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In addressing post-socialist China's challenges to public health care, I focus on: 1) the current state of access to health care, and, 2) HIV/AIDS.

Public Health and Financing Health Care in China

First the good news, GDP spent on health care has risen from 4.11% in 1991 to 4.82% in 2000, but at the same time government spending on health care has decreased from 22% of the total expenditure on health to 14%, and in addition, the percentage of government health spending allocated to public health has decreased slightly from 75% in 1991 to 70% in 2000. These indicators have left incredibly wide disparities in health care especially between rural and urban China, leaving many to call China a country with two health care systems. In an effort to redress the rural health care system, decentralized health insurance management organizations were launched in the 1980s and 1990s to restore the cooperative medical systems of the early 1960s with support from bilateral organizations UNICEF, WHO, and the World Bank to name a few. However, virtually none of these systems have been sustained for several reasons: 1) with lack of local and government support farmers were unduly burdened to pay for their own health care, 2) the central government prohibited additional taxes on farmers and many local officials defined new insurance premiums as additional taxes, 3) low insurance premiums resulted in limited benefit coverage for both outpatient and inpatient services, 4) services at the village or township hospitals were always inferior to country or urban hospitals, so farmers traveled to the cities for care, and, 5) widespread fear of corruption in the use of funds collected for insurance premiums (see Liu 2005 & Hu 2004).

In terms of financing health care, several experts have promoted such schemes as higher taxes on cigarettes (China has one of the highest rates of tobacco use in the world); currently Chinese cigarettes are taxed as 40% compared to the median international tax rate of 66%. Furthermore during the last outbreak of SARS (severe acute respiratory syndrome), the Chinese government recognized the importance of investing in health, and providing for health-care services has become a key element in many economic development plans. However, I have found that the realities of rural health care even in areas of high international NGO funding to be spotty at best.

Theoretical and Methodological Approaches

In my research on HIV, I take a critical medical anthropological approach, meaning that I use critical theory to understand health in

China and apply a combination of both a phenomenological approach - capturing individual subjectivity and individual's stories - with a political economic approach - capturing larger structural constraints and contexts. I balance my anthropological research with my public health practice, meaning that in every research project I also conduct public health work, e.g., designing AIDS peer education programs and materials, helping indigenous NGOs that support AIDS activists get started, and, devote time to working with public health practitioners. But there is a slippery slope that one walks down in terms of being a critically engaged academic and also an actively engaged practitioner. In furthering this dialogue, I focus on my area of expertise on the rise of the HIV epidemic.

Infectious Diseases: the Case of HIV/AIDS

Current predictions that AIDS in China and India will surpass Africa's epidemics in severity are fraught with discrepancies in terms of the rise of infections in Asian countries such as Burma and Cambodia, and often incomplete and unreliable surveillance methods. Currently no country in Asia has experienced a generalized epidemic; however, Cambodia, Indonesia, Myanmar, Nepal, Thailand, and Vietnam have reached the concentrated stage, as have China's Yunnan Province and certain states in India. In concentrated epidemics, prevalence is more than 5 percent in one group (e.g., injection drug users and plasma blood donors) but below 1 percent among women in antenatal clinics (Bloom et al. 2004: 10-11). As Joan Kaufman (2004) points out, China's AIDS situation has been unfolding now for over a decade and is accelerating. In an interesting turn of statistics, the Chinese government reduced its figures from 840,000 persons infected with HIV in 2003 to 650,000 at the beginning of 2006, only to turn around the next year and raise the numbers again. Although China's infection rate is less than 1 percent of the population, those infected are concentrated in several provinces and sub regions within those provinces. Among injection drug users, who account for 44 percent of all estimated HIV cases, seven provinces—Yunnan, Xinjiang, Guangxi, Guangdong, Guizhou, Sichuan, and Hunan—account for 90 percent of infections (MOH 2006: 1). Kaufman notes that even if China were able to keep rates of new infection closer to 2 to 3 percent, as Thailand has, given the sheer size of the population, tens of thousands of people will still require treatment and care (see Kaufman, Saich, and Kleinman 2004)

The Yunnan Centers for Disease Control and Prevention report that after testing 95,755 individuals from defined high-risk groups— injection drug users, sex workers, and migrants—the incidence rate was 1.5 percent. The majority of those who were HIV-positive were twenty-to-thirty-year-old males who are injection drug users, Han Chinese, and unemployed peasants. As homosexuality is not openly discussed in much of rural China, data available on men who have sex with other men (MSM) is still limited in rural areas, but in 2006 urban MSM accounted for 7.3 percent of all HIV infections (Settle 2003; MOH 2006: 2). Sexually transmitted infections that are surrogate markers for

increased HIV have overtaken tuberculosis to become the third most common category of infectious disease after dysentery and hepatitis (Parish et al 2002; M. Cohen et al. 2000; M. Cohen 2001). Since women are more vulnerable because of the biology of genital tissues and women's personal difficulties in negotiating consistent condom use, they too are increasingly becoming infected at rates that will soon reach or, as some predict, surpass gender parity. Despite the continuing rates of HIV in Yunnan Province, which made it ground zero of the Chinese epidemic, there have been significant strides made in combating HIV in the last decade.

Through joint efforts of the CDC in Beijing, and the Ministries of Civil Affairs, Education, and Health, many new NGOs and joint venture projects have been launched. When I left Yunnan in 1997, the NGOs were Save the Children-Hong Kong (SCF) and the Australian Red Cross (ARC); and shortly afterward, Oxfam-Hong Kong and Médecins Sans Frontières-Belgium. According to AIDS journalist Odilon Couzin, there are now over 200 NGOs (international, national and local) working in Yunnan Province alone on the single-issue of HIV (Couzin 2004).

As new NGOs appear to be heading into China at an ever-growing pace, AIDS has become a virtual health care industry in China, especially for NGOs working in health care and STI/AIDS prevention. In December 2003 Premier Wen Jiabao and Vice-Premier Wu Yi announced a policy for comprehensive HIV/AIDS prevention and treatment called "The 'Four Frees and One Care Policy'". It had the following aims: free anti-HIV drugs to AIDS patients who are rural residents or people with financial difficulties living in urban areas; free voluntary counseling and testing; free drugs to HIV-infected pregnant women to prevent mother-to-child transmission, and HIV testing of newborn babies; free schooling for children orphaned by AIDS; and free care and economic assistance to the households of people living with HIV/AIDS" (UNAIDS 2004; Li Hong et al. 2001). Most recently in 2004 and 2005 the Chinese government has begun to implement these policies, with some interesting results. One policeman in Liuzhou said, "Dispatching condoms at hospitality facilities is somewhat contradictory to our crackdown on prostitution. But disease prevention is a life and death issue and therefore more important than a crackdown" (Zhou Yan 2005).

According to Peter Piot of UNAIDS in Geneva, China is far ahead of India and Russia in addressing large-scale AIDS epidemics. For Dr. Piot it was the rise of the SARS epidemic in 2003 that put an implicit panic and fear into Chinese officials about the destabilizing effects of a widespread epidemic (Yardley 2005; see also Kleinman and Watson 2006). Prevention, however, is not the only arena where strides are made. The new policies in 2006 will institute mandatory condom distribution campaigns like the one in Yunnan, making condoms available in all public places, especially the entertainment industry venues; enhance access to antiretroviral therapies; and expand legal protection for PLHIV. These policies, however, do not come without

clear costs. Human rights activists argue that in many cases PLHIV are still being discriminated against by the insistence they no longer marry; however, this time the law has been rewritten as "postponing marriage." There are still no legal protections to ensure that PLHIV have access to medical care. Instead, according to the Aizhixing Research Institute, there is a strong emphasis on the "duties" required of PLHIV, including submission to mandatory surveillance and testing even though people whose status is disclosed will have neither legal protections nor definitive access to treatment and care. In some cases people who are infected will be fined or jailed for infecting others, which leads to disincentives for getting people to know their HIV status (Aizhixing Research Group 2006).

China has just doubled the amount of money targeted to combat AIDS and has received a Global Fund award of 29 million U.S. dollars (combined with a 20 million from the Chinese government) to combat the spread of new infections (see China AIDS Info 2006). These policies however are still implemented unevenly across China. Antiretroviral therapies are currently available to only 20,453 people living with AIDS, which is but a fraction of infections (MOH 2006: 9). Access to the drugs is still expensive by Chinese standards and unevenly distributed and managed. Furthermore, certain state sectors have not welcomed all the civil society activities on behalf of those with HIV. Chinese AIDS activists continue to be arrested when they overstep the boundaries of what the government considers acceptable public protest. Following an organized hunger strike to protest detention and human rights violations, several AIDS activists associated with the Beijing Aizhixing Institute, the Chinese Democratic Party, and the Empowerment and Rights Institute in Beijing disappeared after being harassed, tailed, and in some cases beaten by the police. All across China, complaints have been voiced about corruption among local officials, the diversion of funds marked for PLHIV, and milder forms of expropriation of funding. Overall, compared to ten years ago, progress is being made, even though implementing policies set in Beijing takes time and is far from widespread. The question remains: is this progress too late?