Testimony

Implications of U.S.–China Collaborations on Global Health Issues

Addendum

Jennifer Bouey

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Implications of U.S.–China Collaborations on Global Health Issues

Testimony of Jennifer Bouey[1]
The RAND Corporation[2]

Addendum to testimony before the U.S.–China Economic and Security Review Commission

Submitted August 19, 2019

Following the hearing on July 31, 2019, the commission sought additional information and requested answers to the questions in this document. The answers were submitted for the record.

Question 1

How long will it take to implement your recommendations?

Answer

In my testimony on July 31, 2019, I provided a brief overview of China's global health assistance activities and summarized U.S.–China collaborations on global health issues. I suggested that China has increased its contributions in promoting the health of resource-poor communities in recent years through its Chinese Medical Team Program dispatches; the construction and expansion of hospitals and medical facilities in partner nations; training programs in health care professions; public health and health security program support; and pharmaceutical donations, production, and investment. China's contributions are largely motivated by its global ambitions, but its current efforts are still dwarfed by the global health assistance programs led by the United States and other developed countries. However, unlike many developed nations, China's global health assistance activities focus more on infrastructure building than on targeting specific diseases. As a consequence, in Africa, governments more

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often go to the Chinese government for infrastructure-building support but turn to the West for help with research and comprehensive disease control programs.

My recommendations for what the United States can do to aid in developing China's global health assistance programs include continued U.S.–China collaboration on building global health capacity, as well as increased coordination between the programs of the two nations. Capacity building for China's health assistance program will require the creation of more global health academic curricula that can be integrated into China's higher education system, as well as a consistent on-the-job training program. In addition, the United States can encourage the Chinese government to continue efforts to centralize aid programs, allowing them to increase effectiveness and transparency. If these changes are implemented, I believe that China can produce a highly competent global health workforce within the next decade. These changes require substantial political will from both the U.S. and Chinese governments and China's continued engagement with multilateral international organizations.

In terms of the "China threat," specifically in regard to the questionable quality of active pharmaceutical ingredients (APIs) supplied by China, the illegal fentanyl supply coming from China, and competition posed by China in the field of biomedical research, I suggest the following U.S.–China collaborations.

Short-, Medium-, and Long-Term Collaboration

In the long term (ten to 15 years), the United States can assist China in improving its regulatory capacity for the development, manufacturing, and delivery of medicine, medical products, and vaccines. In the medium term (three to five years), the two countries can collaborate on building public health surveillance programs that target illicit synthetic drug production and synthetic drug abuses, similar to the countries' collaboration on the successful influenza surveillance program (described below). In the short term (one to three years), the United States can engage China in multinational efforts to address global synthetic drug issues.

The long-term solution will depend on the Chinese market's successful consolidation of its currently fragmented pharmaceutical industry, the extent of capacity building in biomedical regulatory science, and China's willingness to harmonize its regulations with other countries. This may take decades. Building U.S.–China collaborations to address illicit drug use and production obviously depends on the relationship between the two countries and might take three to five years (as with the influenza surveillance system). If China is invited to join an international alliance to combat synthetic drug abuse, I believe many of the legal and public health actions required will be initiated relatively quickly.

Learning Lessons from Public Health Programs

Collaborations should take advantage of lessons learned from China's tobacco control and influenza surveillance programs.

In the case of tobacco control, the Chinese government changed its attitude from prolonged noncooperation to active participation with the World Health Organization (WHO's) Conventional Framework for Tobacco Control (CFTC). Chinese physicians first called for action against tobacco in the 1970s, but not much happened until China ratified the CFTC in 2005.

Within three years, the University of California, Los Angeles and the Yuxi Bureau of Agriculture were participating in a joint four-year tobacco crop substitution project. Also in 2008, Johnson and Johnson was invited by the Party School of the Central Committee of the Communist Party of China to conduct two years of research on tobacco. Johnson and Johnson's report, *Tobacco Control: International Experience and China's Strategy*, was a tipping point. Many changes happened within the next three years, including directives to government officials; regulations issued by the Ministry of Education; tobacco clauses in national advertising and philanthropy laws; the creation of a smoke-free Beijing; an increase in tobacco taxation; and a national smoke-free law.[3] Most scholars still attribute the Chinese government's attitude change to the CFTC, because it helped erase the Chinese idea that "China is a special case" by establishing universal standards and by calling on China to be a model for public health.[4]

In the case of influenza surveillance, the Chinese government invested large amounts of funding to expand the surveillance system after the U.S. Centers for Disease Control and Prevention (CDC) helped China build its surveillance capacity. In 2004, China's National Influenza Center and the CDC's influenza division signed a collaboration agreement. In 2005, the network of influenza laboratories increased from eight to 63 and the number of sentinel hospitals rose from 31 to 197. In 2007, the CDC and its Chinese counterpart signed an additional collaborative agreement on emerging diseases (including influenza); within two years, the Chinese government provided funding to expand the network to 411 laboratories and 556 sentinel hospitals in 2009. The enhanced network shares data between China and the United States and with the WHO.[5]

Question 2

What costs are associated with implementation, and who might oppose your recommendations?

Answer

Promoting multichannel collaborations for capacity building between the two countries' governments may be more feasible and cost effective than other measures, such as bringing the API industry back to the United States, adding insurance to API imports, or pushing for the Chinese government's agreement to a dramatic expansion of the Food and Drug Administration (FDA) regulatory program in China. Bringing the API industry back to the United States could raise the cost of API because of higher U.S. labor costs. Adding insurance to API imports could also add to the cost of API. Those costs would likely be transferred to the cost of healthcare in

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[3] Judith Mackay, "China: The Tipping Point in Tobacco Control," *British Medical Bulletin*, Vol. 1, No, 1, 2016, pp. 15–25.

[4] Mackay, 2016; Gonghuan Yang, "Introduction: China and the negotiation of WHO FCTC," in *Tobacco Control in China*, Singapore: Springer Singapore, 2018.

[5] Yuelong Shu et al., "A Ten-Year China-US Laboratory Collaboration: Improving Response to Influenza Threats In China and the World, 2004–2014," *BMC Public Health*, Vol. 19, Suppl. 3, 2019, p. 520.

the United States. Further FDA expansion in China would mean that the U.S. government would have to provide significantly more funding and personnel to its Chinese offices. Taking a public health approach, such as expanding collaborations between the CDC and its Chinese counterpart, could cost less and encourage the Chinese government to invest in its own capacity building.

At the same time, I do not think that the problems raised at the hearing—the quality of API from China, the fentanyl supply chain, the expansion of China's global health assistance programs, China's progress on biomedical research—are motivated by intentional hostility toward the United States. Most of these problems are the result of China's slow adaptations in regulatory policy, law, and management capacity, compounded by its fast-growing market economy. These are fixable problems and can be solved through potential collaborations across each field.

Those who are frustrated with certain Chinese government behaviors or who consider U.S.–China relations to be a zero-sum game might oppose my recommendations. Currently, the two countries are facing rising tensions and are going through a difficult and potentially critical moment in their relationship. The escalation of the trade war has profound psychological effects on the Chinese government and on investors within the Chinese stock market, which negatively affects the market itself as well as the exchange rate of the Renminbi. It will also likely negatively affect the confidence and expectations of the Chinese market.[6] The level of diplomatic dialogue has declined both in terms of substance of the issues discussed and the seniority of representation.[7] Even some U.S.–China academic collaborations and scholar exchange programs have been affected.[8] The combined effort of these strategies appears to hamper positive outcomes in potential U.S.–China collaborations.

This is a good time to ask whether opportunities for conflict resolution and consensus building between these two global powers still exist in the current negative political atmosphere. The deepening suspicion on both sides is leading both countries toward implementation of an "Iron Curtain" approach and a potential Cold War situation, likely leading to greater costs to both countries as well as to the global economy. As James Millward recently wrote,

> Yet decoupling is unrealistic; nor can the world afford for the United States and China to fritter away years waging cold war as the climate warms. The United

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[6] Lau, Lawrence J., *The China-US Trade War and Future Economic Relations*, Hong Kong: The Chinese University Press, 2019.

7 These include the following:

- U.S.–China Diplomatic and Security Dialogue (currently suspended)
- U.S.–China Law Enforcement and Cybersecurity Dialogue
- U.S.–China Comprehensive Economic Dialogue (currently suspended)
- U.S.–China Strategic and Economic Dialogue (closed)
- U.S.–China Social and Cultural Dialogue
- China–U.S. Science and Technology Cooperation Agreement (closed)
- U.S.–China Human Rights Dialogue (currently suspended).

[8] "Academics Caught in US–China Visa War," *Voice of America*, April 25, 2019. As of August 14, 2019: https://www.voanews.com/east-asia-pacific/academics-caught-us-china-visa-war

> States should thus both respectfully engage China and forthrightly confront the Chinese Communist Party, in pursuit of the human values we all share.[9]

In conclusion, global health is an area in which the United States and China have had many successful collaborations in the past, and their future collaborations have the potential to greatly benefit both countries and the entire world.

[9] James Millward, "We Need A Better Middle Road on China. Here's How We Can Find It," *Washington Post*, August 6, 2019. As of August 14, 2019: https://www.washingtonpost.com/opinions/2019/08/06/better-middle-road-china