

Mental Health Care in China: Recent Changes and Future Challenges

Lawrence Park, AM, MD, Zeping Xiao, MD, PhD, Jonathan Worth, MD, Jennifer M. Park, MD

After 1949, the communist government under Mao Zedong built strong collective health care and public health systems. While mental health care did not receive specialized attention, the overall health of Chinese citizens was improved due to the emphasis on basic health care. Within thirty years, these Chinese systems became the envy of many developing (and developed) countries struggling to provide universal access to health care at reasonable costs. However, since 1978, decreased central government support and significant policy changes have largely dismantled these comprehensive systems of public health and basic health care. During this period, policies were enacted that decentralized and privatized the health care system. Once a model for

universal basic health care, the majority of Chinese citizens currently do not have insurance coverage. Moreover, decentralization has led to large inequities between rural and urban areas, and privatization has contributed to skyrocketing costs and systemic inefficiencies. Mental health care, already in a weaker state than general medical care, has been disproportionately affected by these developments. Availability of mental health care is virtually nonexistent in rural areas and accessible only to the insured and/or wealthy in urban areas. Providers in urban areas struggle to provide services due to an unfavorable reimbursement structure and a lack of clear mental health care policies. Even in Shanghai, one of the most economically prosperous cities in China, it remains a challenge to provide

.....
Lawrence Park, AM, MD, is instructor of psychiatry at Harvard Medical School (HMS), director of inpatient psychiatry at Massachusetts General Hospital (MGH), and NIMH fellow at the Department of Social Medicine at HMS. Zeping Xiao, MD, PhD is professor of psychiatry at the Medical College of Shanghai Jiaotong University and president of Shanghai Mental Health Center. Jonathan Worth, MD, is director of the Adult Outpatient Psychiatry Department at MGH. Jennifer Park, MD, is director of the Acute Psychiatry Service in the Emergency Department of MGH.

affordable and clinically optimal mental health care. Most recently, the central government has demonstrated some signs of increasing funding for some mental health care initiatives. However, this remains a far cry from the long-term commitment necessary to ensure adequate treatment for persons with mental illness. Such an effort would require passage of national mental health care legislation, sufficient financial support, shifts in delivery models toward community-based care, improved quality and amount of training for mental health practitioners, and the guarantee of human rights (including access to health care) for persons with mental illness.

Brief History of Health Care Policy in China

In 1950, the First National Health Congress proposed four basic directives for organizing Chinese health care:

1. Medicine should serve the workers, peasants, and soldiers.
2. Preventative medicine should take precedence over therapeutic medicine.
3. Traditional Chinese medicine should be integrated with Western scientific medicine.
4. Health work should be combined with mass movements.¹ (e.g. public health campaigns such as mass immunizations, eliminating prostitution, ending opium use, improving overall nutrition, sanitation and water quality, targeting infectious diseases such as schistosomiasis)

In accordance with China's communist

roots, a strong emphasis had been placed on social equality and justice. As core values of the society, these guidelines served as the foundation of a collective system of health care based on coverage from the government and the work unit. The state developed a system of cooperative medical services, operating within the commune model in rural areas. The ability to provide basic health care at a reasonable cost was dependent on the proliferation of health care practitioners throughout the countryside who had received rudimentary medical training and provided basic front-line medical care – this was the so-called “barefoot doctor” model. Funded mainly by the central government, this system of universal coverage promoted social equality by offering equal access to basic health care to all individuals. Offering the same access to care for everyone formed a powerful statement about the primacy of the collective and the equality of the citizenry. In this way, central government support of the nation's health care system also served as an effective mechanism for the redistribution of resources from wealthier urban areas to poorer rural areas.

In 1978, Deng Xiaoping began reforms to replace the socialist agricultural system with a market economy. The transformation of the economy influenced many aspects of life in China, including health care. Blumenthal and Hsiao, in a recent report in the *New England Journal of Medicine*, describe the changes in the Chinese health care system.² The decollectivization of the rural economy and the establishment of a competitive market led to the rapid demise of the communes. With the end of the communes came the sudden loss of health insurance coverage to nine

hundred million rural Chinese. Paralleling changes in the overall economy, the health care system underwent processes of decentralization and privatization as well. With regard to decentralization, the central government transferred the authority and responsibility of providing for health care to provincial and local governments. Most cooperative medical services in rural areas did not survive due to inadequate financial support and ineffective administration. In urban areas, health care providers were able to survive, but have been subject to policies promoting privatization and cost control. Such policies have provided the incentive for the delivery of relatively expensive procedures and medications and have discouraged efforts for basic health care and prevention.

The move from a socialist to a market economy has been quite successful in transforming China into a world economic power. In the process, however, many changes that were instituted seem at odds with the collective ideology upon which modern China was founded. Decollectivization and decentralization have resulted in the loss of coverage for the vast majority of China's rural population and the end of the rural health care system. The trend toward privatization has shifted the focus from social equality to maximizing financial gain. With the elimination of central government control and funding, health care services and insurance coverage were able to survive in urban areas but not in rural areas. Over time, the gap between rural and urban became wider, inequity became more pronounced, and resentment in the rural population grew. As Hsiao described, "...the new policy is to accept less equality in order to achieve more rapid

economic growth."³ The implication in Hsiao's statement is that some understanding existed about the sacrifices that would have to be made. Indeed, it is difficult to imagine that Chinese policy makers did not predict the detrimental effects these policies would have. Perhaps the health care system was viewed as a necessary casualty in the evolution of the Chinese economy into a privatized market system. In many undesirable ways, the Chinese healthcare system now resembles that of the United States, sharing such common problems as skyrocketing costs, lack of universal coverage, disparity in access to health care, lack of prioritization of basic health care or prevention and low priority of mental healthcare services.

Mental Health Care in China

The problem of mental illness in China is significant and rising. In 2001, the Vice Minister of Health reported that 16 million Chinese suffer from mental disorders with an annual incidence 13 per 1000. Moreover, it is believed that mental illness is on the rise because of increased societal and economic stress, and an aging population. The World Health Organization (WHO) estimates that mental illnesses will increase in prominence to account for 17.4% of all illness in China by 2020 (3% higher than 2001).⁴ Compounding the increasing problem of mental illness is the precarious position of mental health care delivery in the overall Chinese health care system. Mental health services are characterized by a lack of specific efforts to systematically address mental illness, slow development

of specialized training and treatment of mental illness, and an absence of an elaborated mental health care policy to secure rights for persons with mental illness.

In the commune-based delivery model, little distinction was made between mental health and physical health, and most mental health care was administered in basic health care clinics. This lack of distinction may have had cultural roots, as traditional Chinese medicine did not distinguish between mental and physical disorders as strongly as Western conceptual models.⁵ Furthermore, the development of psychiatry has been interwoven with the Chinese emphasis on social order. Persons with mental illness were seen as potential sources of social instability because it was feared that they could be behaviorally out of control. Pearson reviews mental illness in the context of the Chinese social, political, and legal systems.⁶ The 1958-1962 five-year plan was one of the few five-year plans to deal directly with mental health (though much of the plan was concerned with how mentally ill persons disrupted the public order and how to secure the safety of the collective in the face of the dangerousness of those with mental illness). Psychiatry in China developed with close links to the security structure and was susceptible to being politicized during such periods as the cultural revolution. Historically, mentally ill persons have been viewed as a threat to the social order and this is one of the reasons that they have been highly stigmatized.

Stigma also contributed to the severe lack of resources dedicated to mental health care. Prior to the privatization of the economy, the majority of mental health care was provided in non-specialized basic

health care settings. After the commune system gave way to the market economy, essentially no mental health services existed in rural areas. Chang and Kleinman describe how the mental health system suffers from a severe lack of resources and low quality of care. Moreover, with the loss of insurance coverage for rural citizens, the disparity in access to mental health care between rural and urban areas grew significantly. If individuals living in rural areas required treatment of mental illness, they were forced to travel to facilities in urban areas and pay for care from their personal savings. "As a result, the majority of rural patients with severe and persistent mental illness received no professional care at all."⁷

Even in urban areas, mental health care facilities were disproportionately affected by changes in the economic model. For example, in Tianjin, a large industrial port city in Northeast China under central government control, mental health care facilities struggle to survive. One of the authors (L. Park) has followed the evolution of a mid-tier psychiatric hospital over the past 12 years. In 1994, the hospital was an independent 300 bed facility whose dedicated and well-trained staff delivered high quality psychiatric care. The hospital was nearly always at 100% occupancy. Five years later, significant downsizing had occurred, with the original hospital relocated to two floors of a nearby general hospital. In the transition, inpatient capacity was reduced to 60 beds. Nevertheless, the staff remained optimistic and hard-working, and the hospital remained fully occupied. In the past year, the author visited this facility again. Though the unit remained in the same location, there were drastic changes. The administration of the department,

once independent, had become subsumed under the overall administration of the general hospital. Although the total number of beds remained the same, the census was rarely at full occupancy. The cost of hospitalization had increased significantly, from 2000 Yuan (\$250 USD) per month to 5000 Yuan (\$625 USD) per month. Additionally, many of the outpatient services were underutilized. Only a fraction of the original staff continued to work on in the department. The director seemed demoralized. He described the difficulties of running the service given the current circumstances, expressed concern about the financial viability of the unit, and solicited ideas about how to help bolster the financial standing of his unit.

Mental health care services in Shanghai are, perhaps, the best in China. There are currently 42 psychiatric facilities with 10,496 inpatient beds and 1,221 qualified psychiatrists practicing in Shanghai.⁸ A strong tradition of community psychiatry exists in Shanghai. The "Shanghai model," initiated in the 1970s, served as a pioneering effort to design a system of community-based care. It focused on providing care to three groups of patients with different neuropsychiatric disorders: psychosis, mental retardation, and seizure disorders.⁹ Services were organized into a three-tiered system, with care provided at the community, district, and provincial levels. Initial care was provided at the community level, which was most cost-efficient, and then progressed to the district and provincial levels as clinically needed. In the 1980s and 1990s, other community rehabilitation programs also came into existence in other areas of China and proved to be effective in minimizing deterioration and

promoting rehabilitation of psychiatric patients.^{10,11}

Despite the tradition of community psychiatry, community-based care currently plays only a minor role in the delivery of care in Shanghai. Lack of a reimbursement model and the inertia of a hospital-based model of care have led to the relative weakening of community-based services over time. For a population exceeding 16 million, Shanghai has only 98 outpatient occupational therapy/rehabilitation workshops and neighborhood care networks involving 52,000 members.⁸ Throughout China, 80% of health care funding goes to hospital-based care in urban areas.⁷

Recent Changes in Policy

In the past five years, policy makers have attempted to respond to escalating health care costs, lack of coverage, and the increasing economic burden on individuals and families. Three major initiatives have been undertaken since 2000. First, a new cost-sharing plan was put into place for health insurance. The previous system of insurance included two main programs: coverage for government employees (the government insurance system, or GIS) and coverage for workers from their work unit (the labor insurance system, or LIS).¹² Those individuals who had coverage through LIS paid up front for health care costs and were later reimbursed by their work unit. However, because many work units were in poor financial straits, many individuals waited years for reimbursement, or never received reimbursement at all.¹³

In 1998, a new system of coverage called the urban employees basic health care in-

insurance plan was unveiled. This plan is essentially a cost-sharing plan, establishing a medical savings account from contributions from the individual, the work unit, and the government. Depending on several variables (including geographical location, number of years of employment, and retirement status), individuals contribute 2-10% of their annual earnings to the fund. In Shanghai, the medical savings account is made up of 2% of the salary of the individual. Health care expenses are initially paid from the individual's contribution; once the maximum individual contribution has been reached, the work unit and central government cover the remainder of the expenses to a maximum of 400% of the individual's annual salary. The work unit contributes up to 12% of the individual's annual salary, with the remainder covered by the central government.¹⁴ In terms of coverage, hospitalizations are covered 100% and outpatient services and medications are covered 80%. All retired employees and government workers are covered 100% with no deductible for all services. The government reports that this system is currently operating in 90% of urban areas, covering up to 105 million individuals.¹⁵ Unfortunately, non-urban areas are not yet covered, and while there are plans to expand this system into rural areas, the majority of citizens remain without health insurance. In addition, unauthorized migrant workers who have moved to urban areas are not eligible for this insurance. Another major concern for this system is that there are significant gaps in coverage, particularly in the area of mental illness. The plan excludes coverage for "suicide attempts, self-mutilation, fights, drug abuse and traffic accidents..."¹⁶ These gaps in

coverage must be eliminated if access to comprehensive mental health care is to be ensured.

In a second initiative in Shanghai and other urban areas, cost control measures have been instituted. Budget outlays for hospital costs and medications have been reduced in an attempt to control escalating hospital and pharmaceutical costs. In order to control hospital costs, the municipal government has decreased payments to the city's medical insurance fund by 4%. Hospital costs will be affected, since all hospitals in the city (including psychiatric facilities) will have a budget set for them according to size and services delivered. The hospitals will be compensated from the budget in advance. If the hospital exceeds the budget, then added expenses must be shouldered by the hospital without help from the city's health fund.¹⁷ If the hospital comes in under budget, it will be allowed to keep the savings. In terms of pharmaceuticals, prescribers in mental health, have opted for the newer, more expensive medications.¹⁸ In Shanghai, the government announced a series of new policies to discourage the overprescribing of medications, and to cut back on the use of unnecessary tests and procedures (per Zhou Haiyang, director of the Shanghai Medical Insurance Bureau).¹⁷

China has also begun to actively promote the private sector, experimenting with private service delivery models as well as allowing for the establishment of a private insurance industry. In some areas, mental health care providers have been able to establish private practices and open their own private clinics. In Shanghai, private practice is currently being considered and may be approved in the near future.

Many private hospitals already exist (79 facilities with 4000 beds), and more may be on the way.¹⁹ These hospitals are privately owned and operated, and receive reimbursement from individuals on a fee for service basis, government-sponsored insurance, and private insurance. Additionally, some of these hospitals, as well as other health institutions in China, have established or are exploring relationships with foreign institutions for joint venture opportunities with clinical, research, or business objectives.

With regard to insurance, many areas in China are also experimenting with private insurance. In a few cities, some private insurance companies have been allowed to operate. These companies may be pre-established international companies entering the Chinese market or domestic companies developing health care related services. As China becomes more affluent, more individuals may be able to afford private insurance and may opt for such coverage as an add-on to the medical savings account coverage they already have or as primary coverage if they currently have no insurance.²⁰

Many different health-care related activities are currently underway in China. The variety and degree of these activities create a diverse (and at times chaotic) environment with the danger that many of these activities will not receive the appropriate oversight needed to insure quality care. With the most recent changes, China continues to parallel the patchwork system of care that has developed in the United States. Significant attention to the coordination of and communication between clinical services is paramount for this type of system to function optimally. An ap-

propriate amount of support must be allocated to each part of the system; too much support for one part of the system leads to inefficiency, while too little may lead to gaps in coverage.

Directions for Mental Health Care in the Future

Chinese policymakers have made statements which indicate that they realize the health care system is at a critical juncture. Recently, there has been significant discussion about health care policy, and mental health in particular. The current Chinese Minister of Health, Gao Qiang, acknowledged that the lack of coverage is one of the most significant problems, as many of the uninsured are children, farmers, and the unemployed. He reiterated the government's responsibility to improve public health and felt this could be achieved by increasing support, developing health plans, and increasing supervision over the market. Furthermore, he identified the next step in medical reform as an emphasis on improving affordability of medical services; he outlined three strategies the Chinese government would employ to improve affordability – increasing citizens' income, increasing insurance coverage and controlling costs.²⁰

In addition, the government has stepped up funding for mental health care projects. Chinese colleagues report a program called the "686" initiative that has allocated 6.86 million Yuan (\$860,000 USD) for training in mental health. This year, the Department of National Science and Technology has also allocated 10 million Yuan (\$1.25 million USD) for mental health research

(likely to be dedicated to schizophrenia research).²¹ While these developments are cause for some optimism, they are nowhere near the level of support needed to provide mental health services for a population of 1.3 billion individuals. Large-scale, consistent investments over time will be required to significantly improve mental health care throughout the country.

Increased expenditures alone will not be effective in solving the problems of lack of universal coverage and absence of services in many areas of the country. Astute policy decisions will be required to rebuild a stable and effective health care system. First and foremost, the health care delivery system needs to be re-constructed in rural areas. While some Chinese sources report that the rural health care system is receiving more support, the majority of rural citizens remain uninsured and without access to services.²² Rural health care delivery systems generally remain in a state of disrepair and require significantly more financial and political support if they are to be effective institutions for providing health care to the rural citizenry. In addition to rebuilding systems of care, health insurance must be expanded to cover a significantly greater proportion of the population. Ideally, a system of universal coverage would be re-instituted. However, barring a reversal of recent changes in policy, government sponsored universal coverage seems unlikely. A more feasible change would be to expand the cost sharing basic insurance initiated in urban areas to rural areas. Given, the economic disparity between urban and rural areas, this would require significantly more support through increased central government expenditures.

Another important issue for mental health reform is in the area of legislation

and protection of rights for persons with mental illness. One early policy achievement for disabled and mentally ill persons was the establishment of the All-China Disabled Persons Federation. Championed by Deng Pufang, Deng Xiaoping's disabled eldest son, this federation came into existence in 1988. Due to lobbying from influential psychiatrists, the organization included psychiatric illness as a type of disability covered under the federation. The federation serves as an advocate for the rights of the disabled and mentally ill.²³ However, development of other mental health care legislation and advocacy is limited. At the current time, there are no national laws safeguarding rights or guaranteeing access to care. Further elaboration of forensic psychiatry would be beneficial as well. The interface between psychiatry and the law vis-à-vis concepts such as guardianship, commitment, and competency are not well-defined. In order to secure basic rights for the mentally ill person in society, such laws are indispensable.


Over the past several years, China has drafted a proposal for a national mental health care law. This legislation was designed as an initial step to protect the rights of people diagnosed with mental illness and improve access to mental health services. Its aim is to guarantee persons with mental illness the right to receive medical treatment and convalescence services. This effort has been showcased as part of China's commitment to improve care for the mentally ill and help them gradually return to normal life (per Vice Minister of Health Zhu Qingsheng).²⁴ Unfortunately, this effort has been stalled and has yet to be passed by the Chinese government.

In terms of the delivery system, many steps need to be taken to increase the quantity and quality of mental health clinicians. According to Dr. Ma Hong, a researcher at Beijing University's Institute of Mental Health, there are only 14,000 psychiatrists practicing in China.⁴ Of those 14,000, it is estimated that only 4,000 are academically trained.⁷ The Chinese government recognizes that there is a significant shortage of mental health care professionals. The Ministry of Public Health in Shanghai has recently announced that it will increase the number of psychologists it will train.²⁵ In addition, allied mental health professions such as social work, psychiatric nursing, case management, and occupational/rehabilitation therapy are experiencing an acute shortage of practitioners and would benefit from increased support for training programs. Coupled with increasing initial mental health training, continuing education and licensing regulations are important issues for assuring quality. Licensing efforts in China are in their infancy. Shanghai has instituted a regulation requiring licensure for practicing psychiatrists and psychologists. This regulation is the first of its kind in China.²⁶

Finally, programs should be designed to most efficiently and effectively treat those with mental illness. For instance, community psychiatry efforts should be promoted as an alternative to hospital-based care. The government has instituted a "key program" in long-term planning (2006-2010) to explore community mental health. As financial support for hospitals decreases, community-based programs could be developed to replace care that had once been provided in the hospital setting. One potential area for increasing services would

be psychiatric rehabilitation. Another area of potential development is the integration of psychiatric services into basic primary care services. In the US, a comparison trial of integrating psychiatry into primary care in Chinese Americans demonstrated improved access to mental health services and increasing treatment engagement.²⁷ In reviewing the international literature, Patel and Cohen conclude that the data for the efficacy of such programs in developing countries is growing, but not overwhelming at this point.²⁸ They report that the success of such programs is often influenced by specific characteristics of the local health system, such as the role of traditional practice in providing primary care, the status of the primary care system, the availability of mental health providers, and the attitudes and priorities of policy makers and the society-at-large.

In developing new psychiatric services, specific programs should also be tailored to the needs of specific patient populations. Furthermore, as new programs are instituted, systematic assessment will be important for evaluating the effectiveness of these programs. Specialized treatment programs may help to improve the quality of care and the efficiency of service delivery. For instance, recent reports have noted a rise in the need for alcohol/drug abuse programs and geriatric psychiatry. In response to this need, several programs focusing on substance abuse and geriatric psychiatry have been developed in China.⁷ Continuing this trend of greater specialization of services and matching specific services with clinical needs will serve to provide higher quality care to patients, and may help to increase the efficiency of delivering those services.

In conclusion, mental health care in China is at an important moment in history. The changes of the past five decades have resulted in an uneven landscape of mental health services, with sophisticated services in certain areas (such as Shanghai) and no services throughout the much of the rest of the country. While health care in general has been affected by the move toward privatization and decentralization in the general economy, mental health care occupies a unique position with specific challenges. These challenges include ensuring universal access in the face of widespread lack of coverage, an acute shortage of services particularly in rural areas, improving the quality of care throughout the country, advocating for the rights of the mentally ill, and transforming a system of hospital-based care to an efficient community-based system responsive to the specific needs of the patient population. Recently, there has been some cause for guarded optimism with increased discussion and some initial support for mental health initiatives. However, these preliminary programs should in no way be construed as a sufficient response to the lack of mental health care services throughout most of the country. What will be required is a long-term, sustained commitment to mental health as well as elaboration of a clear and comprehensive mental health policy that protects the rights of persons with mental illness. Moreover, it is imperative that development of mental health services extend into rural areas. Without sufficient support and effective policy directives, the unequal and suboptimal treatment of an already stigmatized and disenfranchised population will continue. 

Acknowledgements

The authors wish to express their gratitude to Byron Good and Alex Cohen for their comments and suggestions.

References

1. Hesketh T, Zhu W. Health in China: from Mao to market reform. *BMJ* 1997;314:1543.
2. Blumenthal D, Hsiao, WC. Privatization and its discontents—the evolving Chinese health care system. *NEJM* 2005;353(11):1165-1170.
3. Hsiao, WC. The Chinese health care system: Lessons for other nations. *Social Science and Medicine* 1995;41(8): 1047-1055. p 1047.
4. People's Daily Online. 2001. China to draft law on mental health services. http://english.peopledaily.com.cn/200110/10/eng20011010_81962.html. Accessed May 16, 2005.
5. Park L, Hinton D. Dizziness and panic in China: associated sensations of Zang Fu organ disequilibrium. *Culture Medicine and Psychiatry* 2002; 26:225-257.
6. Pearson V. *Mental Health Care in China: State Policies, Professional Services and Family Responsibilities*. 1995. Gaskell: London.
7. Chang, DF, Kleinman A. Growing pains: mental health care in a developing China. *The Yale-China Health Journal*, Autumn 2002; 1:85-98.
8. Zhu ZQ. Mental health service in Shanghai. Presented at Comprehensive Mental Health Care for Shanghai: Approaches to Improving Mental Health Systems. Shanghai, PRC. June 14-16, 2005.
9. Zhang M, Yan H, and Phillips MR. Community-based psychiatric rehabilitation in Shanghai: facilities, services, outcome, and culture-specific characteristics. *British Journal of Psychiatry*, 1994; 165(suppl. 24): 70-79.
10. Wang QT, Gong YZ, Niu KZ. The Yantai model of community care for rural psychiatric patients. *British Journal of Psychiatry* 1994; 165(suppl. 24): 107-113.
11. Jin DX, Li GS. The role of human rights and personal dignity in the rehabilitation of chronic psychiatric patients: a rural therapeutic community in Yanbian, Jilin. *British Journal of Psychiatry* 1994; 165 (suppl. 24): 121-127.
12. Grogan CM. Urban economic reform and access to health care coverage in the People's Republic of China. *Social Science and Medicine* 1995;41(8):1073-1084.
13. China.org. 2001. Eighty million Chinese to benefit from new medical care system. www.china.org.cn/english/MATERIAL/8605.htm. Accessed May 7, 2005.
14. China Daily Online. 1998. Shanghai retools health

- costs. www.china.org.cn/english/MATERIAL/838.htm. Accessed May 7, 2005.
15. China Daily Online. 2003. Health insurance benefits urbanites. www.china.org.cn/english/Life/81964.htm. Accessed May 7, 2005.
 16. China.org. 2000. Reforms in health-care costs ready. www.china.org.cn/english/SO-e/3998.htm. Accessed May 7, 2005.
 17. China.org. 2002. Shanghai cuts hospital spending. www.china.org.cn/english/government/30992.htm. Accessed May 7, 2005.
 18. China.org. 2001. City sets budget for hospitals. www.china.org.cn/english/SO-e/24279.htm. Accessed May 7, 2005.
 19. People's Daily Online. 2003. Shanghai wants more private capital in healthcare. http://english.people.com.cn/200311/06/eng20031106_127688.shtml. Accessed May 7, 2005.
 20. Gao Qiang. Improving the health of the 1.3 billion Chinese people: major challenges and strategies. Presented at the Harvard School of Public Health, Boston, MA, October 2005.
 21. Personal communication, Michael Phillips, November 16, 2005.
 22. People's Daily Online. 2003. Shanghai promises health care for farmers. http://english.people.com.cn/200301/18/eng20030118_110339.shtml. Accessed May 7, 2005.
 23. Phillips, M.R. The transformation of China's mental health services. *The China Journal* 1998, 39, 1-36.
 24. People's Daily Online. 2001. China to draft law on mental health services. http://english.peopledaily.com.cn/200110/10/eng20011010_81962.html. Accessed May 7, 2005.
 25. People's Daily Online. 2002. China shifts health focus to mental illness. http://english.people.com.cn/200201/14/eng20020114_88609.shtml. Accessed May 16, 2005.
 26. China.org. 2004. Mental health pros need license. <http://www.china.org.cn/english/China/85337.htm>. Accessed May 16, 2005.
 27. Yeung A, Kung WW, Chung H, Rubenstein G, Roffi P, Mischoulon D, Fava M. Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans. *General Hospital Psychiatry* 2004; 26:256-260.
 28. Patel V, Cohen A. Mental health services in primary care in 'developing' countries. *World Psychiatry* 2003; 2(3):163-4.