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## The Sick Man of Asia

China's Health Crisis

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Although China has made remarkable economic progress over the past few decades, its citizens' health has not improved as much. Since 1980, the country has achieved an average economic growth rate of ten percent and lifted 400–500 million people out of poverty. Yet Chinese official data suggest that average life expectancy in China rose by only about five years between 1981 and 2009, from roughly 68 years to 73 years. (It had increased by almost 33 years between 1949 and 1980.) In countries that had similar life expectancy levels in 1981 but had slower economic growth thereafter -- Colombia, Malaysia, Mexico, and South Korea, for example -- by 2009 life expectancy had increased by 7–14 years. According to the World Bank, even in Australia, Hong Kong, Japan, and Singapore, which had much higher life expectancy figures than China in 1981, those figures rose by 7–10 years during the same period.

A look at China's disease burden also reveals a worrisome picture. Like many less developed countries, China still battles a legion of microbial and viral threats, including HIV/AIDS, tuberculosis, viral hepatitis, and rabies. For instance, more than 130 million people in China have the hepatitis B virus -- accounting for about one-third of all HBV carriers in the world. Meanwhile, chronic noncommunicable diseases, which are typical of developed countries, are becoming an even more intractable problem. According to the 2008 National Health Services Survey, conducted by China's Ministry of Health, 61 percent of respondents who said that they had been sick within the previous two weeks had chronic diseases, compared with 39 percent ten years earlier. A 2010 study by *The New England Journal of Medicine* suggests that China has the largest population of diabetics in the world and that the disease is spreading



at a faster rate there than in Europe and the United States. Nearly ten percent of adults aged 20 or more in China now have diabetes -- close to the rate in the United States (11 percent) and far higher than those in Canada, Germany, and other Western countries. Noncommunicable diseases, including cardiovascular disease, chronic respiratory



diseases, and cancer, account for 85 percent of total deaths in China today -- much higher than the average worldwide, which is 60 percent. One major contributing factor is the rapid aging of the population. The 2010 census showed that the proportion of people in China aged 60 or more had grown to over 13 percent, up by almost three percentage points since 2000. According to a recent World Bank report, if effective measures are not adopted to promote healthy aging, the burden of noncommunicable diseases in China could increase by at least 40 percent by 2030. It is forecast, for example, that by 2040 there will be more people with Alzheimer's disease in China than in all the developed countries combined.

More Chinese are suffering from mental illness. Data from the Ministry of Health suggest that the incidence of mental disorders climbed by more than 50 percent between 2003 and 2008. A major national survey conducted between 2001 and 2005 partly by the Beijing Suicide Research and Prevention Center at Beijing Huilongguan Hospital and based on interviews with 113 million Chinese throughout four provinces found that 17.5 percent of the population, or more than 227 million Chinese, suffered from some form of mental problem, such as mood and anxiety disorders. This is one of the highest such rates in the world. An estimated 287,000 people kill themselves in China each year; at 23 per 100,000, this, too, is one of the highest such rates worldwide and more than twice the suicide rate in the United States.

Despite the seriousness of these issues, in their single-minded pursuit of economic growth, China's leaders have long overlooked public health. After the Maoist health-care system began to collapse in the early 1980s, government spending on health as a share of GDP declined, from about 1.1 percent in 1980 to about 0.8 percent in 2002. (In 2002, U.S. government spending on health accounted for 6.7 percent of GDP.) The introduction of market-oriented reforms in the 1980s further hurt an already debilitated health-care system: by 2003, more than 70 percent of China's population had no health insurance at all. There have been some reforms since, but China's disease burden continues to grow -- threatening the country's health-care system, the economy at large, and even the stability of the regime.

## TRUE LIES

Throughout much of China's history, health care was seen as an individual responsibility, not a right. The attempts by Mao's regime to build a system of state-sponsored health care thus marked an important departure from the historical norm. The early 1950s saw the establishment of health insurance plans for government officials and state workers and the construction of state-owned hospitals and clinics at the county and district levels. With the Great Leap Forward, which began in 1958, the state found another reason to get involved in the health-care sector. In exchange for free and accessible health care, peasants would support agricultural collectivization and the spread of people's communes -- which, in turn, would serve as the institutional and financial foundations for the new health-care regime. By 1959, China had built a three-tiered health-care system in rural areas consisting of county hospitals, commune health-care centers, and village (so-called brigade) clinics. This system delivered not only medical treatment but also preventive care, which played a critical role in implementing the government's strategy to prevent infectious diseases.

After the launch of the Cultural Revolution in 1966 and the mass purge of senior health officials that followed, the Ministry of Health was marginalized from the policy process. With less bureaucratic obstruction, policy became better coordinated. An unprecedented number of health personnel were sent to the countryside. Some farmers were given informal medical training, and these “barefoot doctors” would then treat common illnesses and promote preventive health care. So-called cooperative medical care (a community-based health insurance scheme) spread rapidly. By 1976, there were 1.8 million barefoot doctors; more than 90 percent of the brigades, or villages, were covered by cooperative medical care; and almost every commune had a health-care center. China had more doctors, nurses, and hospital beds than virtually any other country at its level of economic development. The health of the Chinese people improved remarkably: the mortality rate dropped from 20 per 1,000 in 1949 to about 7 per 1,000 in 1975. According to both official Chinese figures and international sources, average life expectancy increased from 35 years to 65 years during the same period.

Mao’s death and the ensuing economic reform dramatically changed this landscape. The demise of people’s communes and the return to household farming in the early 1980s eliminated communal welfare funds, which had been the main source of financing for the Maoist rural health-care system. In 1978, 82 percent of all brigades were tasked with implementing cooperative medical care; by 1983, the figure had fallen to 11 percent. The number of barefoot doctors dropped by about 23 percent during that time. The rural economic reform increased the disposable income of peasants, who could now afford to bypass the village health-care stations or township health-care centers and seek medical care at urban hospitals. This development both undermined the three-tiered referral chain in the countryside and generated strong demand for more and better health care in cities. The system’s urban bias had returned.

The rehabilitation of bureaucratic leaders who had been purged during the Cultural Revolution brought demands that selected social groups, particularly government officials, receive more attention in health care. This led to the reemergence in the 1980s of a coalition that Mao had sought to break up in the mid-1960s: city administrators, health bureaucrats, and urban residents with a common interest in qualified urban health care. Thus, when health-care institutions in the countryside started falling apart, rather than take corrective action, the leaders of the Ministry of Health publicly called for their demise and promoted a policy of modernization to be implemented mostly in the cities. By 2004, nearly 80 percent of government health spending was going to urban health-care institutions, even though city dwellers represented only 42 percent of the country’s population.

This transition was compounded by a shift in the government’s agenda regarding economic development. Public health was relegated to the back burner. Using economic development as the new yardstick of performance, local government officials pursued growth at the expense of public health. As a result, communicable diseases that had been all but eradicated during the Mao era reemerged and spread quickly in the 1980s. The government retreated even further from providing health-care services with the 1994 tax reform, which allowed it to recentralize fiscal power but further decentralize fiscal responsibilities. Government spending as a percentage of total health expenditures dropped precipitously -- from 39 percent in 1986 to 16 percent in 2002 -- leaving individual Chinese to pick up the slack. Local governments had to shoulder almost all state subsidies to health-care institutions: more than 97 percent between 1991 and 2007, according to publications from the Ministry of Finance and the National Bureau of Statistics of China. Moreover, only a small percentage of the government’s health funding was spent on the general public: as Yin Dakui, a former vice minister of health, revealed in 2006, 80 percent of China’s health budget was spent on just 8.5 million government officials.

Dwindling government support, in conjunction with market-oriented economic reform, also changed the behavior of health-care providers. They became revenue-making machines. Public hospitals began aggressively selling drugs and providing extra, often high-tech services in order to recoup losses caused by shrinking government support and fuel growth in revenues. Overall health expenditures increased exponentially. And this occurred at a time when there was virtually no social safety net: the 1998 National Health Services Survey found that more than 87 percent of the rural population and more than 44 percent of urban residents had no health insurance of any kind. The growing costs had to be covered by out-of-pocket payments. By 1999, the private share of health-care spending exceeded 59 percent. In some cases, rising costs deterred the sick from seeing doctors. In 2004, the vice minister of health, Zhu Qingsheng, said that 60–80 percent of farmers who were seriously ill died at home because they could not afford care. Just a generation after Mao's death, a 2000 World Health Organization report assessing health-care systems worldwide ranked China 144 out of 191 countries -- even though by then, China was already the sixth-largest economy in the world.

### A SICKLY, SLEEPING GIANT

The 2003 SARS debacle jolted the Chinese government, highlighting the importance of balancing economic development and social services. Within nine months of the virus' appearance, a total of 8,422 cases and 916 deaths had been reported worldwide; in China alone (excluding Hong Kong and Macao), the outbreak had infected more than 5,327 people and killed 349. The government's initial mismanagement of the crisis -- including a clampdown on information and a period of inaction -- spawned anxieties and rumors across the country. It was the most severe social-political challenge the Chinese leaders had faced since the 1989 Tiananmen crackdown.

In the wake of the crisis, the government invested tremendously in its capacity to tackle public health emergencies. By 2008, it had built a multilevel disease-surveillance and disease-reporting system, allowing hospitals (including township health-care centers) to directly report suspected outbreaks to the Chinese Center for Disease Control and Prevention. It had also launched a new rural cooperative medical-care program under which participants would receive partial reimbursement for their medical expenses in exchange for a small annual fee (about \$1.50 in 2003). A new round of reforms was formally kicked off in 2006 with a view toward providing, as President Hu Jintao put it, "safe, effective, convenient, and affordable" health-care services to everyone in China. In January 2009, China unveiled a three-year plan to pump at least \$123 billion into the health-care sector by the end of 2011. (The figure was later increased to \$173 billion.) Thanks to this revved-up state commitment, government spending as a percentage of total health-care spending increased from almost 16 percent in 2002 to almost 24 percent in 2010. By the end of last year, more than 94 percent of the population reportedly had some kind of health insurance, according to government figures. During 2009–10, the central government also invested billions of dollars in strengthening rural and community-level health-care institutions by building infrastructure, buying equipment, and training personnel.

Yet major problems remain. Some issues, such as mental illness, have yet to figure high on the government's reform agenda. Of the more than 26 million Chinese who suffer from depression, just ten percent receive any medical treatment. (There are only 20,000 psychiatrists in China, or 1.5 for every 100,000 people -- one-tenth the ratio in the United States.) And there are discrepancies in financing. The central government shoulders only about 30 percent of all public health funding. Local governments are supposed to finance the rest, but they are so preoccupied with GDP growth that they have few incentives to spend much on health care. The government's proposed plan for universal coverage also fails to address the huge gap in access to health care between rural and urban areas. According to a

government formula based on per capita incomes, in 2010 an urban employee in the formal sector might have been reimbursed for inpatient services up to six times as much as a farmer.

Major urban hospitals are continuing to expand rapidly, and their growing demand for personnel is causing a brain drain from lower-level hospitals and hospitals in the countryside. The resulting shortage of qualified health-care personnel at those lower-level and rural hospitals is undermining the government's efforts to upgrade rural and community-level health-care institutions. Thus far, the government has made no serious effort to reform the administration of public hospitals, which account for nearly 70 percent of all hospitals in China. Instead of separating ownership and operations, officials at the Ministry of Health and their counterparts at the subnational level are at once the rule-makers, the regulators, and the general managers of all the public hospitals. This not only allows the government to meddle in the operation of hospitals but also makes it difficult for officials to play their role as independent and authoritative regulators of the health-care sector. Inefficiency and corruption result. As public service institutions, these hospitals receive fiscal allotments, and their staffs enjoy near-permanent employment. But in the absence of full government funding, what are officially not-for-profit hospitals become profit-seeking monsters shielded by the government's administrative power. Without adequate regulatory oversight, the hospitals' revenue-making motives drive up total health-care costs.

This in part explains why even though the rate of health-care coverage is now high, the level of benefits is still very low. In 2010, the government gave just 120 yuan (less than \$19) to every person covered by the new rural cooperative medical-care program, a subsidy that totaled only 8.6 percent of total health-care expenditures per capita. This means that at least 836 million rural residents who were officially covered by the plan still had to pay the lion's share of their medical bills. For example, even a farmer in one of the country's richest areas, near Shanghai, has to pay around 12,000 yuan (about \$1,900) for stomach-cancer surgery -- the equivalent of the annual per capita net income in the region.

Equally important, China has failed to effectively address some significant risk factors, such as smoking, environmental degradation, unsafe drugs, and tainted food. China signed the World Health Organization's Framework Convention on Tobacco Control in 2003, pledging to ban smoking in workplaces and indoor public spaces by January 9, 2011. But the deadline passed without any major change. More than 300 million people in China -- equivalent to approximately the entire U.S. population -- smoke today. Another 740 million are regularly exposed to second-hand smoke (including 180 million under the age of 15), an increase of 200 million over the past five years. Meanwhile, China's cigarette production rose by 17 percent over the same period. Experts believe that China's anti-tobacco policies are among the least effective in the world. Although the Ministry of Health banned smoking in indoor public places (excluding workplaces) in March, the ban has largely been disregarded. As noted by a recent report co-authored by Yang Gonghuan, deputy director general of the Chinese Center for Disease Control and Prevention, the fundamental reason that China has failed to honor its international obligations is that representatives of China's tobacco industry, a pillar of many provinces' economies, have interfered with the drafting and enforcement of tobacco-control policies.

Pollution and other environmental problems, still marginal issues on the government's health-care agenda, are harming people's health as well. A study conducted in 2007 by the World Bank and the Chinese State Environmental Protection Administration (the predecessor of the Ministry of Environmental Protection) found that 750,000 Chinese people die prematurely every year, mainly because of air pollution in large cities. Using 2006 air-quality data, a report by the Hong Kong-based think tank Civic Exchange estimates that close to 10,000 deaths annually can be

attributed to air pollution in the highly industrialized Pearl River Delta, Hong Kong, and Macao, with some 94 percent of those deaths occurring in the Pearl River Delta alone. According to a Ministry of Health report, the operations of 16 million companies and factories in China are poisonous or hazardous, and about 200 million workers are directly exposed to occupational hazards. Because of industrial pollution, especially water contamination in the countryside, China now counts 459 so-called cancer villages, villages with an unusually high number of cancer patients. Environmental pollution is also believed to have significantly increased the infertility rate for all couples of childbearing age, from three percent in 1990 to 12.5–15.0 percent today. According to a 2009 epidemiological study by the nongovernmental organizations China Women and Children Development Center and the Population Association of China, more than 40 million couples in mainland China may now be infertile.

Food- and drug-safety problems are ubiquitous. Since 2006, China has been hit by a slew of scandals involving substandard foods and drugs -- tainted milk, duck eggs, infant formula, and vaccines. According to a series of public opinion surveys published in 2009, respondents ranked corruption, health-care reform, and food and drug safety as their top three concerns. Although the government has passed some measures to tighten regulations on product safety over the past few years, a string of scandals -- over steamed buns dyed with dangerous chemicals, watermelons contaminated with growth accelerators, and pork products tainted with clenbuterol (a steroid used to keep pigs lean) -- has renewed fears recently. Inadequate government oversight certainly is still to blame, but shoddy business ethics is a much bigger problem.

To a visitor who had just returned from China in 1816, Napoleon allegedly said, "China is a sickly, sleeping giant. But when she awakens the world will tremble." The metaphor was echoed a century later when, riven by internal divisions, China had become a pushover to Western powers and was known as the "sick man of East Asia." Like the "sick man of Europe," a reference to the weakening Ottoman Empire, the phrase touched a raw nerve among Chinese nationalists at the time, and the Chinese Communist Party used it to justify its revolution and radical social engineering. Today, China is proving itself worthy of the title once again.

#### WEAKNESS IN GREAT ONES

Can a rich state with a weak people really be a great power? China's mounting public health challenges do not bode well for sustainable development in the country. An official report predicts that between 2000 and 2025, the number of patients in China will increase by nearly 70 percent, hospitalizations by more than 43 percent, annual outpatient visits by more than 37 percent, and overall medical spending by more than 50 percent. (The population itself is expected to increase by only 15 percent during the same period.) Poor health has already become a major hurdle to further bringing down poverty, and it could even jeopardize the country's achievements to date. A 2004 survey conducted by the Development Research Center of the State Council found that disease and injury were the leading cause of poverty in rural areas: almost 41 percent of the farmers below the poverty line (defined by the government as annual earnings of 860 yuan, or \$106 at the time) reported having fallen below it after they became sick or injured.

Disease is taking a heavy toll on economic activity. For instance, Chinese health economists have estimated that in 2003, the medical costs of treating clot-induced strokes alone accounted for more than three percent of total health-care expenditures. And according to research conducted by Peking University's China Center for Economic Research, the total economic cost of smoking in 2005 amounted to nearly 300 billion yuan (about \$37 billion) -- far more, incidentally, than the 240 billion yuan (nearly \$30 billion) in fiscal revenue drawn from the tobacco industry.

A 2011 report by some of China's leading economists and public health experts estimates that in 2005, disease cost more than five billion working days and 2.4 trillion yuan (\$296 billion) in lost economic activity -- about 13 percent of China's GDP.

More generally, in the absence of a well-developed safety net, poor health also suppresses domestic demand. When people have to worry about expensive medical bills, they are less likely to spend money on other things. Between the mid-1990s and 2006, more than 50 percent of total health-care spending was out-of-pocket payments by patients, making medical expenses one of the consumption items that most worry ordinary Chinese. Between 1990 and 2008, health-care spending as a share of consumption expenditure increased from 2 percent to 7 percent for urban residents and from 5 percent to 6.7 percent for rural residents. If consumer demand continues to be depressed this way, China's economic development is unlikely to be sustainable.

The burden of infectious diseases also threatens China's future economic development. Ten years ago, Nicholas Eberstadt, a researcher at the American Enterprise Institute, developed a model suggesting that even a mild HIV/AIDS epidemic, with a peak HIV prevalence rate of 1.5 percent, would shave more than half of one percentage point a year off China's economic growth rate over the following 25 years. And HIV/AIDS is an epidemic of attrition, whereas an outbreak of an acute infectious disease could derail China's economy in a very short period of time. As demonstrated by the 2003 SARS epidemic, a major disease outbreak could seriously disrupt the service industry -- which makes up more than 40 percent of the Chinese economy -- causing retail sales to plunge, entertainment venues to close, and tourism to plummet. As other countries closed the door on China, China's foreign trade and other business activities could fall. (During the SARS epidemic, 110 of the 164 countries with which China had diplomatic relations placed at least some restrictions on travel to and from China.) If such an outbreak disrupted production lines in manufacturing industries, multinational corporations would be forced to reconsider their business strategies with regard to China. The increased risk of doing business there could reduce foreign investment and exports, thus hurting the country's manufacturing sector, which accounts for nearly half the country's GDP. In the wake of the SARS crisis, Beijing did become somewhat more transparent and more cooperative with other countries, but as the H1N1 crisis of 2009 showed, Beijing still misreports or covers up facts, and those habits would only worsen the negative reactions of other states in the event of an outbreak.

Especially in rapidly changing societies, such as China, poor health can fuel social agitation. Hardships brought on by economic change are breeding frustration in China, and there are no adequate institutional mechanisms for addressing private grievances. The high costs and inaccessibility of health care lead to frequent disputes between patients and health-care providers, and these could easily devolve into violence. More than 73 percent of China's hospitals reported violent conflicts between patients and health-care workers in 2005, and close to 77 percent of them reported instances in which patients refused to be discharged after treatment or to pay hospital charges. In 2010, Shenyang, the capital city of Liaoning Province, in northeastern China, sought to hire police officers to handle conflicts between patients and health-care providers at the city's 23 major hospitals.

In other words, public health problems have important implications for political stability. Since political legitimacy in China is performance-based, poor health indirectly hurts the regime's standing by jeopardizing the country's economic growth. The state cannot wash its hands of public health issues without running the risk of breaking its implicit contract with society. On the other hand, if it seems incapable of providing adequate services, more citizens might feel marginalized. Even if these people remain loyal to the government, they will have less reason to cooperate with it when it comes to taxes, land development, or population control. With the burden of disease also exacerbating

poverty and other stress factors, desperate people might be emboldened to take collective action against the state. As Charles Tilly, Theda Skocpol, and other sociologists and political scientists have pointed out, the sudden withdrawal of government services or a government's failure to deliver collective goods can spur revolts.

The Chinese government could avoid these dangers by allowing underserved people to form independent organizations to fight for their health interests. This has happened, for example, in rural communities in southeastern India. But China's closed political system offers few institutional channels for disadvantaged groups to express grievances, and such obstacles could cause many Chinese people to eventually turn their backs on the government. In the 1990s, when the national health-care system was inaccessible to or too expensive for many Chinese, millions turned to Falun Gong, a spiritual movement that includes a form of traditional Chinese exercises said to marshal supernatural forces to achieve good health. By 1998, there were as many as 70 million Falun Gong members in China. And in April 1999, some 10,000 of them gathered at the residential compound of the country's leaders in silent protest, triggering a nationwide crackdown on the movement.

#### HU'S YOUR DADDY?

In essence, China's health crisis is a governance crisis. The Chinese state is failing the governance test in the health-care sector in terms of incentives, capacity, and effectiveness. In such a hierarchical, authoritarian system, government officials are accountable to their superiors, not the general public. Any provision of public goods and services results not from an institutionalized negotiation between the government and the governed but from a unilateral grant by the government: it treats health care more like a charity than an entitlement. And with the legitimacy of the government, both national and local, hinging on the delivery of steady economic growth, Chinese officials, especially local ones, have little interest in promoting health care. Their lack of action is reinforced by multiple interest groups. The tobacco industry is resisting stricter controls, for example, and health-care providers and government health departments have sometimes colluded to hijack the reform of public hospitals.

Another problem is the lack of bureaucratic capacity when it comes to health policy. In addition to an ill-defined fiscal system, which has crippled the government's ability to fund public services, policymakers in China cannot effectively monitor the behavior of policy implementers. In democracies, there are citizen groups to keep misbehavior by officials in check. But as long as China refuses to enfranchise the general public to monitor administrative measures, upper-level bureaucratic actors will continue to be foiled in their efforts by their subordinates. This problem is of particular concern in the health-care sector because the Ministry of Health is one of the weakest bureaucratic actors in China. Its budget is determined by the Ministry of Finance and the powerful National Development and Reform Commission. Since health care is often treated as a resource-dependent, nonproductive sector, in order to get things done, the Ministry of Health must negotiate with other central bureaucracies or call on superiors to intervene in cross-sector bargaining. The ministry nominally occupies the same rank as provincial governments, but the power to manage provincial public health bureaucrats lies with those governments. As a result, it is the horizontal coordinating bodies at various administrative levels -- province, city, and county -- that have the final say in designing and implementing local health policies.

That said, the central government's capacity can be beefed up when needed, especially in times of crisis. During the SARS epidemic, for example, it took less than a week for the Chinese government to build a state-of-the-art hospital with the capacity for 1,200 patients. But because Beijing has not seriously taken into account the people's needs, wants, and interests, strong state capacity has not yet translated into greater effectiveness. Beijing was quick to

mobilize resources during the 2009 H1N1 pandemic, but it also resorted to draconian policies -- such as large-scale quarantines and other strict containment measures -- that failed to stop the rapid spread of the H1N1 virus across China and squandered funds that could have been spent to fight more serious diseases. The Chinese government has acknowledged the role that civil society can play in preventing diseases and managing health care, especially in raising awareness about health-related issues, providing needed services to affected individuals and families, and promoting the human rights of sick people. But it continues to harass and prosecute human rights lawyers and the leaders of nongovernmental organizations. Two of China's best-known anti-AIDS crusaders, Wan Yanhai and Gao Yaojie, fled the country last year after government harassment intensified. China's health-promoting nongovernmental organizations remain small and weak, partly because competition over limited resources has led to infighting, which in turn has given the government an opportunity to further manipulate or suppress them.

Nevertheless, the government may still be able to undertake certain politically acceptable measures to prevent the current health crisis from spiraling into a political one. For one thing, it should immediately try to address China's huge disease burden. To that end, the government should adopt a more proactive approach to preventing and controlling noncommunicable chronic diseases, including mental illnesses. Given that population aging exacerbates the burden of chronic diseases, China should abandon its notorious one-child policy, especially in cities. Doing so would help maintain China's future competitiveness by lowering the ratio of people of retirement age to people of working age, and given the country's already low total fertility rate -- around 1.3, far below the replacement level -- the shift in policy would not cause the population boom that Chinese policymakers have long tried to avoid.

The government should also take measures to limit risk factors, including tobacco use, lack of physical activity, alcoholism, and unhealthy diets. Health experts widely consider interventions in these areas to be cost-effective, "best buy" solutions. A recent study published by *The Lancet* found that the accelerated implementation of the World Health Organization's Framework Convention on Tobacco Control in China -- through tax increases, product labeling, advertising bans, and smoking restrictions -- would cost only 14 cents per person per year and bring major benefits. Greater regulation of the tobacco industry alone would have great spillover effects because smoking is a significant risk factor for a variety of chronic disorders, including respiratory diseases, lung cancer, and cardiovascular disease. Such oversight would require a sustained commitment to shielding policymakers and policy implementers from the influence of interest groups. The criteria used to promote local government officials should be redesigned. Instead of having their performance measured based on GDP, they should be evaluated according to their ability to exercise "police power" and enforce the public order for the betterment of the general welfare of the inhabitants in their jurisdictions. As a corollary, fiscal relations between the central and the local governments should be restructured so that local governments, especially township and county governments, can have access to greater financial resources to promote health care locally.

It is also critical that the Chinese government strengthen the health-care system so that it can effectively deliver affordable health services and essential drugs to those who need them. By significantly increasing the coverage of various insurance programs, the government has already made great strides toward achieving its goal of providing universal access to primary health care by 2020. A recent positive sign is that the reimbursement cap for inpatient expenses was raised to at least 60 percent of an individual's medical bills. With the state's coffers growing and the government's increasingly populist approach to governance, the new leadership, to be anointed at the 18th Party Congress next year, is expected to push forward still further. Yet if the government does not stem the rise in the total costs of health care, even the people covered by insurance will struggle to afford care.

To make health care more accessible to and more affordable for the general public, the government has already made immense investments in government-run health-care institutions. But officials at health departments and public hospitals invoke the public nature of government-run health-care institutions to claim more open-ended government funding. This comes at a tremendous cost, both financial and social, and is unlikely to be sustainable in the long run. Worse, it does not help stop institutional collusion between the Ministry of Health (and its local counterparts) and public hospitals, the main factor behind ever-rising health-care costs. The guiding principle of any health-care reform should be to maximize the benefit to the public of health-care services. This would mean reorienting government funding from the supply side (hospitals) to the demand side (patients) in order to reduce out-of-pocket spending, especially for those who cannot afford quality health care.

Meanwhile, doctors' salaries should be raised to a level that would attract the country's best minds to the profession. Yet doctors' pay and benefits should not come from direct government compensation; they should be funded by independent third-party purchasers, such as HMO-type managed-care organizations. The restrictions imposed by responsible third-party purchasers would give public hospitals an incentive to keep costs down and improve accountability. This will eventually require that China move away from its overreliance on a fee-for-service payment method, which is often associated with escalating health-care costs. It will also require that public hospitals be given more autonomy to decide how to finance and deliver health-care services. Public hospitals should be allowed to reform their personnel management and organizational structures so that they no longer act as adjuncts of government health bureaus and instead become independent corporate actors. Meanwhile, Ministry of Health officials and their local counterparts should act only as rule-makers and regulators. Civil-society groups, ranging from health-promoting nongovernmental organizations to faith-based organizations, can play a constructive role in this process, too. They can help reduce the disease burden by collecting health data, disseminating health-related information, and reporting and monitoring outbreaks.

By no means would such measures solve the fundamental governance problems that cripple China's health-care system. But they would keep China's health crisis in check, bringing better and more affordable care to the Chinese people while keeping the Chinese Communist Party in power. Economists call such an outcome a Pareto improvement; game theorists, a win-win situation.

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