linkage between the ranking title and medical expertise that affects patients' decision on where and from whom to seek medical care.

The current ranking evaluation in China relies heavily on requirements regarding the number of publications and English-language skills. These do not necessarily translate to clinical capability, but rather deprive the time from clinical practice and may contribute to physicians' burnout. An assessment conducted among physicians in eight Chinese hospitals indicated that the professional ranking system was significantly related to physicians' job burnout.[4] The medical profession representatives at the National People's Congress and the National Committee of the Chinese People's Political Consultative Conference have advocated for a reform on the evaluation of medical professional rankings with more focus on clinical performance.[5]

The ranking title of a physician is the most visible information to the public. Patients in China usually perceive that the higher ranking the doctor and the larger the hospital, the better health care a patient can receive. Therefore, Chinese patients tend to seek care in tertiary hospitals and choose physicians based on their ranking titles, regardless the severity of the illness. In a system with a paucity of family physicians, the yearning for top-ranking doctors increases the difficulty in access to care in a sense of the ratio between the number of those doctors and the number of patients who seek specialty care with them. In the absence of triage, succumbing to ascribed medical hierarchy may affect quality of care as well given the ranking not necessarily reflect clinical capability so the appropriate care may be delayed and the inappropriate care-seeking behaviors of patients again may reinforce the difficulty in care access.

Hierarchy in professional ranking has its rationale, but the information asymmetry-is attributing to patients' misperceptions towards the linkage between the quality of care and the ranking title among medical professionals. And the ranking criteria favoring the number of publications and English skills have become the contributing factor to physicians' burnout. To alleviate the perverse influence of medical hierarchy, the development of an integrated care and a reform

on the appropriate recognition of practitioners' clinical qualifications coupled with the standardized residency training are the possible approaches China's health system can take in pursuit of improving the access to care and the quality of care.

References

[1] Holm S. The medical hierarchy and perceived influence on technical and ethical decisions. *Journal of Internal Medicine* 1995; 237(5): 487-492.

[2] Jurkat HB. German medical hierarchy: the ladder to quality of life? *Lancet* 2006; 368: 985-986.

[3] Srivastava R. Speaking up- when doctors navigate medical hierarchy. *N Engl J Med* 2013; 368: 302-305.

[4] Zheng FZ. and Chen L. The study on the relation between physicians' burnout and background factors (in Chinese). *Medicine and Society* 2007; 20(6): 4-6.

[5] Medical ranking system discussed at People's Congress and People's Political Consultative Conference. *Chinese Medical Doctor Association* March 19, 2013 (online).

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POLICY AND PRACTICE UPDATES

Xuezheng Qin, Peking University, China

浙江全面启动公立医院综合改革 4 月起药品零差率销售

《浙江在线》 2014-03-27

http://zjnews.zjol.com.cn/system/2014/03/27/019935762.shtml

根据刚刚出台的《浙江省人民政府办公厅关于启动实施省级公立医院综合改革的意见》，浙江省所有省级公立医院自 2014 年 4 月 1 日起实行药品零差率销售，启动以药品零差率为核心的综合改革。

《意见》指出，改革主要包括五个方面主要任务：一是建立省级公立医院经济运行新机制，破除"以药补医"机制；二是有效推进医疗资源的科学配置，科学规划省级公立医院资源，落实对基层医院支援工作；三是探索省级公立医院综合改革新举措，建立和完善现代医院管理制度，推动建立适应行业特点的人事薪酬、绩效评价等制度，支持省级公立医院通过多种方式与社会资本合作；四是切实加强省级公立医院综合管理，强化医疗费用监管，强化医疗质量安全管理；五是全面改善省级公立医院医疗服务，完善惠民便民措施，强化医德医风建设，优化医疗执业环境。

医保经办机构垄断有望打破

《新华网》 2014-04-30

http://www.zgylbx.com/ziqagjafnew64380_1/

近日召开的国务院常务会议强调，我国将继续加大投入，注重发挥市场作用，实行医疗、医保、医药三联动。本月，发改委下文松绑民营医院的价格管理，其中提到"建立经办机构与定点非公立医疗机构的谈判机制。"

目前在我国大部分地区，医院和医保经办机构之间真正的谈判机制尚未建立，有业内人士认为，其原因在于医保经办机构一直处于高度垄断状态。这种高度垄断主要表现在三方面：一是医保服务管办不分，经办机构与主管人社部门具有"父子"一样的特殊关系；二是在每一个医保统筹地区，只有一家由主管部门派出的经办机构，参保人没有选择第二家经办机构的余地；三是经办机构与主管人社部门本应是平等的协议关系，但现实却是两者之间完全成了监管和被监管的关系。

县级公立医院改革可成医改突破口

《财经频道》 2014-04-15

http://finance.eastmoney.com/news/1355,20140415376425959.html

国家卫计委等部门近日联合下发了《关于推进县级公立医院综合改革的意见》（下称《意见》），这也意味着，县级公立医院改革到了攻坚阶段。其实，中央对县级公立医院综合改革尤为重视，早在 4 月 4 日全国县级公立医院综合改革推进电视电话会上，国务院总理李克强就已经指出，当前深化医改正处在爬坡过坎儿的紧要关头，要全力以赴打好这场攻坚战。

此次综改的关键是，要求以破除"以药补医"机制为关键环节，全面推进管理体制、治理机制、补偿机制、价格机制、药品采购、人事编制、收入分配、医保制度、监管机制等综合改革，建立起维护公益性、调动积极性、保障可持续的运行新机制。

卫计委：新农合国家级平台扩大到 15 个今年试点新农合异地就医即时结报

《人民网》 2014-05-04

http://society.people.com.cn/n/2014/0504/c1008-24972799.html

国家卫计委正式决定，2014 年，与国家级平台联通的省份将扩大到 15 个，在此基础上，开展跨省就医费用核查和结报试点。此举，将继续推进医药费用报销便捷化，使得全国有超过 88%的地区实现了参合农民省内异地就医即时结报，在实现国家新农合信息平台初步完善，实现了 9 个省级平台和部分大型医疗机构互联互通的基础上，为跨省就医报销试点工作搭建基础环境，并完成跨省医药费用的核查功能在部分地区的初步实现。
此外，国家卫计委表示，2014 年，在继续推进医保城乡统筹等工作的同时，将继续做好新农合重点领域和重点环节的工作。对此，不仅要进一步提高新农合筹资标准和保障水平，更要完善各种形式的重大疾病医疗保障机制，加快推进商业保险机构参与新农合经办服务和大病保险工作，并全面推进新农合信息化建设。

贵州"医保一卡通"6 月全覆盖可异地即时结算
《贵州省人民政府网》 2014-05-20
http://info.gzgov.gov.cn/system/2014/05/20/013520139.shtml

贵州省人力资源和社会保障厅表示，预计在今年 6 月底之前，贵州省可实现省内异地就医即时结算。
开通省内异地就医即时结算业务后，全省的城镇职工基本医保参保人员，持全省统一发行的社会保障卡，可实现省内跨市、州普通门（急）诊和零售药店购药的即时结算。即参保人员无需办理手续，可持本人社会保障卡，在开通了省内异地就医业务的医院或药店直接刷卡结算；参保人员的个人账户有余额的，由就医地社保经办机构与医院、药店结算；未建立个人账户或个人账户余额不足的，由本人现金支付。
对于异地住院的，则需在各市、州开通省内异地就医即时结算业务的定点医院进行，并按参保地规定办理相关手续。

广州明年实施城乡居民医保合并后或不分档缴费并成立大额病历专家评审会
《中国广州网》 2014-05-22
http://www.guangzhou.gov.cn/node_2190/node_2215/2014/05/22/1400725464431338.shtml

由广州市医保局透露，明年 1 月 1 日起广州将正式实施城乡居民医保政策，将目前城镇居民医疗保险及新农合合并，涉及近 500 万参保人群。同时，同步启动大病医保。 因为两险的医保年度不同，因此今年 9 月 1 日~12 月 31 日将作为过渡期。目前城镇居民医保年度为当年的 9 月 1 日至次年的 8 月 31 日，而新农合年度为自然年度，明年城乡居民医保实施后，"自然年度"将作为城乡居民医保年度。

针对大病医保，广州市已成立进行"大额病历专家评审会"，在全市各大医院经由医保结算系统产生的每年 1.3 万件左右大额病历中进行初步筛选，初步筛选出存疑的病历，交给专家评审，以解决误诊、大处方以及过度检查等方面的问题。

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ABOUT CHPAMS

CHPAMS Sets a New Stage

By Qi (Harry) Zhang, Ph.D., Old Dominion University, USA.

CHPAMS turns to a new page in the last quarter of 2014. With China Medical Board (CMB)'s strong support, CHPAMS started to build a sustainable infrastructure. Coincidentally with the national day of China, CHPAMS was incorporated as a non-for-profit organization and registered in the State of Virginia in the U.S. on October 1, 2014. The new bylaw was adopted on the same day. Under the governance of the new bylaw, anybody who subscribes the CHPAMS email list will automatically become our non-voting members. CHPAMS will initiate a new registration process to upgrade the status to voting members. After an open nomination process, seven members of CHPAMS were appointed as the first Board of Directors. To see their biographies, please visit our newly designed website at www.chpams.org.

More excitingly, CHPAMS received a 501(c)(3) status in the same month from Internal Revenue Service, which gives the official recognition of the tax-exempt status for charity organizations. Under the 501(c)(3) status, CHPAMS is exempt from business income tax by operating any educational, scientific, or charity activities. All donations to CHPAMS can be deducted from individual and business taxable income. The 501(c)(3) status is a significant booster for CHPAMS's continuous operation.

In November 2014, CHPAMS received a two-year grant from CMB to build up the sustainable infrastructure. This support is crucial to support our members, especially junior members, to establish their careers related to health policy or public health in China. The organization appreciates the generous support from CMB. The board will initiate a series of activities to utilize the grant to benefit our members.

Thank you for all your supports in 2014 and best wishes for your career and lives in 2015!

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Dr. Zhang is an associate professor in the School of Community and Environmental Health at Old Dominion University, USA. He currently serves as the President of the China Health Policy and Management Society and a Board Director of the Chinese Economists Society.

HAPPY NEW YEAR