The real ethics of rationing

Donald W Light

National Primary Care Research and Development Centre, University of Manchester, Manchester M13 9PL

Donald W Light, *Glaxo-Wellcome visiting professor of primary care*

dlight@fs1.cpcr.man.ac.uk

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Since 1996, the *BMJ* has published a series of articles about the nature of rationing in health care, several by the Rationing Agenda Group, an influential group of policy advisers.[1] This brief essay will question some of their arguments and then suggest that the real ethics of rationing should first address the sociological and managerial forms of inequality, power, and privilege upstream that force rationing downstream at the point where doctors treat patients.

There is a strange kind of schizophrenia in the arguments about rationing. One part holds that funding for the NHS is adequate and likely to be so for the foreseeable future[2]; another holds that rationing takes place in the NHS and always will, because rationing is inevitable.[3] Yet these two central themes of policy are not joined. Surely the amount and kind of rationing, affects perceptions of the adequacy of funding. If it does not, then "rationing is inevitable" can be a paternalistic justification for playing Scrooge. It can justify as low a level of funding and supply of doctors and nurses as those in power want. If we conclude from the start that we can never adequately meet all needs, why bother trying to meet them as inadequately as we do already? Why not cut the NHS budget by 10% or 20%?

Summary points

One part of the rationing debate maintains that NHS funding is adequate by ignoring how much rationing takes place, and another part holds that rationing is inevitable; surely the latter affects judgment of the former

Our goal should be to minimise the need to ration by eliminating ways that entrenched institutional, political, and professional interests lock in waste, not to figure out how to ration fairly in the context of a segmented, unintegrated system with wasted resources. This is the real ethics of rationing

There are extensive inequalities that lead to rationing, the largest being unexplained inequalities in how many resources different doctors use; private insurance that skims off the easy, profitable cases rather than being structured equitably; and an arrangement that rewards minimising surgery to NHS patients in order to maximise private surgery. These inequalities should be eliminated

A central plank of the new charter for the NHS in 1998 should be to provide effective treatments at minimal cost in an equitable manner

"NHS funding is fine"

If we examine the funding article[2] of the Rationing Agenda Group[3] more closely, we learn that the extra burdens of aging fall within the projected growth of real NHS expenditures and that changes of morbidity will neither accelerate nor retard expenditures. The authors show that so called efficiency and activity gains are increasing faster than expenditures. Expectations may change, but they are subjective, political, cultural, and impossible to predict; so on balance NHS funding is likely to be adequate for years to come.

One telling detail in this "funding is fine" argument is that no estimate is made for the increasing cost of improvements in technology and pharmacology. The authors indicate that past improvements have increased costs substantially but then make no provision for them in their estimates of how adequate NHS funding will be. Nor are these costs offset by any measure of benefits. Yet these are at the heart of modern medicine and of its ability to help patients reduce pain and regain health. Moreover, the article has a reassuring, Olympian—and unreal—tone, as if it were about a healthcare system with clean modern hospitals, good support staff, ample specialists and hospital beds, and prompt service. No mention is made of crumbling, unsafe hospitals; a £10bn backlog of needed maintenance; nurses and doctors stretched to the limit; million-plus waiting lists; and thousands of patients who never even get on the waiting lists, though little local difficulties are acknowledged in a subsequent article.[4]

This "see no problems" argument might be called the Procrustean bed approach to adequate funding: you set a budget, chop off what you cannot afford, and point out that the service fits into the funding. For example, when I helped to develop the first needs based purchasing plan for child and adolescent psychiatry, we found that about 90% of sexually and physically abused children, children with conduct disorders, and children with other important disturbances are not seen by a qualified mental health team because the training, supply, and funding of specialty teams effectively shuts them out.[5] Yet there is no

concern about the tragic consequences for these children or the large knock-on costs to the NHS, to schools, to the criminal justice system, and to welfare for not treating them. The funding is accepted "as is." Many other subspecialties could document similar serious shortages.

The NHS already rations on a massive scale. The NHS rations by delay to get on waiting lists, and then on the waiting lists themselves, and then with the further wait after an appointment has been made. It rations by undersupply of staff, doctors, machines, facilities, etc; by undercapitalisation of run down facilities; by dilution of tests done and services received; by discharge earlier than desirable; and by outright denial to even the chance to wait or be undertreated. Yet the Rationing Agenda Group points out that no criteria have been established for defining need and for when rationing takes place. Lack of criteria and measurement can be used to conclude that rationing is not taking place.[6] An important task for the medical and nursing professions is to establish criteria and a system for recording the clinical effects of undersupply and underprovision—for without documentation, any arguments of underfunding run on anecdotes.

Rationing is inevitable

Oddly juxtaposed to the argument that NHS funding is adequate are arguments about how to deal with the inevitability of rationing. But to say that "rationing is inevitable and therefore we should focus on how to ration reasonably" is like the medical profession deciding that "death is inevitable and therefore we should focus on how to die reasonably." Death is inevitable, but the conclusion denies the whole purpose of medicine. Likewise, our purpose should be to postpone and minimise rationing as much as possible. This should be the first goal of the Rationing Agenda Group, and it forces us to be frighteningly honest about the ways in which current practices hasten and maximise rationing. But first I want to pause and address whether rationing is inevitable.

The myth of the bottomless pit

When the argument that "rationing is inevitable" is applied not to situations with effectively absolute shortages like liver transplants, but to the healthcare system as a whole, it assumes that there can never be enough money, or surgeons or drugs or child psychiatrists, to satisfy all the needs that people have. Interestingly, I hear this argument most in Britain, which spends the least money from direct taxes trying to meet those needs and demands. And I don't hear it from ordinary citizens, only from people with university degrees. Ordinary citizens tell me about a family member who is not getting adequate care for a serious health problem and wonder why. They don't know that they could get it if they were in a nation with an adequately funded free health service with no waiting lists, like Holland or Germany.

The claim that health needs are bottomless is an empirical question, not an assertion or article of faith. What makes it a myth and an indefensible form of paternalism is that no one making this claim goes out and tests it. Yet the depth of the pit can be determined by taking people in a well funded healthcare system who face no barriers of time, distance, money, or delays and measuring their rates of surgery, or drug use, or visits to the doctor. If the advocates of the bottomless pit are correct, average citizens in such a system would see the doctor every day, take multiple drugs, and have an operation a week. They and their doctors would come up with a new "need" as quickly as you can say "Rationing." In fact, Dutch people or Germans see the doctor and have operations at somewhat higher rates than do the British, but the rates are far from infinite.

What this means is that rationing by any reasonable definition is avoidable, and the British can have a healthcare system without widespread denial of care, waiting lists, run down facilities, and underservice. It's just that the layers and layers of rationing and underprovision make it seem as if the pit of medical need in Britain is bottomless. For if tomorrow all those waiting more than eight weeks for specialty services were seen, the increased supply of specialists and availability of services would lead general practitioners to put forward patients whom they are now keeping off the lists. To minimise the danger of provider induced demand, however, it is vital that agreement be met and criteria set for the levels of need to be attended.[2]

Upstream sources of rationing

While healthcare systems are inherently "inefficient" compared with most industries, NHS resources are substantially locked up in organisational, professional, and political arrangements that force rationing downstream. The real ethics of rationing should focus on these arrangements, for when moral philosophers or concerned individuals focus on how to ration fairly in a given situation, they in effect legitimate and support those who have set that budget or who benefit from institutional, budgetary, or professional arrangements that help produce the existing situation of scarcity. The first priority of moral philosophy is the ethical dimensions of the larger political system and institutional arrangements, not the ethics of individual cases. Now that bioethics has reduced paternalism in doctors, it is time to attack more powerful forms of paternalism

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upstream. This is the real ethics of rationing, the kind of bioethics we are developing at the Center for Bioethics at the University of Pennsylvania under the leadership of Arthur Caplan.[7] It holds that principlism (medical ethics deduced from abstract principles) has serious limitations and that bioethics must be fully engaged with the social sciences and empirical studies. I shall illustrate this approach by describing briefly some upstream causes of rationing faced by patients and their doctors.

Entrenched waste causes rationing

If the government and the healthcare professions seriously want to minimise the rationing of care to sick patients, they need to address the sorts of waste that have been identified by the Anti-rationing Group[8] —including overtesting, inappropriate prescribing, the organisation of follow up for new outpatients, and the provision of care by doctors that can be done by nurses.[9] The Anti-rationing Group has concluded that if these sources are eliminated, the waiting lists "would disappear within a year, never to return."

Beyond these documented forms of waste that lead to rationed services are other forms entrenched in the structure of the NHS, like budgets and contracts that protect hospitals, consultants, and general practitioners from more cost effective forms of integrated services through integrated contracts. Other forms of waste which I found seven years ago and which still remain lead to low productivity, high staff turnover, and gross underuse of facilities.[10]

The sociological and ethical point is that these forms of waste do not merely exist; they reflect powerful interests that give priority to their own concerns over treating sick patients on the waiting lists. They remain entrenched because there are no rewards or penalties attached to the degree of health attained or even to the amount of disability and pain caused by protecting forms of entrenched waste. Will the new government's "relentless war on waste"[11] and policy of integrated services take on these sources of waste?

Critical to reducing such waste and the need for rationing is the strong implementation of evidence based medicine.[12] So long as good outcomes are not measured and resources directed towards them, everything will be a "cost" without a benefit and wasteful practices will have equal weight with effective practices. As Muir Gray points out, the NHS must shift from maximising the number of episodes, as the efficiency index does, to maximising the number of effective interventions and beneficial outcomes. Fortunately, the new government promises to implement this historic change.[11]

Unnecessary rationing caused by inequalities

Inequalities in health care are an upstream cause of clinical rationing for less advantaged people downstream. The new government is committed to reducing differences in access for patients of fundholding versus non-fundholding practices, but this will leave three other forms of inequality that are more substantial and better documented: unequal funding between regions, unequal funding between districts, and unequal use of resources by general practitioners. Clinically unexplained variations in treatment and referral rates due to differences in "practice style" are forms of inequality that force others to be rationed.

Parasitic privatisation

Although private work is a fact of life, it should not exploit NHS patients and resources to create large inequalities that need not exist. But the NHS suffers from a two tier system of parasitic privatisation. One part consists of laws that allow private insurance companies to write policies that cherrypick the acute, easy cases and healthier people, leaving the NHS with proportionately more of the chronic, difficult cases and ill people. The private insurers also exploit subscribers; in recent years they have gone from keeping 11% of premiums for themselves to keeping 20%.[13] I know of no good moral defence of risk rated health insurance,[14] and bioethicists should insist on its being abolished. Just like a parasite that weakens its host, these laws foster more inequality and rationing. They need to be changed quickly, before private insurance expands, to laws that prohibit selection on the basis of risk and require community rated, egalitarian policies like those in Holland, Ireland, and other countries where insurance companies subscribe to these principles of solidarity.[15]

The other part of this two tier system causes a 30-fold difference in access to surgery between patients who can afford private care and NHS patients. One group waits 3-6 days, the other 3-6 months. This gap, I contend, is caused in whole or in part by an arrangement that rewards rationing surgery to NHS patients in order to maximise surgery to private patients. NHS surgeons do very little surgery in a week, averaging only 3-6 hours at the table compared with 20 hours at the table for full time surgeons elsewhere.[16-18] If NHS surgeons operated on NHS patients just 15 hours a week, NHS patients who now wait 3-6 months or longer would wait only 3-6 days, like private patients. Employers and subscribers would save millions in premiums they now pay for private insurance they would not need.

At the heart of this manufactured inequality that makes access depend on having money is a two tier system of little accountability, loose requirements, and the "maximum part time contract." This contract allows surgeons and other consultants to give up just 9% of their full time NHS salary in return for doing all the private work they want at rates that are many times their NHS rate of compensation. (The high private rates also mean that people with private insurance are paying much higher premiums than they need to.) Moreover, as consultants have explained to me in detail, they have to show up for a maximum of only 3½ days a week, giving them plenty of time to do private work on a nearly full time contract. To top it off, the surgeons control the waiting lists.

This arrangement provides strong incentives to minimise (that is, ration) operations for NHS patients and use the NHS as an operating base for maximising private work. The shortages in admission beds, theatre nurses, and recovery beds, as well as the short hours that NHS surgeons operate, can be partly traced back to the perverse incentives of this open ended invitation to ration services for NHS patients, with corrupting effects. I have been told by consultants that some surgeons walk out with NHS *x* ray films for their private patients under their arm. This is stealing. If a cook walked out with a ham, she or he would be arrested. Some surgeons work out deals with general practitioners to take care of their NHS patients promptly if the general practitioners will steer patients who can

pay over to their private practice. Some surgeons are said to manipulate their waiting lists and what they tell a given patient in order to get patients with money to go private. I am told that the distorting effects of these "sweetheart contracts" lead the minority who exploit them to believe that politicians and NHS patients should feel grateful for whatever work they do for the NHS, given the pittance of £50 000-70 000 of lifetime salary, plus pension and perks, they are paid for the 91% of the time they are supposed to spend treating NHS patients. As Frank Dobson says, staff find the effects of two tier medicine "repugnant,"[11] and the chairman of the BMA's Council, Sandy Macara, told the plenary audience at the Institute of Health Service Managements' June meeting that he thought consultants should work full time for the NHS.

Given the reality of private work, consultants should work full time for the NHS or full time for the private sector. Consultants should not manage the waiting lists. They are a payer's tool for maximising equity and efficiency in allocating work. Most consultants dedicate long weeks to helping NHS patients, but as the 50th anniversary of the NHS comes up, this structure for manufacturing inequality should be eliminated. A central plank of the new charter for the NHS in 1998 should be "to provide effective treatment at minimal cost in an equitable manner."

Conclusion

Concern about rationing should focus on how to minimise it in the first place, by eliminating large sources of waste built into the organisation and structure of the NHS and by ending parasitic forms of privatisation that allow the privileged to ration ordinary citizens. If the new government delivers on its deep commitment to equality, most forms of rationing and long waiting times will come to an end.

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Health in China

Traditional Chinese medicine: one country, two systems

Therese Hesketh, Wei Xing Zhu

Summary

China is the only country in the world where Western medicine and traditional medicine are practised alongside each other at every level of the healthcare system. Traditional Chinese medicine has a unique theoretical and practical approach to the treatment of disease, which has developed over thousands of years. Traditional treatments include herbal remedies, acupuncture, acupressure and massage, and moxibustion. They account for around 40% of all health care delivered in China. The current government policy of expansion of traditional facilities and manpower is being questioned because many hospitals using traditional Chinese medicine are already underutilised and depend on government subsidies for survival. Research priorities include randomised controlled trials of common treatments and analysis of the active agents in herbal remedies. As more studies show the clinical effectiveness of traditional Chinese medicine, an integrated approach to disease using a combination of Western medicine and traditional approaches becomes a possibility for the future.

An ancient textbook

Over thousands of years traditional Chinese medicine has developed a theoretical and practical approach to the treatment and prevention of disease. The first documented source of Chinese medical theory, the Huangdi Nei Jing ("Inner Classic of the Yellow Emperor") was written between 300 BC and 100 BC. It describes the diagnosis and treatment of a huge range of disorders and gives advice about healthy lifestyles, exercise, and diet which conforms remarkably well with current recommendations for the prevention of chronic disease. There is also accurate dietary advice about how to avoid micronutrient deficiency diseases such as beri-beri, xerophthalmia, and goitre.[1]

This is the last in a series of five articles on changing aspects of health care in China

Centre for International Child Health, London WC1 N1EH
Therese Hesketh, *research fellow*

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Health Unlimited, London SE1 9NT
Wei Xing Zhu, *programme manager, East Asia*
Correspondence to: Dr Hesketh.

As with most forms of traditional medicine, the theoretical and diagnostic basis of traditional Chinese medicine cannot be explained in terms of Western anatomy and physiology. It is rooted in the philosophy, logic, and beliefs of a different civilisation and leads to a perception of health and disease that is alien to Western scientific thinking. But it is an entirely coherent system, with internal logic and consistency of thought and practice.

In the early 1950s it was feared that traditional Chinese medicine would be superseded by the "more modern" Western medicine. To counter this, a systematic assessment of the effectiveness of the traditional treatments was thought necessary. So thousands of experiments and clinical studies were carried out during the 1950s. Most were case series of patients with a specific Western disease who were then treated with traditional techniques—for example, a series of 112 cases treated for angina pectoris and another of 121 cases of bronchial asthma treated with subcutaneous acupuncture. The result of all this research activity was that in 1958 it was declared that traditional Chinese medicine and Western medicine should be given equal respect and place in the healthcare system.[1] Since then there has been a consistent policy of support for the traditional system.

The treatments

The main traditional treatments are herbal remedies, acupuncture, acupressure and massage, and moxibustion. Acupuncture and herbal medicine are most widely used. The basic idea of acupuncture is that the insertion of fine needles into certain points can restore internal balance; it is the internal imbalance which leads to illness. Each acupuncture point has a defined therapeutic action, and a range of points is usually used. Acupressure simply means applying pressure to the acupuncture points, and moxibustion means applying heat to them. In the West acupuncture has become associated with analgesia, its appeal being increased by plausible biological mechanisms for its action (such as the gate theory and endorphin release). It also gained fame for its use in operative anaesthesia, but it is rarely used for this now.

Doctor trained in traditional Chinese medicine weighing out herbs in the traditional Chinese medicine hospital in Hangzhou

Herbs are used much more commonly than acupuncture. The first pharmacopoeia was written at the time of the Nei Jing. The substances used range from herbs and minerals to rather strange animal products such as cows' gallstones or parotid gland secretions. The traditional doctor usually chooses from around 500 common classical prescriptions. Typically these are combinations of some five to 15 herbs that are boiled up together to make a drink.[1] Nowadays many formulations are available in the more convenient form of tablets, capsules, and ampoules. The pharmaceutical industry is booming: sales of Chinese medicine increased by 52% between 1988 and 1992 (and sales of Western medicine increased by 51%).[2] The licensing of drugs and official regulation of their sale is equally stringent for Western and Chinese medicines. But in these days of the market economy, unregulated medicines are widely sold and many products are available over the counter. It is estimated that only 20% of China's hospitals buy medicines from licensed state wholesalers, because the black market products are much cheaper.[3]

Two systems of medicine

China is the only country in the world where Western medicine and the traditional medicine work alongside each other at every level of the healthcare system. Traditional Chinese medicine has its own department at the Ministry of Public Health and at provincial and county Bureaus of Public Health. It has its own medical schools, hospitals, and research institutes.

Overall, it is estimated that 40% of health care in China is based on traditional Chinese medicine, with a higher proportion in rural areas.[2] This figure does not include the massive amount of self medication with traditional drugs, which are used not only to treat illness but also as health promoting drugs, ranging from nutritional supplements and tonics to aphrodisiacs.

Every city has a hospital practising traditional Chinese medicine, and there is a plan for every county to have one. In 95% of the hospitals practising Western medicine there are departments of traditional Chinese medicine, most with inpatient beds; when patients arrive at the outpatient department they can opt for Chinese or Western treatment. In Jiangsu province, one of the richer, more sophisticated eastern provinces, one quarter of all outpatients in one year (10 million) had opted for traditional treatment.[4]

The collaboration between the two systems is well illustrated by the fact that in Western medicine hospitals around 40% of the medicines prescribed are traditional. Similarly, in the traditional hospitals 40% of all prescribed drugs are Western medicine.[3] At township and village levels, doctors often prescribe both types of treatment simultaneously, without apparent contradiction. A survey carried out in two village health clinics in Zhejiang province showed that children with upper respiratory tract infections were being prescribed an average of four separate drugs, always a combination of Western and Chinese.[5]

Training in traditional Chinese medicine varies from family apprenticeships to three to five year university training at a college of traditional Chinese medicine, though the educational standard of these undergraduates is generally lower than their counterparts at the Western medical schools. All Western

Signs at the reception desk in Nahe County Hospital, Heilongjiang, show the choice of Western and Chinese medicine. Consultations cost 1 yuan (7.5p); emergency consultations cost 1.5 yuan and a specialist consultation costs 3 yuan

medical schools devote around 10-15% of curriculum time to traditional Chinese medicine, so all doctors have some traditional training. Nurses too are trained in both and many perform acupuncture and acupressure independently.

Expansion of traditional Chinese medicine

Central government continues to have a policy for expansion of traditional Chinese medicine. An increase in the number of traditional doctors is one of the priorities for manpower development; their number continues to increase and is now over 300 000. In addition, 20% of the planned increase in hospital beds is to be for traditional Chinese medicine[6]; since 1985 there has been an annual increase of 8% in inpatient beds.[3]

But the wisdom of this planned expansion is being questioned, especially with the pressures of the health-care market. Many traditional hospitals operate at a deficit. The better equipped Western hospitals, with their better qualified staff, attract more patients. In addition, traditional Chinese medicine is largely an outpatient, low technology specialty, so most of the income of traditional hospitals comes from the sale of drugs. Even with the 25% markup allowed, it is hard to cover operational costs. Government subsidies currently ensure survival, but there is no surplus for improving services.

A study of six traditional hospitals at county level in Jiangxi province found them all to be to be underutilised and overstaffed.[3] The authors questioned the wisdom of continuing the support and expansion of traditional hospitals, which it seems is being done to protect the specialty rather than to meet need. Resources would be more efficiently used by strengthening the traditional Chinese medicine departments in Western medicine hospitals, where support services are better. This would reduce dependence on government subsidies and improve efficiency.[3]

Research priorities

Traditional Chinese medicine has become a source of great interest to the international research community. It is acknowledged that many of the treatments have enormous potential and could be utilised more widely. With this in view, research is essential in a number of areas. Firstly, randomised controlled trials are needed to establish the effectiveness and safety of treatments. There is still a real shortage of controlled trials of the effectiveness of traditional Chinese medicine and there are almost no double blind, placebo controlled trials. In China such trials are considered unethical because it is wrong to withhold potentially beneficial treatment.[1] But the need for such trials is being increasingly recognised, and several are underway in China and other countries. The herb trichosanthin is undergoing trials by the Food and Drug Authority for use in treating AIDS.[2]

Secondly, from a Western standpoint, there is a need to identify the biochemical composition of the active agents in many of the herbal preparations. This approach has been successful in research into the anti-malarial drug qing hao su. This herb has been used in China for treating fever for over 2000 years. In 1971 it was found to have specific antimalarial activity and the active compound artemesin was isolated. In clinical trials, parasite clearance times were shorter than with chloroquine, symptoms responded more rapidly, and there was no serious toxicity.[7] Qing hao su has now become a first line drug for malaria in many parts of Asia.

Thirdly, research is needed to determine which illnesses are best treated through one approach rather than the other. In China, Western medicine is often regarded as more effective in acute situations or where the aetiology is known, while traditional Chinese medicine is more effective for immune conditions, chronic illness, or where the aetiology is unknown.[1] But in practice simultaneous use of both types of treatment is so commonplace that the individual contributions are hard to assess. If the two systems are to be truly complementary more research in this area is essential to facilitate a more rational approach.

As China has opened up more to the West there have been concerns that traditional Chinese medicine would be superseded by Western medicine. This has happened for many types of acute illness, but the opposite has also happened: medicine in the West has become greatly influenced by traditional Chinese medicine. As more studies show the clinical effectiveness of traditional Chinese medicine, an integrated approach to disease using a combination of both forms of treatment becomes a possibility. This may transform the practice of medicine in the new millennium.[2]

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