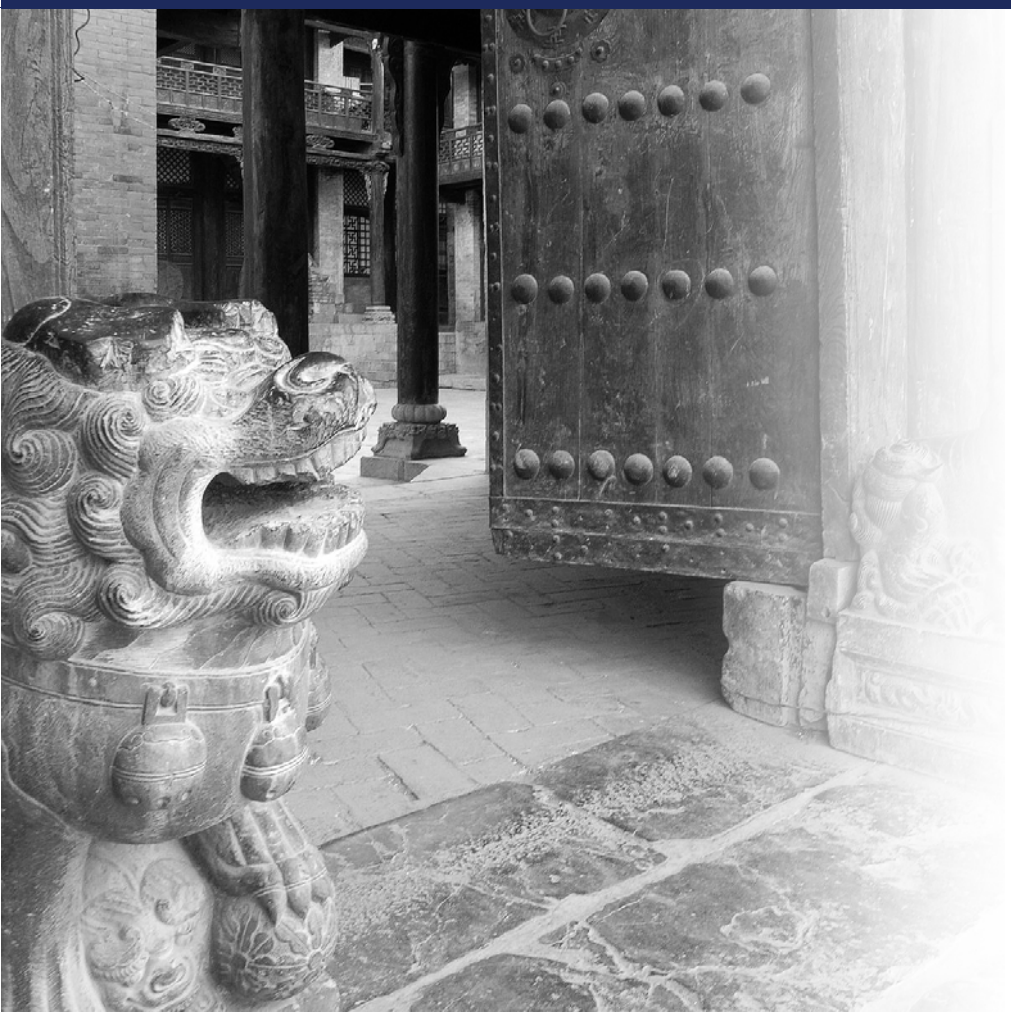
InterChina Insight

More efficient, but not healthier

The status, future, and opportunities of rural healthcare in China

By **Franc Kaiser & Jack Yu & Xu Wei** | May 25, 2011



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The ambitious healthcare reforms China has been implementing since 2009 have achieved their goal of establishing a basic universal medical system to provide low-cost health services to almost all of its 1.3 billion people. Primary care for rural residents, who account for the vast majority of Chinese, has greatly improved. While those changes were taking place, the situation at Rural Health Centers (RHCs) has also changed, and not entirely for the better. The top two problems of RHCs are no longer poor doctor-patient relations and doctor incompetence, but direct symptoms of a failure to fully take into account how to structure the system to make it sustainable in the long-term. Now, overwork due to heavy patient volume, poor pay and a lack of financial viability are the biggest troubles for RHCs, according to InterChina's recent survey of three regions in China. (See the Box for details of the survey) InterChina's previous study found that poor relations between doctors and patients, and medical staff incompetence were the top concerns. (Our newsletter, July 2010, A Phoenix Emerges From The Ashes). The introduction of a national essential drug list (NEDL), a key part of the health care reform, has deprived the RHCs of the prescriptions that provided a large share of their profits in the past. RHCs no longer have authority to buy drugs and they are not allowed to prescribe the more expensive drugs that used to constitute a big source of their revenues.

Study methodology

This study is a follow-up to InterChina's study done in 2010, and was conducted in March and April 2011 by InterChina Consulting. We interviewed presidents, department directors, administrators and doctors of RHCs in three sample regions: Tianjin, Tai'an and Feicheng in Shandong province, and greater Shanghai. The number of interviews was limited to thirty reference points, with each interview being a 1 – 2 hour personal in-depth discussion. We found that answers and opinions were largely consistent across different RHCs and different regions.

We aimed at understanding the current state and perspectives of RHCs, how the Healthcare Reform has affected their operations and work, the changes and challenges they are facing, and what opportunities may exist for pharmaceutical and medical device makers.

The main focus of China's healthcare reform was on ensuring that even low-income rural residents had easy, low-cost access to grassroots healthcare service providers. Even before the reforms were launched, many RHCs were upgrading their facilities. The government has added more clinics across the country, aiming to have RHCs be the main diagnosis and treatment providers for rural patients, and to act as gatekeepers, reducing the burden on bigger hospitals. There are 75,000 RHCs, medium- to small-sized hospitals that usually focus on outpatients, up from 65,000 in 2009 and 71,000 in 2010.

Heavy Patient Volume

The volume of patients served by RHCs has been increasing steadily since 2009, rising 5-10 percent in 2010 over a year earlier. Doctors at RHCs say they expect up to a 15 percent increase this year, though the rate of increase varies, with faster growth in the North (Shandong & Tianjin) than in Shanghai, since Shanghai residents have more level 2-3 hospitals within their reach. Overall, RHCs are now filling their role as gatekeepers to reduce the burden on class 1 and 2 hospitals.

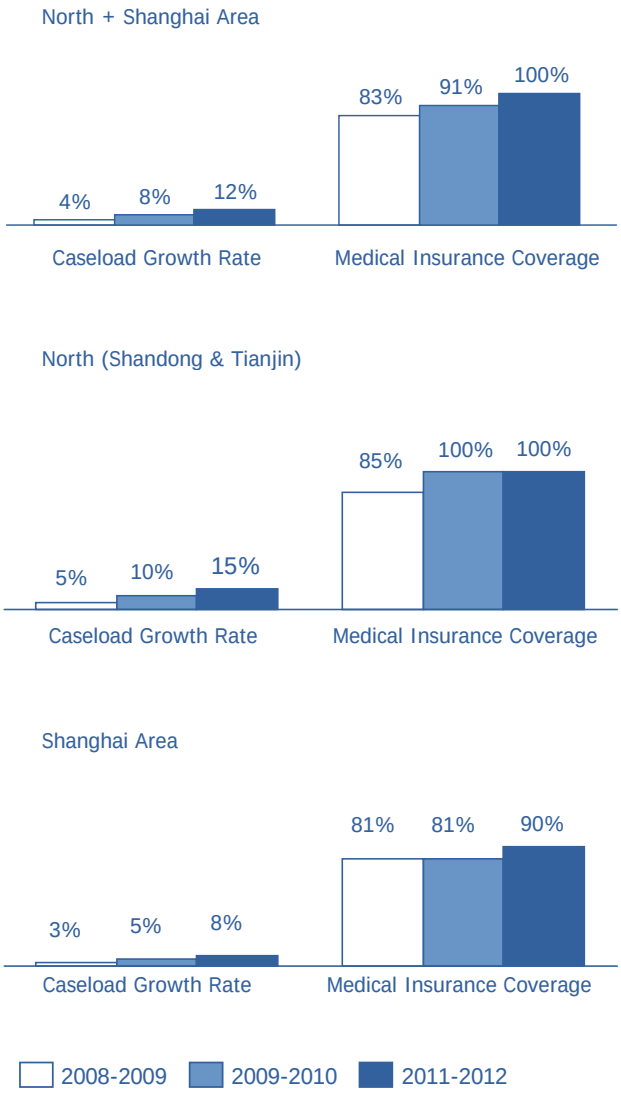
The creation of two insurance programs for low income residents: the New Cooperative Medical System (NRCMI) and Urban Resident Basic Medical Insurance (UEBMI), has prompted more patients to visit RHCs. Almost all Chinese are covered by some form of health insurance and can get reimbursed for medical costs incurred in RHCs. The low cost compared with larger hospitals has made the RHCs much more appealing to rural residents. RHCs have also eliminated some smaller cost hurdles, such as registration fees. The RHCs are located in the countryside, so patients find it convenient to visit them.

In this respect, the reforms have succeeded in providing more efficient and affordable services to the general public, who now has better access to basic drugs and treatments. At the same time, larger and more specialized hospitals whose waiting rooms previously were jammed with elderly rural dwellers seeking basic care can now focus on more serious cases and treatments. Rural patients now better understand where to turn to. The government is pro-actively promoting RHC services through public

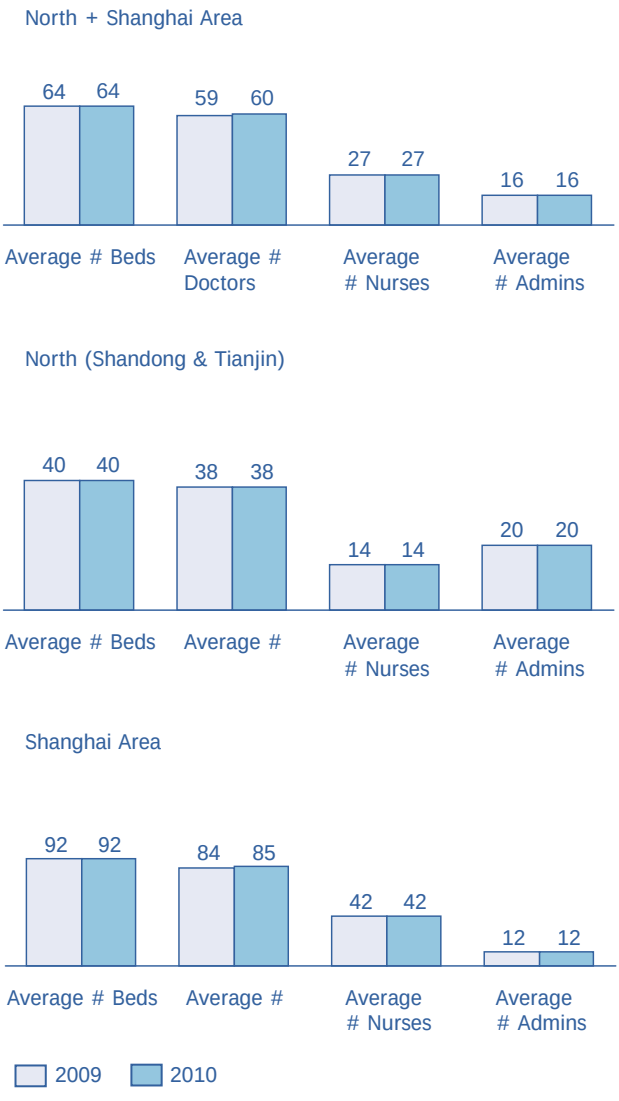
service advertising on TV and in mobile media such as buses, subways and so forth.

However, this effort appears to have been almost too successful, with demand for RHCs' services outstripping their resources. Budgetary constraints mean that RHCs are serving more patients per day without any increase in beds or other facilities. Our survey found that no RHC had added beds in 2010, and only a small number were starting to add beds in 2011. The staffing situation is even worse. Despite the heavier workload, RHCs are running with the same headcounts of doctors, nurses and administrators as in 2009. The fact that the centers' scope of services and treatment offerings has been simplified and procedures streamlined helps to a certain degree. But overall, RHC staff are feeling great pressure to handle a higher number of cases than ever.

Caseload & Med Insurance Coverage



RHC Resources



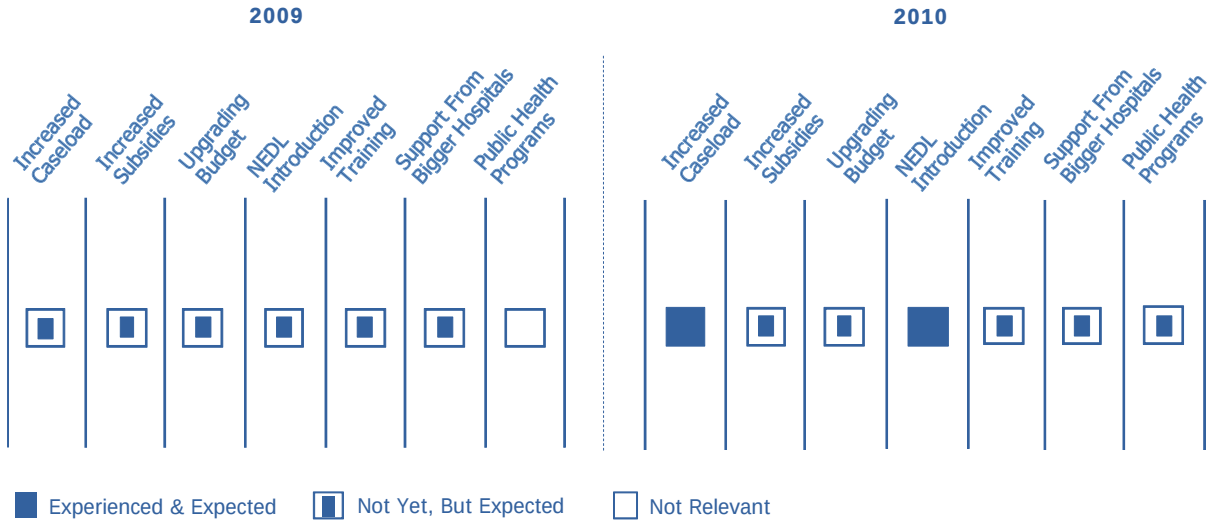
Source: InterChina Interviews & Analysis, 2011.

More Work, Poorer Pay

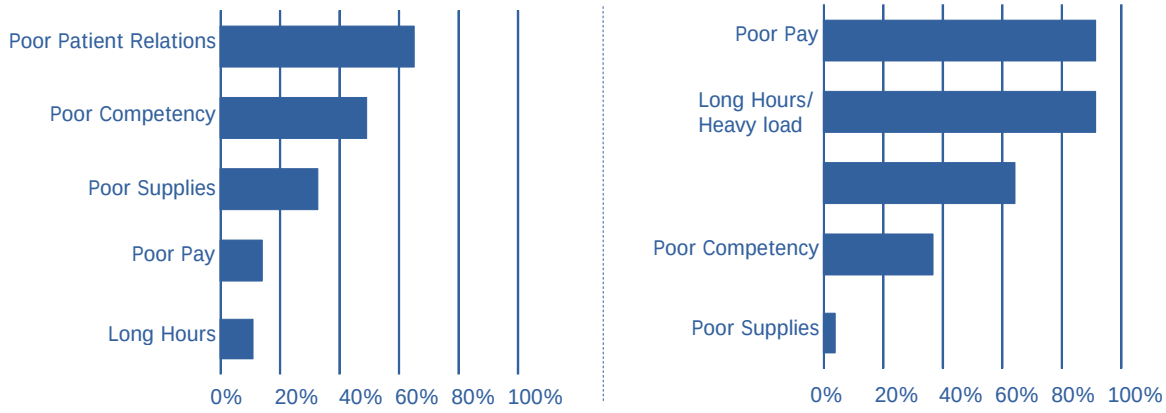
From the perspective of RHC staff, many promises of the Healthcare Reform have not materialized. Back in 2009, doctors were expecting that their salaries would increase in coming years. Over the last year, however, this has not happened. "Poor pay" topped the list of doctors' key concerns. Moreover, the doctors' performance bonuses have been cut in half, meaning to achieve the same bonus as in the past a doctor must treat twice as many patients as in 2009. This has understandably left doctors less motivated than ever.

Inevitably, RHCs are struggling to attract and retain talent. "It's very hard to motivate younger doctors", said the president of one RHC. "They see a lot of uncertainty in their financial as well as professional future." Indeed, it is difficult for a RHC doctor to become a leading specialized physician, because the current system no longer allows sophisticated or specialized treatments, and doctors are publishing fewer academic papers, which in turn hurts chances for promotion. Once a doctor works for a RHC, he or she may be stuck there for good. The RHCs we interviewed said they had "improved training", but this is provided by larger hospitals, and the RHCs have to pay for this training out of their own budgets.

Changes Observed by RHCs since the Start of the Healthcare Reforms



RHC Doctor's Top Concerns



Source: InterChina Interviews & Analysis, 2011

Financial Difficulties

With the introduction and rather rigorous implementation of the national essential drug list (NEDL), RHCs were disempowered from all purchasing and prescription decision-making. They are not allowed any markups on those drugs and also are not allowed to prescribe and dispense (more premium) out-of-pocket drugs anymore.

	RHC-level	Larger Hospital
Drug Setup	• Only NEDL	• NRDL [1)] • Out-of-pocket Drug List
Margin on Drugs	0%	Up to 15% [2)]
Purchase Decision Power	• Centralized at provincial level	• NRDL: centralized at provincial level • Out-of-pocket Drug List: decentralized and decided by doctors
Sales Rep. Visit	None	Frequently

Notes:
1) NRDL not only includes all NEDL drugs, but also some other drugs. The reimbursement ratio of NEDL at Higher level is lower than that in RHC level, which implies government encourages patients go to RHC level to get basic drugs and treatment.
2) The margin level is determined by the level of each hospital. For instance the margin of a level 3 hospital will be higher than that of a level 2.

The NEDL system serves the short-term needs of financially weak patients, but in turn has cut off a crucial revenue source for the RHCs. Government subsidies appear not to have fully offset this loss. Many RHCs are struggling to keep afloat and to pay the meager salaries of their staff. Meanwhile, many are delaying payments to medical device suppliers and drug distributors. Some RHC presidents we interviewed asked their staff to provide cash to help keep their operations going. Doctors and nurses are often providing private loans to inject this cash back into the RHCs.

Given their cash flow woes, RHCs increasingly are seeking credit financing options from their suppliers, especially from medical device makers. This need was much more evident in this year's survey than a year ago. Some RHCs are at risk of declaring bankruptcy. The financial problems of the RHCs may be even more serious than just having doctors quit their jobs. We are unsure if the government will provide further relief or assistance, and what form it might take. What is certain is that the overall situation is not healthy and not sustainable.

The End of Premium Pharma

RHCs are no longer buyers or dispensers of higher quality, expensive medicines since they are limited to the NEDL. The list includes a limited range of 500 – 700 formulae, and for each, an RHC is entitled to only one brand from one supplier. The RHCs also cannot sell 'self-made' TCMs as they did in the past, cutting off another revenue source. These are traditional Chinese medicines that are mixed and prepared by the RHC themselves, according to their own experience. Pharmaceutical makers whose products are not listed in the NEDL have no way to market their products to the rural health system. Those who do have formulae included in the NEDL need to focus on lobbying provincial- level procurement committees. Demand-creation directly with RHCs themselves will do no good. None of the doctors and administrators surveyed in our study could recall any pharma medical representatives visiting them in the last year. It is clear that price alone is now dictating the procurement decisions of provincial committees. The cheaper alternatives are, in most cases, still Chinese generic pharmaceutical makers.

Opportunities for (some) Medical Devices

Medical device makers can still find some opportunities at rural healthcare centers. There is no list such as the NEDL for medical devices, and procurement is managed by district bidding firms, not on the provincial level. For basic and price-competitive medical devices, such as X-rays, type B ultrasonic systems, blood pressure and blood glucose test kits, and various disposables and consumables, RHCs still need better, yet affordable and easy-to-use products. This is a field where foreign and multinational brands can find a market, especially those that have localized production in China. The role of the distributor is becoming ever more important, since very few medical device makers have the vast sales forces necessary to call on the RHCs. Since RHCs need flexible payment terms, medical device makers need to make arrangements with their distributors. This may

involve larger margins for the distributors and longer payment terms than in the past. If a distributor is willing to provide credit to RHCs, this may be a more promising business model. Most of the active players in the RHC medical market are Asian companies such as Korean Samsung Medison, Japanese makers Konica Minolta, and Nihon Kohden, Hitachi Aloka Medical and Chinese makers Wandong, Mindray and Carestream (formerly Kodak). The typical annual purchasing power of medical devices for one RHC ranges between RMB 500,000 – 1 million. This is small for one RHC alone, but if several thousand RHCs are included the market size calculation, it could become an attractive opportunity. This market remains highly atomized, and depends on distributors which have the reach to service the market efficiently.

Streamlined Healthcare

The profession of doctor as we know it may have ended in the RHCs. We have observed doctors transformed from professional, ambitious physicians into nurse-like professionals who are counting the number of cases and looking for fast, simple treatments. Since doctors no longer make decisions about resources and especially drugs, they are becoming more like state-company or government employees than like aspiring medical heroes.

Since working in an RHC can be a dead-end for many doctors' and nurses' careers, newly set-up private hospitals could draw from the growing pool of frustrated talent at the RHCs. We may also soon see RHC doctors setting up their own private hospitals, not the high-end, foreign-invested private hospitals as we know them now in China, but a new tier of private hospitals that are less sophisticated and cheaper than today's private hospitals, but more specialized than public or rural hospitals.

Opportunities for Training Programs, Schools and IT Companies

Given the current situation of RHCs and their limitations, training and remote learning programs have become more important. Doctors and nurses need more training, but have few choices. Many community healthcare workers (RHC and UHC included) are less educated than their colleagues at the class 3 hospitals. Only about 22 percent of them have university degrees or advanced degrees. Many of the training programs for General Practitioners are rather basic, for example a part-time lecture series lasting two to three months is almost all it takes for a RHC doctor to qualify as a General Practitioner.

Pharmaceutical and medical device suppliers and specialized training companies could leverage this demand by offering the right propositions in the right way, such as remote learning programs and courses via the Internet. Programs to address RHCs' underdeveloped IT management systems could also help improve their efficiency.

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