

TOWARDS A HEALTHIER FUTURE

Chen Mengxue

IN THE SUMMER OF 2018, the movie *Dying to Survive* 我不是药神 stormed China's domestic box office and sparked public discussion about the accessibility of medical treatment in China. The movie, which some film critics called 'China's *Dallas Buyers' Club*', is based on the true story of a leukemia patient smuggling in cheap anti-cancer drugs from India to help impoverished fellow patients who could not afford the expensive medication offered by Chinese hospitals. In the film, the smuggler is a divorced seller of Indian health supplements who does not have cancer himself. Within two weeks of opening in July, it had already become one of the highest grossing films in the history of Chinese cinema. The story resonated with Chinese people as it depicted how quickly

even a middle-income family could be dragged into poverty by medical bills, and how being struck by illness and poverty at the same time can be devastating.

The timing of the movie's release coincided with a series of actions by the Chinese government to lower the price of cancer drugs. It removed the tariff on imported cancer medication on 1 May 2018 and reduced the VAT (value-added tax) from seventeen per cent to three per cent. (The majority of anti-cancer drugs on the Chinese market are manufactured by US and European pharmaceutical companies.) Shortly after the movie's premiere, the newly established Chinese National Medical Insurance Bureau summoned representatives from ten foreign and eight domestic pharmaceutical com-



Promotional poster for *Dying to Survive*, 2018
Source: Ali ghafarpoor, Flickr

panies to discuss cutting the prices of cancer drugs, many of which were too expensive to be covered by national medical insurance. On 18 July 2018, about two weeks after the movie's release, Premier Li Keqiang 李克强 ordered the government to speed up the price cuts. To the excitement of many cancer patients, in October 2018, the Chinese National Medical Insurance Bureau announced, following successful price negotiations with both foreign and domestic pharmaceutical companies, that national medical insurance will cover another seventeen anti-cancer drugs.

Policies and Priorities

In recent years, the Chinese government has made public health a central policy priority. At the Nineteenth National Congress of the Chinese Communist Party (CCP), President Xi Jinping 习近平 announced the Healthy China initiative, which aspires to provide full life-cycle health services to Chinese people, promote healthy lifestyles, and modernise hospital management (including making all public hospitals non-profit by 2020). As Xi said at the 2016 National Health Conference held in Beijing in August 2016, 'Prosperity for all is impossible without health for all' 没有全民健康，就没有全面小康. Indeed, good population health is the prerequisite for development, as poor health hinders both individual and national development by reducing productivity, and inequity in health status and accessibility of health services may lead to social frictions and unrest.

Along with economic indices such as GDP and GNP, population health is an important indication of a country's level of development. In the past four decades, much improvement has been made in China's population health. Data from the World Bank and the UN released in 2018 shows that aver-

age life expectancy in China increased from 65.5 years in 1978 to 76.3 years in 2016,¹ while the national infant mortality rate (IMR) declined from 55 per 1,000 live births in 1977 to eight per 1,000 live births in 2017.² (In Japan, by way of comparison, life expectancy in 2016 was 84.2 years and the IMR was two per 1,000 live births in 2017; while in Nigeria, life expectancy was 55.2 in 2016 and IMR was 65 per 1,000 live births in 2017.)

However, within China there are still large urban–rural disparities in health outcomes and access to health services. In 2015, the rural IMR in China was 9.6 per 1,000 live births, more than twice as high as the urban IMR of 4.7. The rural population lags behind their urban counterparts from an epidemiological perspective as well. The urban population today mainly suffers from degenerative diseases and lifestyle-related diseases including strokes, heart failure, and cancer, while the rural population, particularly in western China, still suffers from infectious and parasitic diseases, as well as respiratory and digestive ailments that can be prevented through better sanitary conditions and diet.³

The inequality in health is rooted in unbalanced regional development

and inequality in people's socioeconomic status. Poverty and limited access to public health resources are inextricably linked to poor health outcomes, due to crowded living conditions, malnutrition, lack of access to clean water and sanitation, and vulnerability to extremes of temperature and weather. The poor are often exposed to greater risks from their living and working environments too, as they usually have limited options in life. Worse still, once the poor become ill, the high cost of medical treatment can prevent them from getting proper treatment and achieving full recovery. The loss of potential earnings from taking time off work, and even losing employment due to illness, can destroy the savings of even a moderately well-off family.

Historical Background

Public health service and welfare are important factors that influence population health. When the People's Republic of China was founded in 1949, people living in rural areas had scarce access to medical resources. In 1951, the central government encouraged health workers and epidemic prevention personnel in villages to pro-

vide basic healthcare to local villagers. By 1957, according to the World Health Organisation, there were some 200,000 village doctors in China.

In 1968, two years into the Cultural Revolution, Chairman Mao Zedong 毛泽东 introduced the Barefoot Doctors 赤脚医生 program, which provided several months of minimal medical training at county-level hospitals to 1.5 million healthcare workers who were originally second school graduates or farmers with some medical knowledge. As part of the Rural Co-operative Medical Scheme (RCMS) 农村合作医疗计划, funding for barefoot doctors' wages, medicines, and medical instruments came from the commune's collective welfare fund, as well as local farmers' contributions (about 0.5 to two per cent of their annual income).

The barefoot doctors provided basic medical care and education about disease prevention to the approximately eighty-two per cent of the Chinese population that lived in rural areas at that time. The system modelled a practical approach to primary healthcare for other low-income countries in the world. According to data from the World Bank, China's average life expectancy increased from 43.7 years in 1950 to 66.4 years in 1979.⁴

Both the RCMS and the system of barefoot doctors collapsed with the economic and administrative reforms implemented in the agricultural sector in China in the 1980s, including the end of the commune system. But in the meantime, the government did not implement any new rural medical insurance schemes to replace the RCMS and barefoot doctors system.

From the 1990s into the early 2000s, the majority of people living in rural areas (96.3 per cent in 1993 and 87.32 per cent in 1998⁵) were not covered by any form of national health insurance scheme, and were responsible for all their healthcare costs. At around the same time, the drastic decreases in government subsidies for the public health sector and subsequent marketisation of public health facilities turned them into profit-seeking entities. The government began to allow drug prices to be set above cost, approving hospitals and other health facilities to earn a fifteen per cent profit margin to help their financial survival.⁶ The cost of medical treatment started to rise disproportionately to income gains, and rural families with patients were negatively affected, some even dragged back into poverty by medical bills.

To address these and numerous other issues, in 2002 the government

A propaganda poster for Mao's Barefoot Doctors program: 'Wholeheartedly serve the people'. Designer: Zhou Zhaokan (周昭坎), 1965
Source: chinese-posters.net, Flickr



initiated the New Rural Co-operative Medical Scheme (NRCMS) 新型农村合作医疗. It improved medical insurance coverage in the rural population: by 2015, 670 million, or 98.8 per cent of the rural population were covered by the NRCMS.⁷ However, the absence of a national health insurance scheme in the rural sector from the 1990s to the early 2000s continues to have a profound influence on rural population health outcomes.

Realities

Though the NRCMS has been established to reduce the financial burden of medical cost for the rural population, great disparities persist in the distribution of medical resources and access to healthcare between urban and

rural populations in China. According to the National Bureau of Statistics, the number of hospital beds per 1,000 people in the rural areas was 1.35 in 2017 — far below the national average of 5.72. In the remote areas, there may be only one or two doctors to serve a community of thousands, and in some counties, half of the villages have no doctors at all.

Many village doctors today are original barefoot doctors or their offspring. They typically work in small, shabby, and poorly equipped clinics, and spend hours hiking, sometimes over mountain paths, to make home visits. Some supplement their fees through pharmaceutical sales, or moonlight selling groceries, for example, to make ends meet. Although the



Village doctor in Guizhou
Source: Taj Chom, Flickr

central government has subsidised the salaries of village doctors since 2016, but the funds are administered by local governments and doctors from many places have complained that the local governments do not always pass on the funds, tying up the process of applying for them in red tape. Data from the National Health and Family Planning Commission shows that the number of village doctors has continued to decline since 2011.⁸

The population of village doctors is also rapidly ageing. Few medical students are drawn to the rural medical workforce with its harsh working conditions and low salaries. With the rap-

id ageing of China's rural population and rising demand for medical care, the dwindling number of village doctors will share a much heavier burden in the foreseeable future.

In the past, the government had the power to assign graduates to work in remote areas, but that is no longer the case. Instead, from 2010, the Ministry of Health initiated a scholarship program to fund the education of around 6,000 medical students nationwide each year on the condition that they agree to work in clinics in remote rural areas after graduation.

The unbalanced distribution of medical resources also places extra

burdens on the town hospitals. Rural patients who cannot be cured in their small village clinics (which provide very basic medical care) may have to travel for hours or even days to get to the nearest hospital. In many cities and towns across the nation, it is extremely difficult to get an appointment with hospital doctors — queues are long, and even patients with more serious problems can wait for days or months for a hospital bed to become available, so that they can be admitted as an inpatient. Many doctors in these large hospitals are overwhelmed by their heavy workloads; many have to work sixty to eighty hours each week. These pressures, felt by both sides, has led to a nationwide deterioration of doctor-patient relationships, and the past decade has seen frequent reports of violence against doctors. The problems caused by a weak rural healthcare system are spilling over into the urban sector to become a potential threat to China's overall public health system.

Policy-makers are beginning to act to address this crisis. Poverty eradication and population health improvement were mentioned as two important goals for national development at the Nineteenth National Congress of the CCP. In recent years,

President Xi Jinping made clear the intention to eliminate poverty in China by 2020 and to ensure equity in access to healthcare can be basically achieved by 2030. The Health China 2030 initiative proposed in 2016 set 17 goals, 169 targets, and named 231 initial indicators in public health as milestones to be achieved in 2030. It is the first medium- and long-term national strategic plan in the health sector since the country's founding in 1949.

Eliminating Poverty: The Prerequisite to Health

Forty years ago, over 80 per cent of China's population, then 770 million, lived under the national poverty line. In 2017, 30.46 million people in the rural area lived under the poverty line, which accounts for about 3 per cent of the total population. By lifting over 700 million people out of poverty in the past 4 decades, China has contributed more than any other country to global poverty reduction and the achievement of the first of the UN's Millennium Development Goals — the eradication of extreme poverty and hunger.

In the past thirty years, the government has revised the poverty

threshold almost every year: from 206 yuan (annual income) in 1985 to over 3,000 yuan in 2017. Central and local governments have invested trillions of yuan towards the eradication of poverty; the government's special fund for poverty reduction reached 106 billion yuan in 2018. Investments were made in infrastructure, such as road and water conservancy projects, and subsidising healthcare and education. In some places, local governments promoted the development of tourism and other business by making available low-interest microloans in state-owned development banks for villagers to build their own small businesses and even sell local goods online to benefit from China's e-commerce boom.

Simply raising the living standards of people in rural areas and improving the accessibility of health services reduce the morbidity rates of preventable diseases and improve people's health. Yet hard work remains

ahead for China to eradicate poverty. Among the forty-three million people living below the national poverty line, including in urban areas, ten million suffer from disabilities; they have even fewer resources and far more barriers to lifting themselves out of poverty. Just as poverty engenders poor health, poor health engenders poverty, creating a vicious cycle, exacerbated by the insufficient supply of healthcare services and the dearth of healthcare workers in the poorest regions. The inequality in health, rooted in income, wealth, and socioeconomic status in general, is certain to cause social friction and spark moral debates and soul searching in the foreseeable future. The popularity of *Dying to Survive* shows that this issue is one close to people's hearts. The related problems of more equitable healthcare delivery and poverty alleviation need to be redressed before China can become a truly great global power.

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